

Frozen Tears: [Psychodrama](#) in the Resolution of Trauma and Grief

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“*The deepest pain has no words,*” echoes the ancient Chinese proverb. Today’s trauma theorists, it would seem, agree. Time stands still and so do we when something frightening is happening that doesn’t fit into our framework for “normal.” We freeze like a deer in the headlights- locked in a trauma response that was coded into us from the beginning of survival, from the earliest development of the human brain.

Relationship ruptures or losses whether of a spouse, a secure family unit, or a period in one’s life, can result in symptoms of post traumatic stress disorder PTSD (Van der Kolk, 1994, see “[Symptoms of Trauma and Addiction](#)”). Psychic numbing, along with the *fight, flight, freeze* responses associated with traumatic experience, can render us unable to respond coherently to what may be happening around us. The urges to run or fight along with feelings of disorientation, shutting down, or loss of connection with our inner world, if they persist through time, can make it difficult to conduct successful intimate relationships. When we rupture deep limbic or emotional bonds that have imprinted themselves on our neural systems we can feel “shattered” or “fragmented” making it difficult to pull the lost pieces of self together into a coherent whole. We may have trouble locating and describing our feelings because we have lost access to them due to the psychic numbing, dissociation or memory loss that often accompany trauma. Intense emotions such as sadness, that are an inevitable part of grieving our losses, can make us feel like we’re “falling apart” all over again and consequently we resist the grief process so necessary for healing.

Living with addiction is inevitably traumatizing. The chaos, neglect, abuse, or dramatic shifts between the *sober* and *using* world that often accompany addiction, affect both the addict and those close to the addict in ways that can become profound and pervasive. These dynamics alter our perception of normal, forcing us to make sense of two different realities each of which has its own code of ethics, morality and rules of engagement. The thinking, feeling, behavior, and emotional atmosphere are different for each world and often nearly impossible to integrate into a coherent whole. We never know where to find firm ground to stand on. We, “walk on eggshells” hold our breath and “wait for the other shoe to drop.” In short we become *hyper vigilant* constantly scanning our environment for signs of danger or a repeated rupture of our sense of safety and security.

Why trauma memories don’t get thought about

The part of our brain that responds to trauma developed early in evolution, in order to keep us safe from danger. The cortex, where we do much of our reasoning, critical thinking and long-range planning was an evolutionary “add on.” Consequently when we’re shocked or frozen in fear, critical thinking is greatly reduced. Memories may get stored without reasoning and rational thought attached to them, without being placed into an overall context or framework. “Flash frozen” they lie in wait for a stimulus to trigger them back to the surface. Yelling, violence, chaos, criticism, humiliation or something as seemingly subtle as a change in eye movement or vocal tone can make a previously traumatized person react with an intensity that has little to do

with the situation around them and much to do with what traumatized them originally. “*If it’s hysterical, it’s historical.*” The trauma survivor is reacting to the trigger situation with an intensity of emotion that belongs to another time and place which makes whatever is happening in the present confusing and difficult to work out. We’re *projecting* our distorted thinking and our emotional pain from a past situation onto a situation in the present. This constellation of PTSD symptoms, along with the pain they continue to create in our current lives through this process of projection, may drive someone toward self medicating with drugs, alcohol, food, sex, gambling – or whatever works to deaden a pain that is constantly threatening to reemerge. The past is recreated in the present and if there is no understanding or processing of these historical issues, the present comes to mirror the past and the torch of dysfunction gets passed down for one more generation.

Then there is the physical. Trauma is stored in the body, in the fascia that wraps itself in and around the muscle, in the brain that sends messages to the body to tense up, and in the musculature. A previously traumatized person may respond to being frightened or caught “off guard” with an exaggerated startle response, unusual physical tension, heart pounding, sweating, shuddering, teeth chattering, queasy stomach, as well as head or body aches. Their physical reactions then stimulate more traumatic memories such as flashbacks, or disturbing visual images. These traumatic memories, in return, stimulate more intense physical reactions, creating a vicious circle pulling them deeper and deeper into a reactive state. It doesn’t help that memory tends to be state dependent. That is, when we’re triggered into this state, we tend to be flooded with memories that match it. If our frustration, sense of helplessness and triggered memories give way to a rage state then our brain gets hijacked and any thought of getting out calmly is lost. This is due to the fact that during a rage episode, our cortex gets overwhelmed by the parts of our brain that are associated with traumatic memory storage. (So much for reasoning or rational behavior.)

Telling the trauma story

Sharing the trauma story and having it witnessed is a critical aspect of healing from trauma (Hermann 1992). Trauma memories can get split out of consciousness and consequently out of the emotional and psychological context of our lives. Words may not get attached to feeling states and memories that get stored in our unconscious may lack the advantages of rational thought. Sense is made of the events in the heat of a traumatic moment, when the cortex is not functioning properly, when we’re stuck in fight, flight, freeze. Or the meaning we make out of the events may be based on the developmental equipment available at the time the trauma occurred. When we tell the trauma story we revisit those times and spaces of our lives. We reach back in time and gather up the lost pieces of self in order to attach new insight and understanding to events that may have baffled, wounded or glued us to a place in the past that undermines our ability to live well in the present.

A living laboratory

Psychodrama allows us to *show* and *tell* our stories in body as well as mind. It helps to engage the grief process. The fact that it is an action method gives it a significant advantage in changing behavior both through exploratory, healing role play and role training, or practicing new

behaviors. It offers a living laboratory in which clients can view and experience their lives, comparing and contrasting differing sets of behaviors, separating the past from the present and making conscious choices as to what may work best as they move into recovery. Psychodrama allows protagonists to view the contents of their inner world before they are asked to reflect on it in the abstract (see "[The Process](#)"). This promotes the ability to self reflect, which can be difficult for trauma survivors who are removed from their internal experiences through psychological and emotional defenses.

How psychodrama works to resolve PTSD

Restoration of *spontaneity* or an adequate response to any given situation is the core of psychodrama. The *numbness, emotional constriction, and restricted range of affect* that accompany trauma can be worked through in psychodrama as clients begin to experience the parts of themselves that they have shut down or hidden from conscious awareness. Feelings that have been numbed find their way to the surface as group members witness and identify with each other's dramas while simultaneously exploring their own. Catharsis of emotional and psychological pain helps to engage the grief process. A *catharsis of abreaction* or direct release of anger or sadness gives way to a *catharsis of integration*, where feelings are reintegrated into the self with less intensity and more understanding. *Hypervigilance* lessens as clients learn to repeatedly tolerate the intensity of strong emotions in safety and *trust and faith* get rebuilt as they learn to *take in support* and caring from others. Feelings that have been *fused* together (Van der Kolk, 1987) such as sex and aggression or love and supplication, begin to separate themselves. The *learned helplessness* that developed from feeling that nothing anyone could do could change a painful situation for the better, lessens as the clients are placed at the center of their own experience and empowered to tell their stories through action and word. All of this helps clients learn to *modulate affect and behavior*, to move from *high intensity versus shutting down* to a more moderated state where thought, emotion, and behavior operate as a more integrated whole.

In psychodrama words can be attached to internal experiences and feelings that have previously been unlabeled. As this emotional literacy decodes and describes experiences, new meaning and insight are constructed. The loss of ability to symbolize and fantasize can lead to an inability to visualize and take steps toward actualizing a positive future. (Van der Kolk, 1987). In psychodrama, clients can visit their *futures* through role-play and face anticipated, wished for, or feared scenes for rehearsal and role training.

Psychodrama allows clients the opportunity to watch themselves, "as if in a mirror," (Moreno, 1937). The use of a *stand-in* to represent the protagonist allows clients to view themselves from the outside - a safe distance avoiding retraumatization. This encourages self-empathy as protagonists witness themselves struggling with circumstances that may, as children at least, have been out of their control. Clients regain the perspective that is lost in trauma and begin to separate the past from the present. Inherent in this separation is the realization that the past does not have to be mindlessly repeated.

Due to the deeply imbedded psychological defenses and memory loss that often accompany trauma, it may take considerable time and therapeutic work before the client is able to come to terms with the trauma story in its entirety. Resolution occurs when a person is able to direct their

attention towards or away from traumatic life material by choice (Van der Kolk, 1992), and when their spontaneous response to a situation shifts and is no longer driven by unresolved issues from the past (Moreno, 1937).

Tools and techniques

The following are samples of action-oriented tools that can be used in the resolution of grief and trauma issues. See page **XX** for self tests that can be used in assessing trauma and grief issues. For visual examples of psychodrama, see [The Process](#).

The Empty Chair is a psychodramatic technique that was also adopted by Gestalt therapy. An empty chair can be used to represent another person, an aspect of self, or a situation or object. In issues of grief and trauma much has often been left unsaid and unheard. A client can speak freely to the empty chair *as if* its contents were real – expressing hurt, anger, love, needs, and wishes that might have gone unspoken. Clients may also reverse roles and speak back to the self from the position of the other.

Transitional objects that hold particular meaning such as something belonging to a person who feels lost or that represent an aspect of self or a time in one's life, can be brought to therapy and described as to their particular meaning or talked to in the empty chair. In addictions work, a bottle, paraphernalia, a cigarette, or a trigger food are sometimes brought in and the relationship with the substance is explored.

Photographs can be very useful in concretizing the family, someone a client needs to talk about, or themselves from another time in life. Photos can be described, shared, or clients can literally speak to the person in the picture (Dayton, 1994).

Letter writing is an extremely effective therapeutic tool. Letters are shared in therapy only and should not be sent to anyone. The letter can be shared out loud, read to an empty chair, or a role player can represent a person or an aspect of self. A client can also write a letter that they would have liked to receive and can choose a group member to read it to them. **Letters can contain sorrow, anger, unmet wishes and needs, praise, forgiveness or whatever needs to come to the surface and be communicated within the safety of therapy.**

The Trauma Time Line allows clients to get a visual picture of the pervasive nature of trauma and how it has played out in their lives. The client is invited to create a timeline on a piece of paper that goes from birth to their current age with lines marking every five years, then to enter any traumas that occurred or felt significant in the appropriate place or places along the timeline. Once all have finished filling in their timelines invite them to share them out loud.. A Trauma Timeline helps to “recontextualize” split off experiences, reveal reenactment patterns and clarify when traumas actually occurred. The time line can be *psychodramatized* by allowing the protagonist choose roleplayers to represent the self at the various ages represented and talk to him/herself *reversing roles* wherever he/she feels it is necessary. This is an effective way to encounter, explore, and integrate parts of self that have been split off through trauma. (Dayton 2000)

Spectrograms are essentially imaginary graphs laid out on the floor that get clients up and out of their chairs and exploring issues by standing in the place along the graph that best represents their response to a particular question. Basically, one wall of the room represents “very much” (or 100 percent) and the opposite side very little (or 0 percent). There is an imaginary line going between the two walls mid room and another perpendicular line bisecting at the 50 percent mark. Using the question from the Grief Self Test, “how much depression do you feel” for example, the group member would stand at the appropriate place, e.g., 40 percent, 60 percent, etc. The group members are asked to “locate themselves any place along the line connecting the two walls that best describes their response to a question” and share a sentence or two telling why they chose that location. They may also be invited to share in subgroups with those close to them on the line if it’s a large group. This helps to create group cohesion as clients share with others who are having similar responses to a given question. It is one way the self tests can be used experientially; they can also be used as warm-ups for further group processing and sharing or psychodramatic work (Dayton 1994).

References

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition. American Psychiatric Association: Washington, D.C.

Corsini, Raymond J.,(1994) *Encyclopedia of Psychology*, second edition, John Wiley & Sons, New York, Chichester, Brisbane, Toronto, Singapore

Dayton, T. (1994). [*The Drama Within*](#). Health Communications, Inc.: Deerfield Beach, FL.

Dayton, T. (1997). [*Heartwounds*](#). Health Communications, Inc.: Deerfield Beach, FL.

Dayton, T. (2000). [*Trauma and Addiction*](#). Health Communications, Inc.: Deerfield Beach, FL.

Herman, J. L. (1992). *Trauma and Recovery*. Basic Books, a Division of Harper Collins Publishers: New York, NY.

Moreno, J. L. (1964). *Psychodrama*. Vol. I. Beacon House: Ambler, PA.

Van der Kolk, B. (1987). *Psychological Trauma*. American Psychiatric Press, Inc.: Washington, D.C.

Van der Kolk, B. (1994). *The Body Keeps the Score: Memory and the Evolving Psychobiology of Post-traumatic Stress*. Harvard Medical School: Boston, MA.