Shining a Light on the Blues: the Gift of Psychodrama

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addiction, antidepressants, anxiety, creativity and spontaneity, de-institutionalisation, depression, role theory, social atom, therapeutic community, therapeutic relationship

Introduction

Structural restrains, in terms of mental health funding, a biochemical narrative based on shaky evidence and the profit motive in Big Pharma, contribute to a pathologising cultural force which promotes a medical model that has reduced aspects of human suffering to an illness to be cured by drugs.

Psychodramatists, psychotherapists and counsellors can make a difference by providing psychodrama as a drug-free approach in working with depression and anxiety.

A special contribution of psychodrama is that the theory and practice of this method highly value and promote relationship and community as curative factors. Role theory and the notion of creativity and spontaneity impacting on the social atom, underpins and supports a respectful and normalising engagement with those labelled 'depressed'.

This article refers mainly to antidepressant use. Much applies also to medication for anxiety. I share some of my early formative experiences in mental health care, appraise recent trends, take a look at some evidence and give examples of clinical practice.

Once upon a time

In my mid-twenties, open-eyed, keen and eager to learn about human relations, I worked in the acute ward of a psychiatric hospital. I noticed that many of the patients seemed either not to speak, speak really fast or speak and make little sense. Some had a weird sluggish walk (aka the 'thorazine shuffle') or engaged in repetitive behaviours or looked dazed with their mouth hanging open. New to the field of mental health, it appeared to me that these were outward signs of mental illness and this explained why these patients needed to be medicated.

Over time I discovered that many of the 'weird' presentations I saw were the actual *result* of being medicated. Some patients were completely 'off their faces'. The overriding concern of the institution seemed to be that patients would 'accept their illness' and 'comply with medication'. Suicide was to be prevented through a chemical straight-jacket.

So-called 'group therapy', usually run by a psychiatrist, meant going around the circle of 20 to 30 patients and everyone getting a few minutes. In these brief moments, the psychiatrist's main focus was on checking that the patient was accepting of their diagnosis and complying with taking their prescribed medication. Talking back was pathologised as a sign of denial, resistance or illness. Submission and compliance would be interpreted as a sign of increasing wellness and this meant the patient was one step closer to discharge.

It appeared to me that patients would, as a standard, first be medicated or sometimes electro-shocked. Sometimes, a fuller interview would be attempted, usually behind a one-way screen in a soulless clinical room with not a single plant. The multidisciplinary staff on the other side of the mirror and thus invisible to the patient, would be commenting, sometimes judgementally, in the privacy of being safely screened off. Discussion would often centre around diagnosis and medication and focus on questions like: 'does the depression cause the psychosis or does the psychosis cause the depression?' The purpose of such discussions was to determine what medication would be used.

I met some wonderful staff; nurses, social workers and doctors who treated patients with deep respect and care. They did an amazing job in a terrible atmosphere and seeing these courageous staff in action gave me hope and inspiration. Yet, any attempt to build a truly therapeutic relationship with patients was thwarted by the fact that I could, with little notice, be assigned to another ward. At one time a patient with whom I had built a good connection was given electro-shocks and subsequently could not even remember my name or our previous conversations! Any activity that might stir up feelings, such as psychodrama, was unwanted as the orthodoxy required that 'we need our patients to be settled'.

One response to this story is: 'That was then, but surely we are not barbarians any-more?' to which I reply that I yet have to come across a publicly funded psychiatric clinic or hospital that gives patients an option of drug-free intervention.

De-institutionalisation, promoted as 'community care' was largely intended as a positive move respectful of personal liberty, yet was also motivated by an effort to cut costs. Many former patients now live on the street, end in prison or in rickety boarding houses.

Mike Consedine, a Psychiatric Nurse and inspiring in-service trainer, organised psychodrama workshops and I personally experienced its' power

and effectiveness. I began training in the method and learned about potent psychodramatic interventions. The mainly custodial model used in the psychiatric clinic led to me feeling under-utilised. I resigned in order to take up a position as therapist in the Therapeutic Community that was Queen Mary Hospital, in Hanmer Springs. I felt uplifted and encouraged by seeing many hundreds of patients coming off alcohol, illegal and prescription drugs. The hospital pioneered a beginning bi-cultural approach by instituting a Taha Maori programme. Through group sessions and individual therapy, lectures, films, a 'grief-group', many psychodrama sessions, hiking in the hills, dances and a communal soak in the thermal pools, patients came to relate well, understand themselves and their relationships and were helped to turn their lives around.

Robert Crawford, the Superintendent and inspirational leader of the hospital was for a while my mentor. He organised many stimulating training workshops with Max Clayton and Chris Hosking. He wrote a book about his experiences at the hospital (Crawford, 2008). Chapter three, with a focus on group therapy and psychodrama, is available on the Psychodrama Australia website.

Nowadays

The scarcity of available therapeutic communities is partially responsible for the rise in drug-treatment. Funding for mental health, instead of paying for more medics to prescribe ever more pills, could pay for the establishment and the training of people to staff such communities. The trend in mental health is to reduce things down to the level of the individual and the emphasis on this has an isolating and pathologising effect.

Psychiatry largely has learned to depend on psychopharmacology and left behind psychotherapy. The 'psychiatrist's bible' aka the DSM (Diagnostics and Statistics Manual), with each updated edition invents new 'disorders' which further squeezes and narrows the boundaries of what may be considered 'normal' functioning and legitimises drug treatment.

A psychodramatist who works as a psychotherapist or counsellor offers an in-depth relational approach, which includes a recognition of the complex factors that shape our expectations and experience of 'happiness' or well-being. These factors range from genetic, dietary, attachment styles, family, social, historical, economic, political, environmental and commercial, to spiritual or cultural. This focus supports a *systemic* approach.

Therapists and counsellors are not paramedics, doctor's assistants or quasi-psychiatrists. Our task is not to ensure that a client accepts a diagnosis of illness or to blindly suggest or promote 'compliance' with drug-treatment. Our mission is to work for the advancement of creativity and spontaneity and the freeing up of the creative genius in individuals and communities.

Psychiatric-identity formation

Many people with emotional, mental or interpersonal struggles have been advised by their doctor that they have an illness or 'biochemical imbalance' and are best to take antidepressants or tranquillisers. I regularly hear that patients are told they must take these drugs for the rest of their life. One of my clients said 'stuff that' to their psychiatrist and this person is now an effective and valued leader in the mental health field.

Accepting a diagnosis of 'illness', for some, can hold an attraction, as it suggests that 'your depression or anxiety is a disease that is *happening to you'* (that you're sick and therefore don't need to engage in the challenging process of examining your life and perhaps make changes).

Long-term antidepressant use may set patients up for more depression in the future. Study after study has shown that generally anti-depressants are no more effective than placebo treatment. Yet, placebos are cheaper and don't cause side-effects or withdrawal symptoms! Placebos' apparently similar effectiveness is a testament to the remarkable power of the mind.

Drug-companies: lifesavers or psychopaths in suits?

I support vaccinations and highly value medicine and science. Drugs can be most helpful in maintaining life or curing disease. Drug companies have made some amazing contributions to human well-being. At the same time, the current massive opioid crisis in the USA is the outcome of pure greed by the makers of such drugs as Oxycontin and have cost countless lives.

A place for drug-treatment

Generally, persons with mild to moderate depressive symptoms will benefit from attending to exercise, good nutrition and sleep, social connection as well as counselling or therapy.

There are times when taking prescription drugs for depression can be helpful, generally for a shorter period (say 6 months). Some effectiveness has been shown for drug-treatment of severely depressed persons. Medication, in these exceptional circumstances, can save a life by or help a person to get relief from debilitating symptoms and free up energy that makes therapeutic work possible. But when do we call someone 'severely depressed'?

Inflation

The definition of 'severely depressed' has suffered from inflation (like the word 'trauma'). When something like 10% of the population in the developed world is given a prescription for antidepressants, this means that either we must have an enormous epidemic of severe depression or a severe epidemic of over-prescribing!

About one in 10 New Zealanders are prescribed antidepressant medication each year. In Aotearoa, in 2017, the number of children and teenagers on Prozac-style antidepressants has soared 98 per cent in the previous 10 years to a total of nearly 15,000 young people. (Wiggins, 2017)

The review of 70 trials of the most common antidepressants, involving more than 18,000 people, found they doubled the risk of suicide and aggressive behaviour in under-18s. (Paludan-Müller et al, 2016)

Bio-babble

You have a 'biochemical imbalance', or so the story goes, and 'this drug will correct that unbalance'. The remarkable thing is that this assumption has been promoted as gospel. I have not come across evidence that depression is a medical illness or brain disease. No depressed person I know has ever had a blood test or other investigation to determine exactly what chemical might be missing. The diagnosis of depression is based solely on the person's subjective reporting of their state of mind. Lifestyle and cultural factors such as poverty and deprivation, abuse, oppression, colonisation, lack of exercise, alcohol use and diet are often overlooked in a standard 15-minute medical consultation.

The 'lack of serotonin' theory, because of its simplicity, is ideal for marketing purposes, yet is increasingly being challenged (with one researcher calling it 'bio-babble' — a play on the term 'psycho-babble'). It is not easy for doctors to engage in depth with a patient, in 15 minutes, when both are bombarded by the glossy brochures and clever marketing campaigns of the pharmaceutical companies who manipulate popular culture to increase their profit margins.

A critical look at some evidence

The results of clinical trials are frequently withheld, making it difficult for patients and prescribers to make an informed decision. The British Medical Journal has published an audit of 42 pharmaceutical companies, worldwide. The study concludes: 'Transparency commitments are highly variable between companies, with some making minimal commitments, or none at all. Many companies' policies were poorly worded and internally inconsistent.' (Goldacre et al, 2017)

In Primum Non Nocere: An Evolutionary Analysis of Whether Antidepressants Do More Harm than Good, the authors conclude: 'Our review supports the conclusion that antidepressants generally do more harm than good'. (Andrews, et al. 2012)

Peter C Gøtzsche, MD, a Danish physician, medical researcher, and former leader of the Nordic Cochrane Center at Rigshospitalet in Copenhagen, Denmark, and author of 'Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare', exposes the

pharmaceutical industry, both in research and marketing, as 'well-dressed organised crime'. He says:

> *The main reason we take so many drugs is that drug companies don't sell drugs, they sell lies about drugs. This is what makes drugs so different from anything else in life. Virtually everything we know about drugs is what the companies have chosen to tell us and our doctors. The reason patients trust their medicine is that they extrapolate the trust they have in their doctors into the medicines they prescribe. The patients don't realize that, although their doctors may know a lot about diseases and human physiology and psychology, they know very, very little about drugs that hasn't been carefully concocted and dressed up by the drug industry…* (Health Impact News, 2015)

David Healy, a former secretary of the British Association for Psychopharmacology, reports: 'Suicides in healthy people, triggered by happy pills, have also been reported. The companies and the psychiatrists have consistently blamed the disease when patients commit suicide. It is true that depression increases the risk of suicide, but happy pills increase it even more, at least up to about age 40, according to a meta-analysis of 100,000 patients in randomized trials performed by the US Food and Drug Administration.' (Healy, 2014)

Kirsch states: 'The serotonin theory is as close as any theory in the history of science to having been proved wrong. Instead of curing depression, popular antidepressants may induce a biological vulnerability making people more likely to become depressed in the future'. (Kirsch, 2014)

Reducing or eliminating

The long-term side-effects of anti depressant use are poorly researched. Blunting of emotional life, loss of sex drive and weight gain can all be part of the bargain. Withdrawing from antidepressants can cause anxiety, dizziness, vivid dreams, electric shock sensations, head zaps, stomach upsets, flu like symptoms, headaches, insomnia and.....depression and suicidal thoughts!

Generally, the longer a person has taken these powerful mind-altering drugs, the longer a withdrawal period is required. When a person stops their medication too quickly and relapses into a depression, then this is often seen as evidence that 'the disease has returned' and the best thing to do is to 'accept there is an illness' and resume taking drugs, take a different drug or increase the dosage (described by one client as 'the pharmaceutical lucky-dip').

Looking forward

A drug-free approach

I generally do not advise my clients to stop (or take) medications. Any reduction in, or withdrawal from medications is initiated by the client. The client drives the process. My function is to support the client in their autonomy and self-determination. We work together to determine the level of motivation and readiness. We also collaborate in devising a solid plan, with back-ups and a support-team. Any reduction of medication must not be done impulsively. Even though some manage a 'cold turkey', withdrawal best takes place thoughtfully and gradually and with support (generally the longer a person has been taking medication, the longer the withdrawal period). We chose a time with as few other stress factors as possible. Collaboration with a GP or psychiatrist or case worker is ideal. Some GP's are hostile to the idea of reduction and the client may get a scathing response. In these situations we find a friendly GP who is willing to collaborate in supporting the patient in their attempt to go drug-free.

Social and cultural atom

If clients are not to rely on having their biochemistry altered by drugs then the resulting vacuum needs to be filled with people and positive relationships. Deeply felt positive social experience affects biochemistry, naturally.

Role Theory (sometimes referred to as Role Dynamics) is a humane alternative to labelling. It attempts to describe all behaviour as interpersonal, taking place *within* relationships. In naming a role, the values a person has which underpin behaviour, are taken into account (we can discover the value by completing the sentence 'the world works best when.......').

Some clients, in a first session, may say: 'I feel depressed'. As depression is actually not a feeling but *a state of being*', I may respond by inviting 'imagine that the word *depression* doesn't exist, and now describe your experience — what words come up?' When someone claims to 'have' social anxiety, I might explore how it is that they fear judgement and rejection. A naive curiosity helps in discovering the fullness of the whole person. Whenever a person uses the word 'depressed', I keep a gentle look out for *repression* of feelings or where in their life they might experience *oppression.* Any assessment or diagnosis (meaning 'to know thoroughly') greatly benefits from taking into account *sociometry*: a mutual flow of feeling within the dynamic tapestry of affiliation; parents and children, friends and enemies, spouses, colleagues and neighbours, past and present. Sociometry exists within a social and cultural atom (an instrument for the assessment and working with interpersonal relationships which gives an in-depth description of networks of relationships and role-relationships). An individual's story can only be made sense of and worked with, within the context of their social and cultural atom.

True insight is followed by action: to know means to act

Role Theory is used to create a picture of a Social and Cultural Atom and offers a humane approach to describing behaviour, as it avoids labelling or any judgemental process (but does include appropriate judgement). Role descriptions are the result of collaboration between client and practitioner and are never imposed. In a psychodrama group-setting, everyone can become involved. A role name attempts to capture the whole functioning of a person at a given moment in response to a person or object. Through the significant joint-effort involved in the accurate naming of roles and counter-roles, it is possible to gain a deep understanding of the dynamics involved in relationships.

An analysis is half the work done. The other half consists of action. Any role-analysis is imbued with the notion that all humans are endowed with the capacity for creativity and can act on this by mobilising their spontaneity. The deep understanding gained through role-analysis is made relevant through warming-up to a creative act, a fresh, vital, flexible and fitting response. This act may be in relationship to self or another person or group and leads to *social atom repair*. Role-development moves in a direction from Fragmenting to Coping to Progressive.

Warm-up is of the essence

Working effectively with those withdrawing from psychiatric drugs is not done through painting by numbers and neatly following the prescribed steps. A formulaic approach won't cut it. Our clients need to experience us as a thoughtful, involved, kind and curious human who will respond with vitality and care. In order to be of assistance the therapist themselves needs to experience a joy in life and a love of people. What a therapeutic relationship can offer has to be more powerful than what a drug can muffle. In arriving to this work well-informed, it pays to read some supportive literature.

Peter Breggin has written a handbook for 'Prescribers, Therapists, Patients and Their Families', called: "Psychiatric Drug Withdrawal" which is an excellent guide. (Breggin, 2013) He offers an informed and humane approach to patients seeking to reclaim their lives and I suggest this as a good read to all psychodramatists who wish to work in this area. Breggin's advice dovetails beautifully with a psychodramatic approach.

A few examples from practice

(Permissions have been gained and identities have been disguised.)

Mary

A woman who gets beaten by her husband and is desperate, finally makes it to her GP and dutifully answers the list of stock questions. She is passive and too ashamed to disclose the abuse at home. The doctor does not ask or

probe. She is prescribed antidepressants and goes home. After 2 years of dutifully taking the pills, she musters the courage to reject the 'sick' label. She seeks out a psychotherapist. She withdraws from medication. She joins a psychodrama group which helps to expand and enrich her social atom. The pills acted as a chemical soother that helped her to endure the abuse a bit longer. In the group-setting she receives doubling (a dynamic two-way empathy). Over time she becomes ready to receive a mirroring of her self-blame and passivity in the face of violence. She becomes focused on addressing herself as a long-suffering martyr and effectively confronts her husband's behaviour and their relationship.

John

When John visits his GP, he complains of anxiety, depression and insomnia. What he avoids to mention is that he has had three affairs in the last six months and has been busy lying to all three as well as to his wife. Who, living his kind of life, would not be anxious and have trouble sleeping?

The GP too is anxious. He worries about getting a complaint if he doesn't prescribe and 'something happens'. He prescribes anti-depressants and sleeping pills and he (the doctor) feels better already!

John goes home and plays on his wife's sympathy for his 'illness'. He has no motivation for change. Medication helps the couple to continue an awful status quo. Nothing changes until his wife makes a move that unmasks the devious cheat behind the so-called sick sufferer. Now the truth is out, the work can begin. Instead of anxiety, depression and insomnia being seen as the problem, now lying, conflict-avoidance and truth are being addressed.

Chloe

A young woman, aged 18, is referred by her parents. They are concerned that she spends her days in bed and nights on her computer. She has dropped out of school and has no job. Her parents' main concern is that Chloe hears voices and hallucinates and therefore they avoid pushing her in any way. They wonder if she is schizophrenic or bi-polar, as this 'runs in the family'. They also wonder if Chloe should be on medication and they ask for an assessment. I meet with Chloe. She presents as a quiet, pale and pimply young person, who withdraws behind her hoodie and squints at me suspiciously.

I find out that her parents have adopted a number of troubled children and were pre-occupied with the immense need these children represented. Chloe (their only biological child) has felt badly neglected. Over the last few years, without her parents knowing, she and some of her mates, like wild escapees, have had a number of weekend benders on a cocktail of alcohol and other recreational and prescription drugs. She shares that she hears a frightening and intimidating voice that others can't hear.

In the second session we have a psychodramatic production in my room, using cushions and chairs. I ask Chloe to help me understand how she experiences the voice by her becoming the voice and speaking as the voice to herself. She expresses herself as the voice of a condemning judge: 'You are a useless piece of crap, go on, why don't you just knock yourself off, you loser?'

In the interaction that follows, she lets me know how fearful she is and how she freezes in response to hearing the voice. I double her as a frightened frozen sufferer and we continue to work to develop her ability to talk back. We return to the scene and Chloe expresses curiosity and assertion in response to the put-downs. She feels motivated to act her own version of talking back and she does so with fervour.

I worked with the hypothesis that the voice was an expression of her low self-valuing in response to perceived neglect. Her feelings were distorted and amplified through isolation, computer overuse, a mix of alcohol and drugs and a topsy-turvy day-night rhythm. She had identified with other troubled youths in her life and 'done some bad shit', which further reduced her self-esteem. That the 'voice' was an expression of a condemning judge was confirmed by the fact that the voice appeared mainly in situations where she felt appraised or evaluated, such as in a job interview or meeting new people for the first time.

In the third session Chloe reports that she has hardly heard the voice and feels relieved.

She has committed herself to a normal day/night rhythm, a healthier diet, daily walks and no alcohol. She has been looking for a job and is encouraged to 'get on the horse' and socialise with those friends who are going places. She makes changes to the composition of her 'leisure-time social atom'.

In subsequent sessions she reports that the voice has appeared only briefly — just before a job-interview or when meeting the parents of her boyfriend for the first time. Each time she was able to talk back. When I tell Chloe that she is an inspiration, she seems to glow. Her face now has colour and there is a new liveliness in her being. Her life was on track as 'a psychotic young person on tranquillisers in supported accommodation'. Instead, she now has positive relationships and a fresh direction in life, She dares to have hope for a future.

Andrew

There is a long-term risk when anyone, especially a teenager, slips into the identity of a 'mental-patient'. A possible consequence of this and the significant work involved in social re-connecting are illustrated by the following vignette:

Andrew, now aged 40, has been on antidepressants since 15. At that

time his parents has just separated. He lived with his mother and became her confidante, mummy's little helper, whilst his brother stayed with his father. This situation tore him apart and he started bunking school and had emotional outbursts. His mother had become an alcoholic and never addressed her addiction. She took her son to their GP and, once on medication, Andrew numbed out and fitted in with his mother's needs and demands. He became a 'good boy'.

A medication history (two A-4 pages!) reveals what he calls 'the pharmaceutical lucky-dip' he had been exposed to over 25 years.

Andrew could talk the ears of a person. Half an hour of talking without pause gave the impression of a manic person and this had been a factor in him being diagnosed bi-polar at one stage. However, by checking the side effects of the three medications he was on, we learned that two of them had a stimulant effect!

Andrew takes a year to slowly reduce, one drug at a time, 10% or 15% at a time. Once he is emotionally stable on a new dose he further reduces. If he has a 'relapse' of symptoms then he goes back to the previous dose on which he was stable. Once stabilised, he will try again. His best chance is when he chooses a time of low-stress.

We collaborate in making a sociometric assessment of the people in his life who will support him in his desire to become free of prescription drugs. A support-team is established, so when he feels low, needs to talk or cry or rage, he has somewhere to go. This support team has also been educated as to what kind of behaviours they might expect when Andrew has withdrawal reactions. Instead of panicking through ignorance, they can support him through kind and accurate doubling and mirroring.

He has engaged in swimming and yoga and these activities help to regulate his mood.

His GP, who was scathing of his wish to reduce medication and suggested yet another psychiatric referral, has been sacked. He is now with a new GP who respects his autonomy and self-determination.

In sessions he wants to talk about his early life as a teenager. He is grieving what he has lost as a result of his 'psychiatric career'; not having had children as well as the loss of what could have been a science degree. My response is to listen, double and double some more and maintain a humane and friendly atmosphere. Any in-depth therapeutic work on the early conflicts in his life is mostly postponed until he is medication-free and we both know that what he is experiencing is not distorted and/or amplified by a drug or the withdrawal of a drug.

He has days when he already feels a lot better as well as some darker days. We are catching up with the pain of what was numbed for 25 years. I know that I will be working with Andrew for some time yet.

Conclusion

I hope that, by reading and taking in this article, psychodramatists everywhere are encouraged and feel emboldened to creatively engage in working with those in a deep funk or labelled depressed. I wish you satisfaction and joy in imaginatively applying the psychodrama method in building and restoring relational health between individuals and communities.

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