Australian and
New Zealand
Psychodrama
Association, Inc

JOURNAL

No.5, December 1996

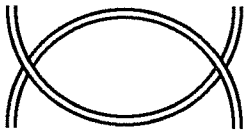
Psychodrama

Sociodrama

Sociometry

Role Training

Group Work



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ANZPA JOURNAL

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This Journal is published by the Australian and New Zealand Psychodrama Association Inc. (ANZPA).

ANZPA Inc. is an organisation of people trained and certified in the psychodrama method and its applications and developments as a Psychodramatist, Sociodramatist, Sociometrist, Role Trainer or Trainer, Educator Practitioner (TEP).

The purposes of the Association particularly include professional association with one another, the setting and maintaining of standards and promoting the establishment and reputation of this method.

Members associate particularly within its geographical regions, at the annual conference, through regular bulletins and this Journal.

This Journal has been published to bring about these purposes through the dissemination of good quality writing and articles on the psychodrama method and its application by practitioners in Australia and New Zealand.

Front Cover: **Detail from the 'Love Sofa' Zagorsk, Russia, circa 1904**

The 'Love Sofa' is in an artists' colony in the forest, just outside of Zagorsk, an ancient town on the Golden Ring and the centre of Russian Orthodoxy since the 11th Century. Many artists, sculptors and painters can trace their heritage right back to this time. The Love Sofa is a garden seat fully inlaid with mosaic. It is situated on a little rise in the forest, with a view of a windy country road and green glades. There is an atmosphere of timelesness in this place of spruce and birch – fresh, green, quiet and inviting. Zagorsk, on the other hand, is a hive of activity. Monks clad in black draw water from a natural spring and bustle around the large and beautiful monastery – the Troitse Lavra.

Photograph by Sue Daniel, Melbourne.

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continued ...

Mainstreaming Moreno

Teaching teachers to use Action Methods

by Keith Tyler-Smith

Keith is an advanced trainee working towards certification as a Role Trainer with the Christchurch Institute for Training in Psychodrama. He is the programme leader for a degree course in Television Production at the New Zealand Broadcasting School, Faculty of Arts and Broadcasting Media at the Christchurch Polytechnic. He recently designed and delivered a course on Action Methods for Polytechnic tutors as a module for the Certificate in Adult Teaching, a national qualification for teachers in tertiary education.

Introduction

At the 1996 ANZPA conference in Brisbane I attended a workshop run by Elizabeth Synnot, in which she used Sociodrama to set out a series of principles to be considered when working psychodramatically with commercial, government or other organisations. The main thrust of these principles were that, to achieve recognition and acceptance by the organisation you are working with, it is necessary to understand and use the cultural norms and language of the organisation and to frame the methods you are using with their own workplace terms and practices.

This article describes how a course on *Advanced Action Methods for Teaching Professionals* was designed, approved and taught for the staff development unit of the Christchurch Polytechnic as part of their Certificate of Adult Teaching (CAT) programme. This course is one module in a series of courses that make up the Diploma of Adult Teaching, a nationally recognised qualification for tertiary level tutors.

The challenge was to design a course that met the needs and requirements of a teaching institution while at the same time preserving the essential principles of spontaneity, role development, sociometry and warm up, as developed by J.L. Moreno.

Changing direction

Three years ago I changed careers and became a Polytechnic tutor, teaching television production in a degree programme. The previous seventeen years had been spent directing and producing television programmes for the national state owned television network, so the change in careers was not wildly dramatic, particularly as I had also done some part time teaching before being appointed a full time tutor.

My adaptation to the teaching role was further eased by virtue of the nearly five years of psychodrama training I had done to that point. This helped considerably in developing those roles associated with managing the group dynamics of the class and being a facilitator of student learning. I also actively took what opportunities I could to use *Action Methods* in my classroom teaching work.

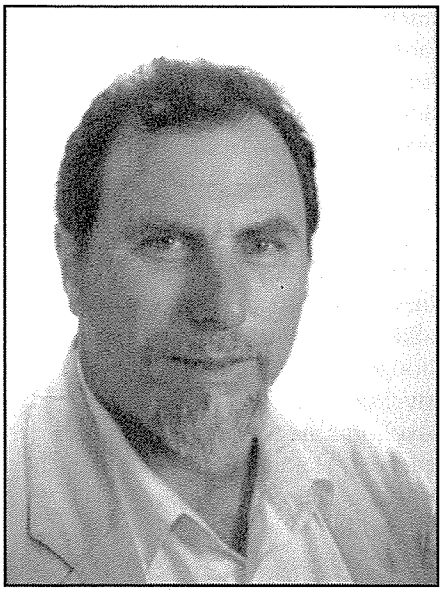
While I had confidence in my group skills and the subject area I was teaching I had a great deal to learn about the educational processes of learning objectives, rationales, outcomes, unit standards, range statements as well as such things as formative and summative assessment procedures. These formal aspects of the educational system required me to become a student again myself as I took advantage of a variety of courses offered to Polytechnic tutors which taught the fundamentals of educational theory and professional tutoring practice.

Two of these courses were significant in my development as a tutor, but for quite different reasons. One of the courses, which was focused on a variety of teaching methods, had a session on what was termed *Action Methods*. This was a very perfunctory, once over lightly session that mostly dealt with action group starters and very basic warm up exercises and "ice breakers". There was little or no explanation given for the terms used, or the theoretical or underlying principles for these activities and how or why you would use them. Almost anything that had students up and out of their seats was classified as an action method and terms like "warm up" and "ice breakers" were virtually interchangeable.

They were largely designed to be implemented as ways of starting off a new group of students or as a way of getting a bit of variety and student participation into classroom teaching practice. As a reasonably experienced psychodrama trainee I found this session quite lacking in depth or understanding of the principles involved, but I was intrigued at how challenging and exciting some of the other tutors found even these very simple action oriented ideas and activities.

The second course I did, which was to have a far reaching effect, was one on how to design a course and write it up in such a way that it could be successfully steered through the rigorous processes of the Course Approvals Committee. Because all courses inevitably involve teaching and tutor resources, space and facilities and in some cases expensive equipment, all new courses have to justify their purpose and value to the institution and have to gain approval by this committee before they can be run. Furthermore, for a course to get approval, it must be presented with all the appropriate documentation which outline not only the content but also a rationale, a resource schedule, all the assessment processes, the learning objectives and outcomes involved and the educational theory on which the course is based.

This course dealt with a variety of education theories as well as all the formal quantitative and qualitative protocols for measuring and assessing the learning outcomes of the students being taught. I found this a very challenging course, both enlivening and frustrating at the same time: enlivening in that it opened up a great many new ideas and understandings for me and frustrating in that designing a formal



Keith Tyler-Smith

course is a very time consuming and complex task.

Course design requires the designer to ask some very fundamental questions about what is to be taught, how it will be taught and what assessment processes will be used to measure the success or otherwise of the various learning outcomes. The complexity stems from the requirement that the learning must broken down into its component parts and be measurable, demonstrable and documentable. As with any discipline, there is a language and a set of concepts to master which become the currency of intellectual exchange within that discipline.

The major part of this course's assessment process was that each of the course participants had to design a course of their own devising.

Psychodrama and the teaching institution

The starting point for deciding on what sort of course I would design came out of the Christchurch Institute of Training in Psychodrama's requirement for advanced trainees to set up and run a supervised group practice in 1996. As part of their training programme each advanced trainee was to set up and run a group under the supervision of their primary trainer. My interest and focus for some time had been to find ways of using psychodrama within the institution I was working and to adapt the method to meet the institution's educational expectations so I was keen to set something up at the Polytechnic.

There have from time to time been workshops run by various experienced and qualified psychodramatists for tutors at the Polytechnic, but these were largely experiential workshops rather than being focused on teaching aspects of the method itself, though no doubt much good teaching took place. The fact that these workshops were very sporadic, with quite long gaps between them meant that their value to the tutors as models for their own practice were limited. Some tutors had tried to apply some of the ideas and activities they had picked up in these workshops, but a lack of continuity and ongoing supervision meant that problems in implementation were not resolved and the resulting loss of confidence and lack of experience meant that the ideas and activities, though exciting and valuable, quickly fell into disuse.

There was a perception, particularly among the staff education and development unit, that psychodrama was too potent and complex for tutors to use in the normal course of their teaching. There was a fear that it was too easy for emotional stuff to be let loose and for the tutor to lose control or

worse, cause damage by inappropriately handling the situation. Additionally, psychodramatic methods were seen as something too vague to measure in terms of educational assessment processes and too difficult and complex to define in terms of educational objectives and learning outcomes.

The experience with the so called *Action Methods* I had had on the CAT course on different teaching methods made me realise that there was a serious lack in knowledge, understanding and practice of the theoretical and experiential processes of *Action Methods* and consequently there existed a significant niche that a properly designed course could fill.

With the confluence of these various considerations, my goal became one of a) setting up a group situation that would further my training and move me closer to becoming accredited as a *Role Trainer;* b) find an appropriate subject area that would be suitable for designing a course for and thus enrich my role as a tutor; and c) design a course that I could get approved and run as part of the staff education and development programme and thus have a psychodramatically based course as part of the Polytechnic's formal teaching programme that was both true to its Morenian principles and had legitimacy as a properly constituted and educationally sound course of study.

Designing the course

One of the first issues I had to deal with, as far as designing a course that was to teach psychodramatic methods for teachers, was concerned with how to break down a very deep and complex subject area into teachable sessions. The inspiration for how to proceed came from a conversation I had with Graham Geddes, a teacher and psychodramatist from Timaru in South Canterbury. We were both residents at a five day workshop being run by Max Clayton and Chris Hosking at a Scout camp called Raincliff near Timaru. Graham was talking about how he had once thought about writing his psychodrama thesis on teaching psychodrama techniques to other teachers. His idea was to take each of the techniques used in psychodrama separately and teach them as discrete units, building up a comprehensive overview of the entire method over time.

This idea sat in my memory banks for a couple of years and when I sat down to think through the detail of how to design such a course I used his concept as the starting point and for that I am very grateful to Graham.

The second issue I had to deal with was what to call this course. I was already aware that there was quite a strong resistance to anything with the term *Psychodrama.* included. Psychodrama was seen as therapy and not appropriate for use in the classroom, particularly one where non-affective subjects were being taught. My strategy here was to co-opt the term *Action Methods* as understood by the institution.

To distinguish it from its low-level cousin I decided to call the course *Advanced Action Methods for the Teaching Professional.* This I felt would give the course a certain stature and would warm up prospective participants to the notion that this would be a useful and enriching course to do particularly those who were experimenting with or using basic *Action Methods.* It

would also be less threatening than using the term *Psychodrama* and would capitalise on what was already familiar and understood by the teaching fraternity at the Polytechnic and its relatively high and accepted recognition factor would be an advantage.

I took as my operating philosophy the definition of *Action Methods* that Antony Williams describes in his book, *Forbidden Agendas: Strategic Action in Groups* (Routledge, London & New York, 1994):

> *In action methods, as distinct from psychodrama, the action may only last a short time, and does not usually involve the family-of-origin. It may be group-centred rather than individual-centred, and could even be a simple illustration of a point – explaining or teaching something perhaps, by having chairs or cushions representing two sides of a debate or two scientific theories. Mostly there tends to be a bit of moving around, and the taking up of roles. The versatility of action and colour makes contrasts clearer, allow new points to emerge and can inject an exhilarating air of experimentation and play. At the same time, their ability to be safe and low key makes action methods suitable for groups, organisations or classrooms where there is no commitment to psychodrama as such, and where indeed the processes of a full psychodrama would be inappropriate.*

In designing a course you start at the end and work backwards. The first thing you have to decide is what the course participant will know and be able to do when they have finished the course. The second thing is to devise a series of assessment strategies that will test whether or not the course participant can demonstrate that they know, understand or can do what they have been taught. Once this has been achieved then what goes into the course will be determined by these other two processes. So in order for my course to cover the wide variety of techniques, theory, functional performance and experiential learning activities I had to design a series of objectives and outcomes that would allow for this to happen.

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The course structure

The course was designed to be delivered in ten, three hour sessions. Eight sessions to be delivered on a weekly basis with two sessions

delivered in a six hour workshop style session. In total the course comprised of thirty hours of class activity and thirty hours of out of class practise, study and reflection.

The course aim

This course was designed for full-time and part-time tutors who regularly teach groups of students. The participants were to explore, experience and apply a range of *Advanced Action Methods* appropriate to their teaching circumstances and practise. They were to be introduced to the principles of Role Theory as defined by J.L. Moreno, as it applied to the use of *Action Methods* and working with learning groups. Emphasis would be placed on designing learning experiences that would cater for individual thinking, learning and interacting styles.

Learning objectives and outcomes

Some of these learning objectives and outcomes were as follows. On completion of the course, participants would be able to:

- Describe Moreno's concept of a role
- Describe Moreno's concept of spontaneity
- Describe the main components of Moreno's role theory
- Identify a range of roles and role relationships of individuals in a learning group
- Describe Moreno's concept of warm up and how it applies to a learning group
- Identify and discuss the nature of a group's warm up to a learning task in terms of its strength and nature
- Identify and discuss the way a tutor's personal warm up affects the learning group's warm up to a learning task and subsequent performance
- Explore and make explicit a range of sociometric relationships within a learning group
- Use sociometric principles to measure and describe aspects of the learning needs of individuals within a learning group
- Chart the workplace social atom of a colleague
- Demonstrate the use of a variety of action methods including Concretisation, Interviewing for a Role, Scene Setting, Role Reversal, Mirroring, Coaching, Doubling, Sociodramatic Enactment and Sociometric Explorations through structured class exercises to an acceptable standard
- Plan a teaching activity that incorporates one or more Action Method as part of a structured learning process
- Design and carry out a sequence of steps necessary to implement Action Methods in a structured teaching/learning session with peers
- Design and carry out a teaching/learning session in own area of expertise, using Action Methods and have the session monitored by a tutor or a peer
- Reflect and evaluate the effectiveness of using Action Methods for a lesson through a structured evaluation process.

The course content

The course content were divided up into the following ten sessions:

1. Experiential learning, and an introduction to Action Methods and Moreno's concepts of warm up and spontaneity
2. Moreno's Role Theory and the concept of role systems, role

relationships, role naming and role analysis
3. Concretisation, making abstract concepts concrete
4. Interviewing for a role, scene setting and role reversal
5. Sociometry and the workplace cultural atom – making explicit, measuring and charting relationships within a variety of teaching/learning groups
6. Mirroring, doubling and coaching as aids to learning and role development
7. Mini-teaching session in which course participants design and deliver a twenty minute action methods based teaching session using the course members as students and receiving verbal and written feedback on their performance
8. As in 7
9. Sociodramatic enactment, exploring group issues and concerns
10. Course revision and specific practice.

Course assessment processes

The assessment processes were to be a mixture of formative and summative assessments. The formative assessments were to consist of a variety of practical sessions within class time in which the course members would practice various methods and receive direct feedback from peers and the tutor. Participants were encouraged to bring specific teaching issues to the session from their own teaching practice so that they could explore and rehearse various options the course work provided. Participants were also encouraged to try out various ideas and activities in their own classes and to reflect on their own performance and success during this course, again having the opportunity to explore, examine, discuss and rehearse in safety.

The summative assessments were to consist of a variety of practical exercises, written and verbal evaluations from peers and the tutor and written reflections on their own practice and performance. Three summative assessment points were nominated:

1. A mini-teaching session in which each participant taught a twenty minute session in class time, using their fellow course members as students. Each session was to be accompanied by a verbal and a written feedback session. Each course member was then to reflect on their own performance and write a reflexive essay which detailed their own primary learning points.
2. Design and deliver a teaching session in a tutor's own class situation in which action methods were to be used. This session was then to be observed either by the *Action Methods* tutor, or a peer from the course. This observer was then to organise an evaluation process with the students to determine the learning experienced and give feedback to the tutor and to write a report based on these findings.
3. The course member was then to reflect on and write a report on their own perceptions of their performance and how the class evaluation squared or otherwise with their intention.
4. Write an essay that reflected on the course member's own role system and functioning as it applies to their teaching role and what had been developed during the *Action Methods* course

Proposing and delivering the course

It took the best part of six months of part time work to finally get all the various parts of the course design in place and have it ready to be assessed. It was passed as completed in July of 1996 and I was deemed to have successfully completed the course. I then approached the Staff Education and Development Unit with a proposal to run this course starting in October of 1996. They were keen to have the course run as part of their end of year programme and the course outline was duly sent to the Course Approvals Committee for ratification. At the same time I sent the course outline to the C.I.T.P. for approval for this proposed course to fulfil the requirements for my psychodrama training in the supervised group practice programme for advanced trainees. In due time both the Course Approvals Committee and the C.I.T.P. gave their go ahead and the course began on Thursday October 3.

I had eight students, seven of whom were women and one of whom was a staff trainer. The course exceeded my own expectations and that of the participants, if the course evaluations are anything to go by. I learned a huge amount and enjoyed teaching the course immensely.

Someone once wrote that if you want to learn more about something; teach it! In my case this was never more true. My own understanding and knowledge of Moreno's ideas were greatly enlarged and developed through having to be well enough prepared to explain it in simple terms to people who were not familiar with the concepts. I came to a greater appreciation of those who have thought long and hard about these concepts and have written about them. Particularly the likes of Tony Williams, Max Clayton and Anne Hale, they and others became important inspirations in the development and maintainance of my own warm up and for the written resources I used in the classwork. I learned how valuable it was to have an auxillary in the group who had some experience with psychodrama and how this enlivened my creativity and spontenaity. Above all though, I came to a greater appreciation of my own qualities as a sponteneous facilitator of learning, a psychodramatic communicator and group leader and a recognition of how much I had grown in those roles during the development and duration of the course.

> *Above all, though, I am very pleased that Moreno's vision is now firmly part of the mainstream of the education thought and practice of this institution, albeit a small, tender and growing part ...*

I enjoyed the growth of the course participants as they came to grips with difficult concepts and took large risks with their own learning and functioning. I have vivid memories of being taught the mysteries of how computers process their data and the specifics of differentiating between a Hawke's Bay Chardonnay or one from Marlborough, all through the use of *Action Methods*. I particularly value the courage and perseverance

exhibited by several course members as they tried something that did not work as was intended, willingly shared their sense of failure and then went back and tried again, each time building on their experience and their greater understanding. Perhaps the single biggest source of satisfaction was to see how the concept of the tutor's warm up, and that of the group and each individual, was taken aboard by those on the course so that it became understood as a continually unfolding process that influences everthing that is done, rather than a one off party trick used to impress or entertain a new group.

Of course there will be a be few things I'll change and approaches to particular elements I'll revisit when I come to do the course again. I'd also like to get hold of more written resources that are focused on using action methods in non-therapeutic settings.There seems to be something of a shortage of such materials that even trawling the internet has not helped as much as I might have expected. My thanks to Francis Batten and Mike Consedine for their generous provision of written materials and support.

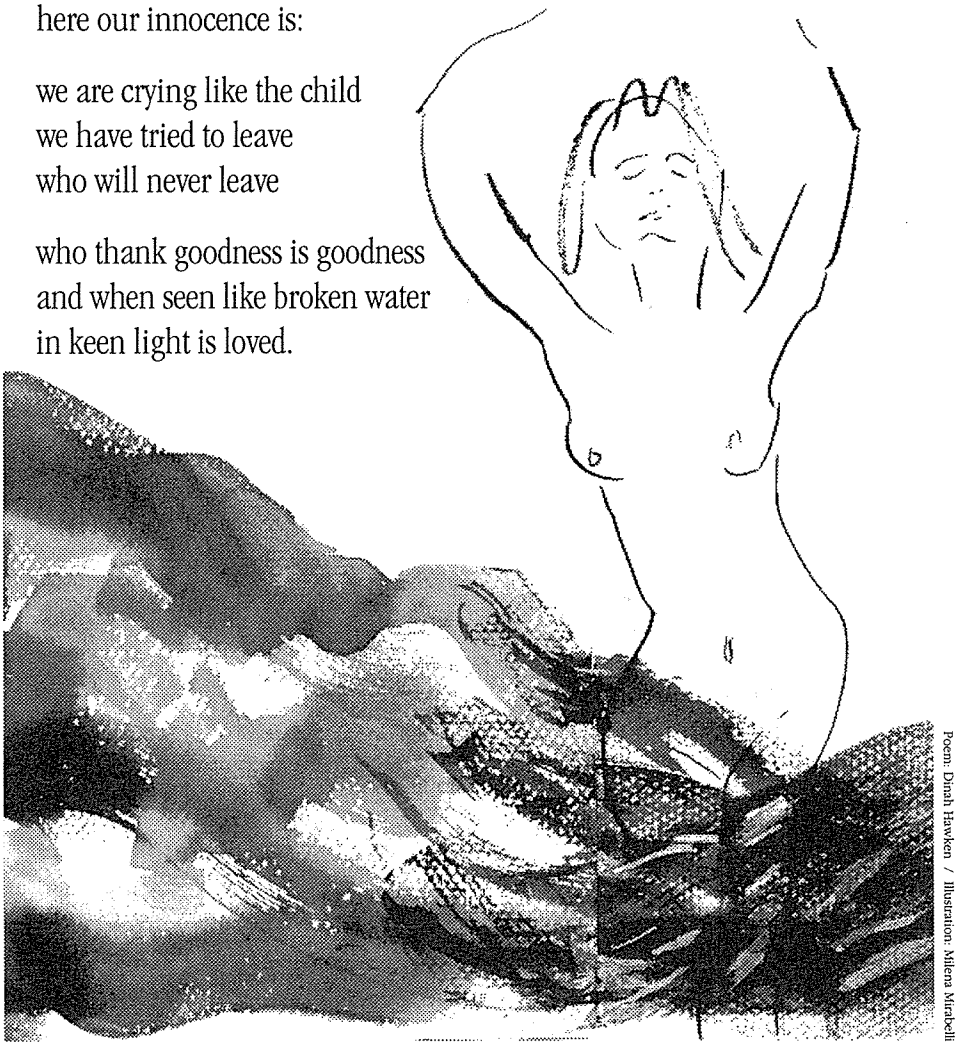
Above all, though, I am very pleased that Moreno's vision is now firmly part of the mainstream of the education thought and practice of this institution, albeit a small, tender and growing part.

Water Breaking

The way water breaks
and is pure white
we fall and break and
here our innocence is:

we are crying like the child
we have tried to leave
who will never leave

who thank goodness is goodness
and when seen like broken water
in keen light is loved.



Poem: Dinah Hawken / Illustration: Milena Mirabelli

New Directions in Medical Education

Integrating action methods into a new curriculum

by Victoria Wade

Victoria (Tori) Wade is a medical practitioner who is currently employed by the Department of General Practice in the Medical School at the Flinders University of South Australia, where she is involved in developing a new curriculum and new teaching methods in medical education. Tori initially trained as a psychologist, then became a mature age entrant to medicine, followed by practising as a GP. She is a psychodrama trainee with the Psychodrama Training Institute of South Australia.

For the past two years, I have been employed by the Department of General Practice in the Medical School at Flinders University. It has been an exciting time to work in medical education because at the beginning of 1996 we changed over from a six year undergraduate course to a four year graduate-entry course, and from an integrated but fairly conventional curriculum, to a problem-based learning curriculum. My aim in this article is to tell you about the new course and about my plans to incorporate action methods into the curriculum.

The New Medical Course

Firstly, the students accepted into the course are all graduates and are selected by a combination of a written test, their undergraduate grades, and an interview. While many are science graduates, we also have arts, commerce, nursing, theology and social science graduates. They have a very wide diversity of backgrounds and experience. This alone would make the medical school very different, but I want mainly to talk about the changes in the methods of education.

Since the medical school was established in the 1970s, the curriculum has always been integrated; by that I mean that instead of separate subjects in anatomy, physiology, microbiology, etc, the course has been structured as a series of body systems, ie cardiovascular system, respiratory system and so on, leading to a greater cohesiveness of knowledge. This was the course I went through myself as a medical student in the 1980s. However the methods of delivery were the conventional

lecture, tutorial and practical class, with a large number of contact hours per week to fit in all the knowledge deemed to be essential.

A number of factors have lead to the need for change – the sheer amount of knowledge has increased to the point that it could not be presented even in a course that was longer than six years, and the rate at which the knowledge changes means that much that was covered during medical school is out of date by the time the students graduate. As well, there is a clear need for doctors not only with good one-to-one communication skills but also teamwork skills.

Problem Based Learning

The solution to these issues has been to introduce Problem Based Learning (PBL). In this method, all the class are divided into groups of eight, and have three 1 1/2 hour tutorials a week in these groups in which they work through a series of problems, the majority of which are clinical cases. For example, they may work on a case of chest pain, or shortness of breath, which is presented either as a written scenario or as a video clip. There is also the potential for the scenario to be presented by a simulated patient, ie a person who has been coached in the role. This has been done elsewhere but not tried in our course to date.

The tasks of the group are then to formulate hypotheses, discuss the underlying mechanisms, discover the limits of their knowledge and set their own learning objectives. At the next meeting of the tutorial, the students present what they have learned to their group, discuss the issues, and then receive more information about the case. At the end of every case (ie every third tutorial) there is a feedback session at which the way in which the case proceeded is processed.

This whole process involves the students in a much wider range of roles than the traditional ones of *passive sponge* and *word-perfect regurgitator.* In going through Problem Based Learning the students are called on to be *creative thinkers, critical evaluators, active listeners and summarisers, supportive validators* and *clear presenters.* In short, they are beginning to develop the identity of the medical clinician, which I now realise is a complex role cluster worthy of further analysis and description.

There are still some lectures (about 3 or 4 a week) and we found that the students value these more highly because there are so few, and there are practical classes and clinical skills sessions, but half the week is non-contact time.

Problem Based Learning was first introduced at McMaster University, Hamilton, Ontario, in the early 1970s, following the ideas and methods of Howard Burrows. Subsequently, it was adopted by medical schools at Newcastle University NSW, Maastricht University in the Netherlands and the University of New Mexico. Now, in the 1990s, there is a second wave of interest in Problem Based Learning, with many more medical schools changing over, including those at Harvard, Toronto, Tufts (Boston) and Liverpool (UK). In Australia, Sydney University and the University of Queensland medical schools will be adopting Problem Based Learning in 1997. The method of Problem Based Learning has proven to be very robust and this year at Flinders we saw it flourish in a situation where all the students and nearly all the tutors were inexperienced, the cases were being tried out for the first

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time, and the curriculum development was running (at times) only a month ahead of the class.

What interests me is the potential of the Problem Based Learning method to be integrated with psychodrama methods. I am beginning to do this, starting in small ways and gradually building up as I work together on the curriculum with other members of staff. Below is a list of these specific ways.

1. Within the Problem Based Learning Cases

Several of the faculty have written cases in which role-playing has been a suggested option during the PBL tutorials. For example, particular doctor-patient interactions have been described and the students are asked to formulate a response to these, either on paper or as a role-play. Many of the PBL tutors are wary of running role-plays and this is entirely reasonable given that they have not received any training in the area. Some tutors have tried anyway and it has worked well at times but at other times has fallen flat, as one would predict for a group who are not experienced with action methods. This year I attended the tutor briefing session for one of these cases and gave a demonstration with the tutors of how the role-play could work if run spontaneously, as opposed to setting it up in advance, but there was not enough time to train the tutors in specific techniques.

2. Tutor Training

a)Foundation Training

Before taking any Problem Based Learning groups, the tutors must attend a two day workshop in which 20 tutors are trained at once. The tutors range from scientists to hospital consultants to allied health workers to general practitioners, and most are not experts in the areas in which they are tutoring. We have discussed, but not implemented, a rule preventing people from tutoring in their area of expertise; the danger being that the tutor would take up the role of *pompous expert* and thereby interfere with the students' own learning.

The training begins with a rapid exposure to the theory and practice of Problem Based Learning in which the trainees are split into three groups of 6 or 7 and experience Problem Based Learning in the role of students. Then they have a short session on basic group dynamics theory, followed by an experiential session on giving effective feedback, where they observe the trainers

modelling this and then practice in pairs. Immediately afterwards they are thrown into taking a group themselves, which consists of students who are not medical students and who are naive to Problem Based Learning (they have been induced to come by a small fee). The trainers coach and supervise in a fishbowl setting, where the group is in the centre of the room with each of the trainees rotating into the group as tutor, which the other 6 trainees are sitting on the edge. During this time the trainees aim to facilitate the group by encouraging the students to participate and to work through the problem using their own resources. In order to prevent the tutor from being seen as the "fountain of all knowledge", the trainees practice behaviours such as moving away from the group, avoiding eye contact, and deflecting questions to the other students. Two days may seem like a ludicrously short period of time for tutor training but we are working within the time limits which both the trainers and the tutors have available.

b) Advanced Tutor Training

We are planning to follow up the foundation training with a series of advanced tutor training sessions but have not been able to do so yet due to lack of time and resources. Fortunately, some of my time in 1997 will be set aside for this purpose. This will have more of a focus on action methods than the basic workshop and will consist mostly of role training. I will give the tutors the opportunity to set out, explore and develop options for dealing with situations that have occurred in their groups. I imagine that tutors will want to tackle situations such as conflict between group members, how to encourage quiet group members to participate, what to do if the group is failing to progress on the case, and so on. All these situations plus a variety of others have arisen in the Problem Based Learning groups so far this year.

In addition, I am planning to give the tutors some theory and practice at running the role-plays that may come up in the course of working through the cases, so that they know the basics of warm-up, concretisation, spontaneity and role identification, and are more likely to give the students a useful experience when these occur.

3. Student Training

When the students commenced first year, we ran two 2 hour sessions to introduce them to the mechanics of Problem Based Learning. For many it was a complete change from their previous studies; some had come from the type of highly competitive environment where other students hid useful books in distant parts of the library. Reactions to our approach, where working together was essential, included relief, intense interest and concern as to whether the others in the group could be trusted to put in enough effort. After the course had been running for a month and the students had some experience of the process, we ran a session with randomly allocated groups in which we asked the students to compare the rules and the roles that had developed in the different groups. At this stage we gave them a standard list of roles, such as *alert initiator, organised summariser, naive questioner,* etc, however next time I run this I am considering asking them to develop their own list. Just as I am planning

some training for the staff on conducing role-plays, I would also like to offer the students some sessions on getting the most out of participating in role-plays.

As the year progressed, it became apparent that a number of the students were frustrated with the way their group was operating but were unsure of how to change this, so we ran an optional session called "Honing up your groupwork skills". About 20 students came along, some of whom were from a couple of the less well-functioning groups. One group had a member with an over-developed sarcastic role who derided the others, and we spent the time considering strategies and roles to mount an effective response. This session proved to be a helpful approach in dealing with the frustration, stimulating a fresh warm-up in many students who attended.

4. Groupwork Service in 1997

One of my initiatives for next year is to offer a groupwork "consultancy service" and the plan is to have members of staff available to sit in and/or mediate for groups who have difficulties.

5. Student Elective in Groupwork

All students can take electives, ie a part of their course in which they can go into one area in more depth. We aim to offer an elective in which those students who are interested in groupwork can observe and study their Problem Based Learning groups, either to conduct research, or as a means of developing groupwork skills. Two of the tutorial rooms have been set up for video recording, and one with a one-way mirror, so we are hoping to make tapes that can be used either for research, training, or in assisting groups who want to improve their functioning. Students taking this elective may also do the tutor training course and, in their final year, be employed as tutors for first and second year groups (if the part-time teaching budget permits).

As well as the initiatives involving the Problem Based Learning process, I am also the convener of the Psychobehavioural Perspective. This is not a separate subject but is a body of theory and practice that runs throughout the curriculum. The other areas that are dealt with in this way are Population and Public Health, Law and Ethics, and Research and Information Technology.

The Psychobehavioural Perspective presents a bio-psycho-social model of human functioning and the aim is for the students to consider these levels of functioning in every person they see. The perspective is integrated into the curriculum in these ways:

1. With the Problem Based Learning Cases

A proportion of the Problem Based Learning cases have psychosocial issues written into them. For example, a case may be created of trauma through a motor vehicle accident with the purpose of studying tissue healing and repair, but the students also have the psychological reaction to the injury presented to them and will study this at the same time. Another example might be of a child with a chronic illness and where the functioning of the family is an important part of the case. Through the cases the students then come to appreciate the effects of psychosocial factors on health and disease.

2. Psychobehavioural Clinical Skills

This is a series of eight three hour practical sessions covering counselling skills and an introduction to behavioural analysis and intervention. In addition to the above content, I took my group through some role training and found that the students wanted to work on the issue of how their Problem Based Learning group was functioning. Many students have a high level of awareness: I recall one saying, in a very confident and direct manner: "The tutors are not providing adequate modelling of self-assessment skills."

3. Personal and Professional Development

Finally, part of the perspective is a series of tutorials I initiated called personal and professional development. I scheduled these for weeks in which the Problem Based Learning cases raised tough issues, such as treatment failure, death and difficult doctor-patient relationships. They have the aim of providing a forum for students to discuss their reaction to the issues and to consider a range of options for dealing with them. These tutorials will also, I hope, fulfil a mentor function. It is my impression that it has become more difficult for students to find mentors because the pace of medicine has increased, expectations have risen, and everyone is working harder to try and keep up.

In the group I took, we spent most of the time on discussion however I used the role training format on a couple of occasions. For example, when we were considering how to break bad news, I asked each student to practice this in action and then through role reversal experience the impact of their approach. I would like to do more of this in the subsequent years of the course when, with increasing clinical experience, the students will face these and other difficult situations more directly.

To conclude, although medicine is regarded as one of the more conservative professions, quite dramatic changes are taking place in medical education which involve a high level of integration and teamwork and much greater attention to the process of achieving this. I have described several ways in which I have used action methods in the new curriculum and there are many opportunities to expand this in the future.

The Grandmother in the Development of Psychodramatic Roles in Grandchildren

by Annette Fisher

Annette is the Director of the Psychodrama Training Institute of the ACT and is a visiting teacher with the Psychodrama Training Institute of NSW. She is a Psychodramatist in private practice and is the Vice President of ANZPA Inc.

Psychodramatic roles are the roles in life we enact that express our life force, our aspirations and our uniqueness. The role does not emerge from the self but the self emerges from the roles. Psychodramatic roles increase the ability of an adult to enact social roles that are relevant and adequate in a variety of life situations.

Through play, imagination and enactment a child can develop psychodramatic roles that will give a basis for the development of a broad range of social roles. Psychodramatic roles allow the child to increase the sense of the self and is followed by the development of role clusters that will relate to social roles that are enacted in adult life.

Applying some of the psychodramatic principles to my life and work has been of major importance to me for the last twenty five years. These have included role theory, social atom repair and the theory of spontaneity and creativity. My involvement in psychodrama has assisted me to develop my abilities in many areas. This has included increasing my role repertoire that has enhanced the parenting of three girls. As a single mother this has not been an easy task, especially during their teenage years. As a parent I was consistently faced with my own

> *During this process of 'bringing up' children I had to face every issue I had attempted to avoid ...*

difficulties, as children have the wonderful knack of mirroring the parents failings. I often wondered who was put on the planet to teach life's lessons, the children or the parents. My conclusion is that the children are the principle teachers.

During this process of 'bringing up' children I had to face every issue I had attempted to avoid. These included commitment, responsibility,

authority issues, my own 'unfinished businesses', rage, unconditional loving and self nurturing. This led to the enactment of many dramas as a protagonist to repair my original social atom and role training to develop roles such as an assertive confronter, a loving nurturer and an open, vulnerable expressor of life. This process has included doubling, mirroring and role reversal. From these experiences I have increased my abilities to form relationships that are satisfying and rewarding, and have left me with a clarity that has made way for the roles that assist a child to develop psychodramatic roles.

The roles that I enact in my relationship with my grandson Jake that assist in the enactment of psychodramatic roles are: wise traveller, lover of life, friendly companion, loving guide, funny comedian, spontaneous scene setter, wise teacher, gentle coach, protective friend, creative genius, imaginative artist and firm limit setter.

However, developing the identity of grandmother did not come easily to me. The first time news of the impending birth moved me to tears. I was working with a group of women and children in a playground in the grounds of a block of government flats. The children were a wild, unruly lot and the mothers sat in the caravan and smoked as the children ran riot. When the phone rang for me in the caravan and it was my daughter, Jodie, telling me the news of the baby, I was stunned. I knew her relationship with her partner was not very stable and she was completing her degree at university, my last child had just left home and I could see a new path, child free.

Hence the 'warm up' to being a grandmother commenced. Jodie and her partner were delighted and my shock and horror soon changed to excitement as the time for the birth approached. We had discussed what we called in the hippie days, a tribal birth. This meant a number of people who were close to the mother would be at the birth. The two midwives and friends were involved in the birthing process and into the world came Jake.

My worst fears came to be, and my daughter and her partner separated. Now I began to take a more involved and active role in the parenting of Jake, so my 'warm up' to my relationship to Jake increased. Jodie and I have similar values and are able to maintain a positive relationship. If we have different ideas or become conflicted we are able to discuss our concerns related to Jake.

It has not been fashionable in our culture for the grandparents to be involved in the day to day activities with grandchildren. After all, in the traditional marriage ceremony the father delivers his daughter to the groom and then the bride and groom disappear into the sunset. The mother-in-law has been stereotyped and has become the brunt of many jokes and is depicted as interfering and a trouble maker. This may lead to the grandmother also being type-cast and the grandmother's wisdom, knowledge of her own life, children, healing abilities, and home skills are lost as she is alienated from meaningful interactions with her grandchildren

As I am not a person who would fit into a stereotyped grandmother sitting at home knitting and politely observing my children and their family at a Sunday afternoon tea, I am fortunate to have a full and on-going relationship with my grandson

Jake. With my life experience, which has included the psychodramatic method, I have been enjoying the development of our relationship and value the opportunity to be involved with this little boy at such a personal level.

The following descriptions are ideas I have come to at this point in my experience as a grandmother and how I have made an effort to apply these ideas of the psychodramatic roles and how this has given me confidence in the roles I enact as a grandmother.

As the grandmother, I am an auxiliary to Jake. During this collaborative experience my aim is to assist him to develop independent action and self confidence. With encouragement for him to use his imagination and spontaneity, my hope is that he will be able to learn to be positive in his response to life, and on the spur of the moment to respond more or less adequately, as the situation arises. He will also be learning skills in relating to others with interactive activities.

The psychodramatic roles that he enacts emerge from his own imagination and dreams. These emerging psychodramatic roles are influenced by his relationships at home and school, books and television. What has been surprising to me has been the archetypal nature of the roles. Many of the roles are related to good versus evil and have a timeless quality. Hence, as an auxiliary the grandmother is a guide and I have attempted not to be prescriptive or an overpowering influence.

Through my own experience of being a protagonist, I am aware that playing a multitude of roles leads to a greater flexibility in responding to the world and the people we meet. By playing the roles of the darker forces, I noticed that I developed a greater sense of my own strength and the fear of impending doom from outside attack became less. With encouragement and enactment, healthy roles have been strengthened and can be expressed with vitality. The impact of enactment also brings out the truth of the matter and assists in the distinguishing between fact and fantasy. I have applied these principles in my relationship with Jake.

As an auxiliary to Jake, I also provided guidance in the areas of safety. He needed assistance with understanding that a superman cape does not mean you can fly and swords and weapons are not to hurt people, animals or property.

As the grandmother, I am an auxiliary to Jake. During this collaborative experience my aim is to assist him to develop independent action and self confidence ...

I will now describe three dramas that demonstrate the relationship I have with Jake and the development of his psychodramatic roles. Through experiencing the psychodramatic method myself as a protagonist and having directed many dramas, I felt confident that entering Jake's world and allowing enactment, concretisation and maximisation of situation, through play and interaction, would lead to role development.

The Pirate

The Scene: Grandmother is in bed asleep. Jake, two years old, appears in the bedroom door.

Jake: Nana, Nana a shark is after me.
Nana: Quick come over here and jump on the boat.
(Jake runs over and jumps on the bed.)
Nana: Hang on Jake the sea is pretty rough.
Jake: Will he get me?
Nana: Grab your sword Jake, this is a pirate ship. (Jake is very fond of pirates and has a toy sword.)
(Jake swirls the sword above his head.)
Nana: Wave your sword harder Jake. Here comes the shark. Now wave your sword. There, I think you have frightened the shark. Now Jake you and I can be the shark.

Nana and Jake then swim in the sea making large mouths with their arms and making snapping noises as the jaws open and close.

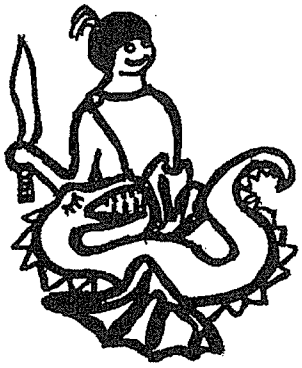
Nana: (as the Shark) Look at the pirate, we haven't got a chance.
Jake: Snap, snap. (looking really vicious).

Both get back onto the bed.

Jake: (back in the role of the pirate and waving his sword) Get out of here shark.

Jake: Now we can go to sleep.

Nana and Jake curl up together and fall asleep.



St. George and the Dragon

A very dejected little boy stood before me and began to tell the story of his dream.

Jake: When I was asleep a dragon breathing fire burnt my face. All the skin on my face was peeling off. I was so frightened.
Nana: Was the dragon like this? (taking on a dragon role and pretending to breath out fire).
Jake: Yes.
Nana: Now you be a dragon with me.
(Both walk on all fours and snort out fire.)
Nana: Now come over here Jake and stand on this hill (a chair).
Jake: I think I will hold my sword. Go away dragon you can't hurt me.
(He draws himself to his full height and lunges at the dragon.)

In front of me I saw the birth of the psychodramatic role *St. George.* This emergence of a role had an almost magical quality and one explanation could be that Jake was able to enact spontaneously in the moment to the situation that we had created.

Batman

On the morning of Jake's birthday he came to his last present, a batman cape and mask. He put them on and announced:

Jake: Now I am three I am not going to say that yucky f..... word again. I will never say that yucky f..... word again. Now I am three I don't say that yucky f.....word.

As a two year old Jake had the usual tantrums and would express his rage unexpectedly at any venue screaming obscenities. Any attempt to change this behaviour had failed.

Jake wore his batman cape and mask all day, to the Pancake Parlour for breakfast and for his party in the afternoon. He stood tall and confident all day and he has not said the f..... word since.

I do not understand why the shift took place. However, I observed that as he put on the batman clothes his body posture changed and he seemed to take on his own authority and had a strong sense of himself and his own views of the world and again he was able to respond spontaneously to the situation of the moment.

Conclusion

This paper is written to demonstrate that the roles of the grandmother can be active and creative. By following the principles of role theory and spontaneity the old rigid conserves of family structure and function can be freed to encourage creative and joyful relationships. With imagination, commitment and love, a valuable contribution can be made to child development.

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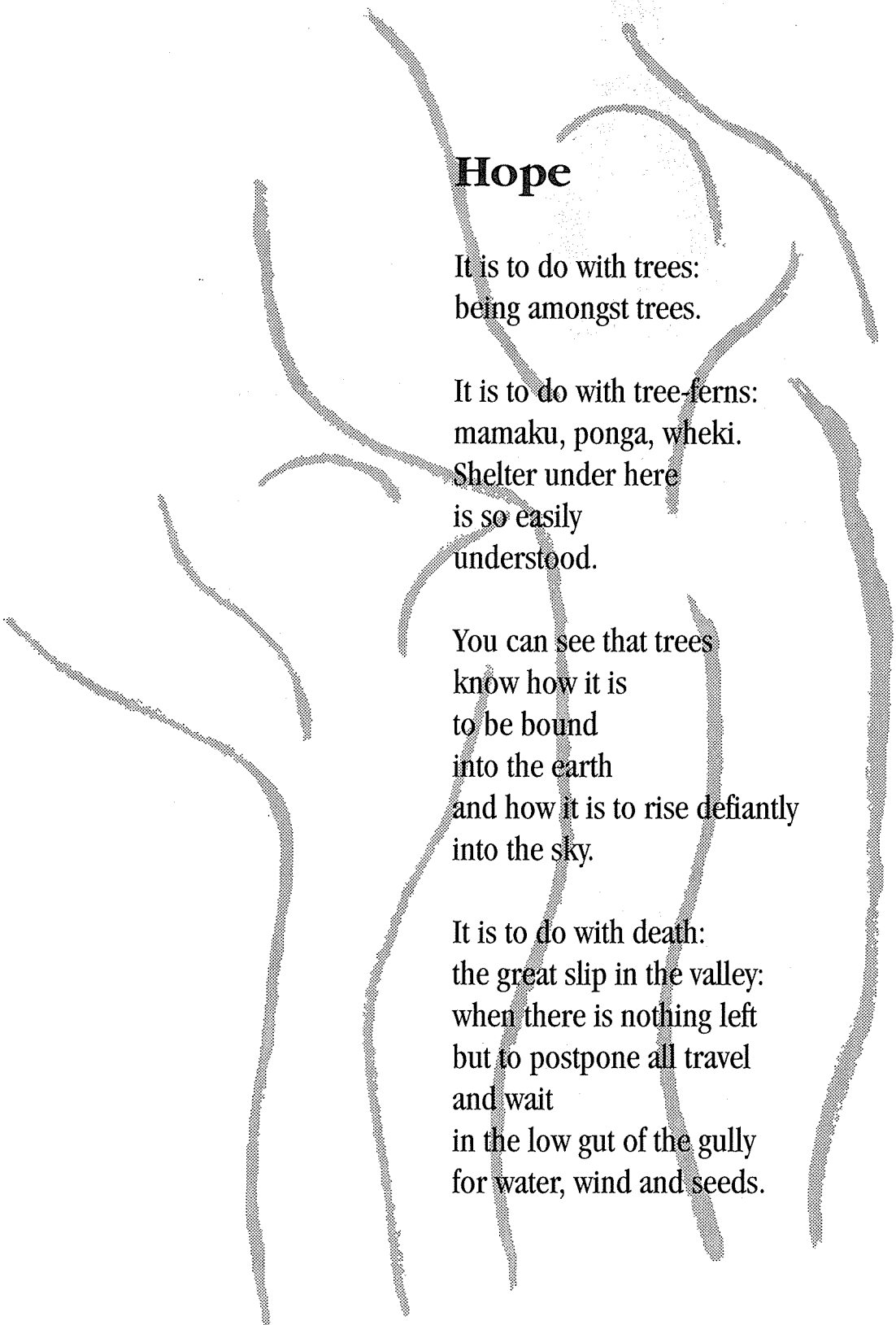


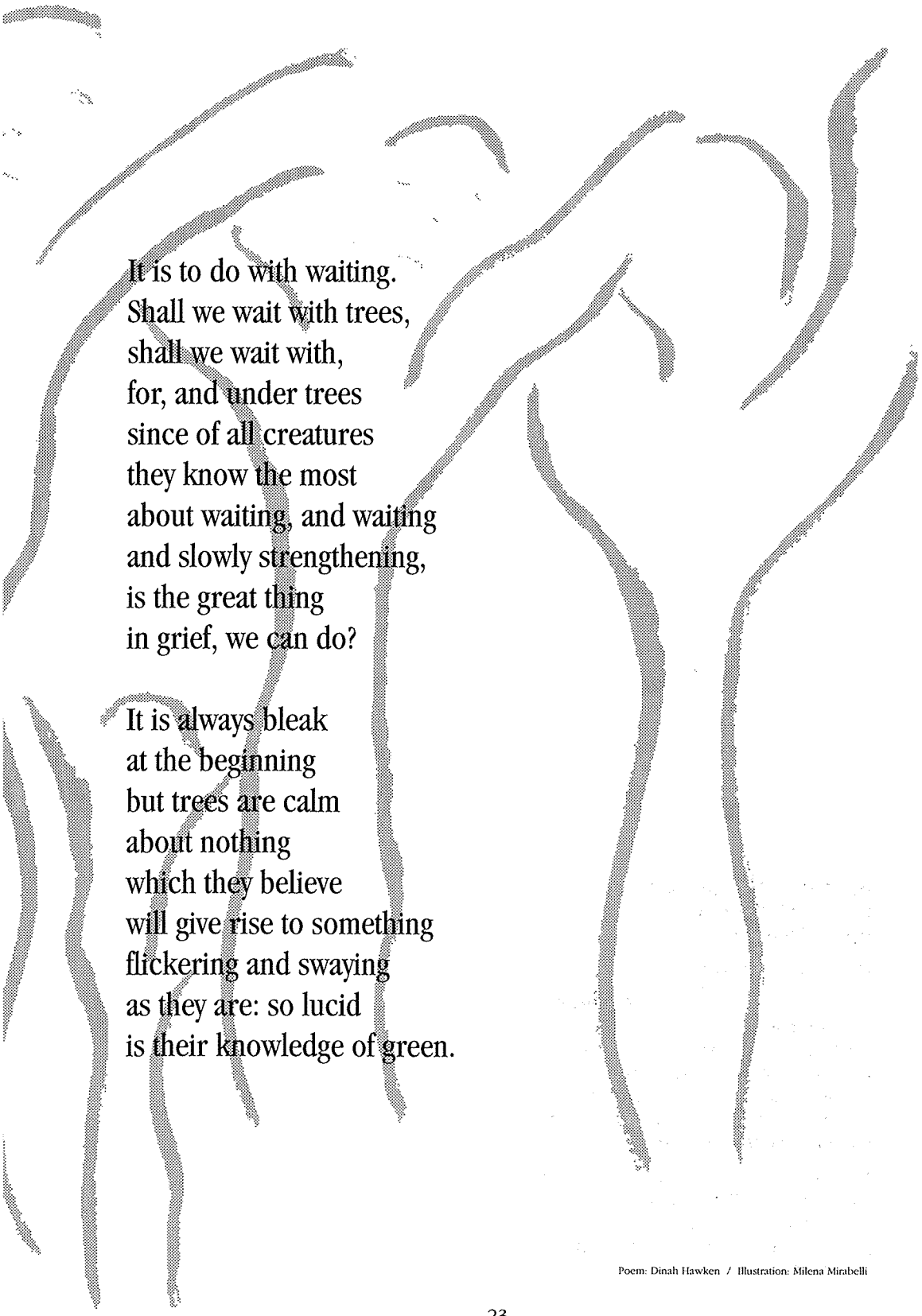
Hope

It is to do with trees:
being amongst trees.

It is to do with tree-ferns:
mamaku, ponga, wheki.
Shelter under here
is so easily
understood.

You can see that trees
know how it is
to be bound
into the earth
and how it is to rise defiantly
into the sky.

It is to do with death:
the great slip in the valley:
when there is nothing left
but to postpone all travel
and wait
in the low gut of the gully
for water, wind and seeds.



It is to do with waiting.
Shall we wait with trees,
shall we wait with,
for, and under trees
since of all creatures
they know the most
about waiting, and waiting
and slowly strengthening,
is the great thing
in grief, we can do?

It is always bleak
at the beginning
but trees are calm
about nothing
which they believe
will give rise to something
flickering and swaying
as they are: so lucid
is their knowledge of green.

Poem: Dinah Hawken / Illustration: Milena Mirabelli

POEMS AND ILLUSTRATIONS
by Dinah Hawken and
Milena Mirabelli

Pages 10, 22 and 40

Dinah Hawken works in the Counselling Department of Victoria University, Wellington and is an advanced trainee with the Wellington Psychodrama Training Institute. She is a poet of some renown and has received public acclaim for her writings over many years.

Milena Mirabelli is a practising artist and teaches others in the area of the creative arts. She is an advanced psychodrama trainee with the Australian College of Psychodrama.

The Vietnam Veteran and the family "Both Victims of post traumatic stress"

A Psychodramatic Perspective

by Michael Burge

Michael presently specialises in the treatment of Post Traumatic Stress Disorder through work with traumatised Vietnam war veterans and their families. He works in Melbourne in private practice and is the founder of the Training College of Trauma. He has passed his practical assessment as a Psychodramatist and is in the final stage of completing his thesis.

There has been much written about the effect of the Vietnam war on veterans; namely the development of post traumatic stress disorder. However there has been less attention given to parallel trauma experienced by veterans' families. Of particular note is the struggle for intimacy.

The present article is primarily about my experiences counselling Vietnam veterans and their families. I discuss the ways in which the Vietnam Veteran's post traumatic stress (PTSD) can infiltrate all of his family's lives. I also demonstrate the way psychodrama can be used for the diagnosis and treatment of post traumatic stress. In particular role analysis, role training, role development and role theory.

In terms of role theory, the essential premise is that individuals who have been traumatised can recover by tapping into and

enhancing their creative and spontaneous resources. This works hand in hand with the recognition, installation, and expansion of healthy life giving roles. Technically this is achieved through the complementary nature of roles. That is, a role cannot exist in a vacuum, it must essentially have a positive or

negative relationship with another role. For example nurse and patient, or teacher and student or performer and audience. The complementary nature of roles also exists within an individual's psychic system and are constantly engaging in self-talk. For example, encourager of self (positive) self critic (negative) in relation to the self goal seeking .

The therapist then, during the course of his/her intervention, can assume and enact a range of roles within the likelihood that complementary positive roles will be developed in the client. These roles may provide the client with power, safety, creativity, dignity, control, containment, meaning, perspective, emotional release and harmony – experience that is most often opposite to traumatic experience. However before focusing on these research and treatment issues a brief discussion of the symptoms of post traumatic stress disorder – PTSD – is warranted.

The most common symptoms (Ref DSM IV for full details) experienced by Vietnam Veterans – are nightmares, flashbacks, intrusive thoughts and images, depression, anxiety, startle response, aggressive outbursts, irritability, difficulty sleeping, difficulty having intimacy and withdrawal.

There are many factors that influence the capacity for the traumatised Vietnam Veteran to develop intimacy with his family. Firstly associated with the symptoms of post traumatic stress is fear of vulnerability and fear of being 'unsafe'. That is, there may be concern to the risk of one's own life, or to the family and friends lives, but there is also the fear of overwhelming emotions. In particular for Vietnam veterans are the memories and feelings of near death experiences and the loss of 'loved' mates. That is because of the many shared life supportive experiences among Vietnam veterans, including recruitment conditioning, the protection of the fellow soldier's life is very much akin to the protection of his own life. This can lead to over protection of the family in later years.

Given the close bond to his fellow soldiers the identity of the group may become incorporated in the individual soldier's intra-psychic structure. Therefore the 'loss' of mates and the fracture of the group identity could lead to the fractured self identity of the soldier – Vietnam veteran, similar to the way in which parents and siblings can be internalised within each family member's psyche.

The experience of the fractured identity, together with the general loss, can make the transition into a traumatised state rapid and enduring. If he has limited coping skills and restricted internal framework there may be too many emotions – experiences – with which to deal. Unfortunately this has direct implications for the traumatised person's family. The veteran faces the dilemma that if he were to be vulnerable enough to openly experience intimacy, the feelings consequently generated may open the proverbial 'Pandora's Box' of non-experienced and blocked emotions related to his trauma; including the unresolved grief for himself and his lost mates. In basic terms to risk 'loving' is to risk losing and to risk even greater disintegration of the identity.

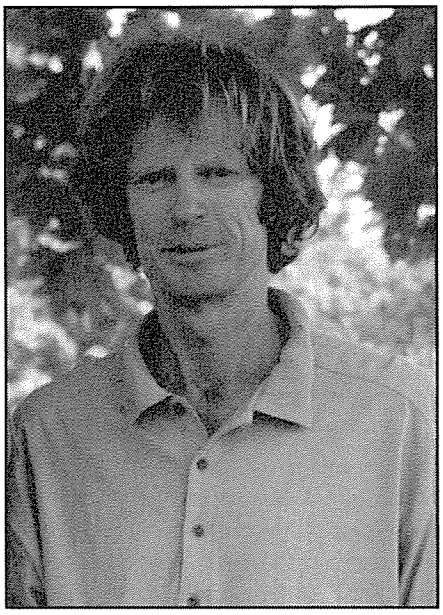
For the Vietnam veteran in particular – although not exclusively to other types of trauma victims – is the impact of unresolved family of origin issues and events after the war

that contribute to the endurance of trauma symptoms – such as poor intimacy or family enmeshment. Systemic family of origin interactive factors are in depth and complex. The patterns of withdrawal and poor intimacy and poor communication skills will impinge upon the trauma victim's capacity to recover from the trauma.

After the war many Vietnam veterans had experiences that made their traumatic conditions worse or created the traumatic condition. These experiences contributed to or created their physical and emotional withdrawal.

On return home from the war Vietnam veterans were treated very poorly by the public, government and often by his family. Rather than receiving the ritualistic and healing welcoming home, as warriors have for thousands of years, they were ostracised and abused. Moreover in many instances the partners and parents did not or could not listen to even the most peripheral of stories about the Vietnam war, thus leaving veterans locked in their misery of unresolved grief. There was no professional debriefing and little or no family and community support. There was instead abandonment. The few veterans who managed to receive family and community support report better recovery, adaptation and integration into the family and the community.

In my practice I have noted that for wives and partners of Vietnam veterans their exposure to being directly involved with the veteran while he experiences these symptoms can be highly distressful. Frequently they report being mistaken for the enemy Viet Cong during their husband's nightmares and flashbacks, sometimes being gripped by the throat or sometimes



Michael Burge

being in the middle of "battle" or "war zone". Often veterans would be in a state of "numbness" and then snap into aggressive outbursts with little or no provocation from their partner. In an endeavour to minimise the veterans outbursts or mood changes, partners would spend much time focusing on the veterans problems at the expense of their own needs. Consequently the partners would become depressed, anxious or have poor self esteem.

The partners would telephone the Counselling Service seeking information on how to handle the veterans; the partners were desperate, indicating that they felt responsible for the veterans problems. Some women were on the verge of leaving the relationship, others wanted couples' counselling; partners reported wanting to leave but were afraid to do so. The relationships were under great stress.

Many partners live in an uncertain and fearful situation and have to bear the full burden of running the family, due to the

veterans PTSD. This exacerbates the distress and difficulties between the couple and the whole family.

Resentments would fester. The veteran would feel his traditional role as "husband" had been severely compromised or lost, and the partner would feel she had lost her supportive husband.

A useful model for conceptualising and treating some of these couple and family difficulties is that of "CO-DEPENDENCY". Melody Beattie coined the phrase in her book Co-Dependent No More (1987). The wives may become so absorbed in the veteran's plight they defer focusing on their own psychological problems, or personal growth. The veteran's dependence provides her plenty of opportunity to administer "apparent control", rather than dealing with her own fear of losing self control. I say "apparent control" because the volatile nature of PTSD means less control in the family, more likely uncertainty and trepidation – there is the sense but not the reality.

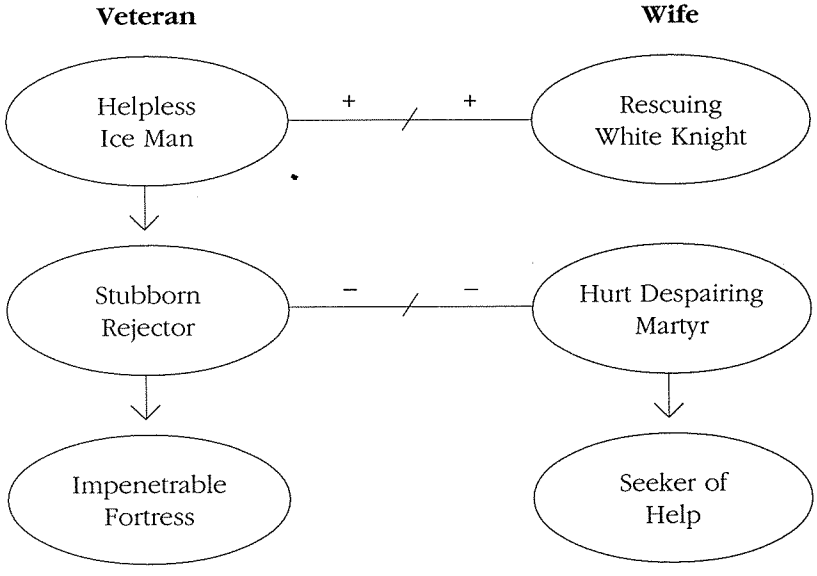
Over the years being exposed to the distress of the veterans trauma the wife develops co-dependency. I have discovered through my counselling practice that family of origin roles are an important influence in the relationship.

The existence of these old roles can lead to the initial attraction between the veteran and their potential partner. For instance the veteran who is helpless and fearful can choose a partner who has need to play the role of rescuer, problem solver, Ms Fix It, warden or

KEY TO DIAGRAM SYMBOLS

- - - - - - - Neutral
+ / + Mutually Positive
− / − Mutually Negative
− → One Way Negative
← + One Way Positive
− / + Positive Negative

DIAGRAM 1



psychiatric nurse. In the process, the veteran may become increasingly helpless or the partner could, through numerous failed attempts at helping – and other frustrated role blocks – become very helpless and victimised. Therefore she may be the one who in the end seeks "rescuing". In some instances there can be a rotation of these role states between the veteran and his partner [refer Diagram I).

Invariably the family of origin issues for the veteran and partner have to be resolved "contemporaneously" or "sequentially" through couples counselling or individual trauma treatment. Children of Vietnam veterans can be severely affected by PTSD

The difficulty for the traumatised Vietnam veteran to establish intimate relationships is a major stressor for the family, contributing to many secondary trauma symptoms.

The ramifications for the psychological well being for the children of the traumatised Vietnam veteran can be substantial. For instance, Rosenheck (1985) describes a condition that he calls secondary post traumatic stress. In one case study of a ten year old boy called Alan, Rosenheck noted that the boy was exhibiting a range of symptoms indicative of post traumatic stress. Alan had difficulty sleeping, poor concentration, had frequent headaches, was tense and confused, had numerous fears, violent at times threatening to kill his younger brother, and when he went to sleep was worried about being killed or kidnapped. His main fear was that his father would be shot like in the war (p. 538).

Rosenheck concludes that the child gained these secondary trauma symptoms through exposure to his veteran father's reliving of the war trauma. That is, through identification and from deep involvement and preoccupation in the emotional experience of his father, there was a deficiency in the child's own boundaries. Rosenheck mentions that similar symptoms exist in children of holocaust survivors. He also mentioned that treatment focused on helping the boy to disentangle his own experiences from that of his father, moreover, to gain his father's approval by doing well at school rather than imitating his father's preoccupation with Vietnam and violent behaviour.

In an extension of Rosenheck's work Laurie Harkness (1993) investigates transgenerational transmission of war related trauma. He reports that the impact of the father's PTSD on the second generation is contingent on how the family handles the situation. Therefore the pattern of family roles figure significantly.

If the veteran used withdrawal as a means of coping, excessive distance between family members develops with poor communication and poor protection. There is an absence of structure and authority. Alternatively, enmeshment patterns can develop in an effort to elude re-experiencing anxieties and vulnerabilities that were present

during the war. That is the family becomes somewhat of a fortress isolated from a "dangerous world". As part of this, there is over protection and control of family members. The down side for the family members is that they see themselves mostly in relation to their fathers problems; they have lack of autonomy and restricted personal growth. There are difficulties in relationship boundaries.

Similar to Rosenheck, Harkness found that when focusing on the father's violent potential, the children's behaviour and symptoms such as depression, anxiety, anger outbursts, are an attempt to understand the father's behaviour.

In terms of transgenerational treatment strategies it was recommended to consider the impact of social supports, poor familial communication skills, early childhood abuse, and in particular preventative programs. He considered it important to assess the family system coping ability as soon as possible after the traumatic veteran (person) is re-united with his family. It is important to create a safe intervention environment, establish a no violence contract, strengthen the ego-functions of the children and teach new ways to overcome old problems.

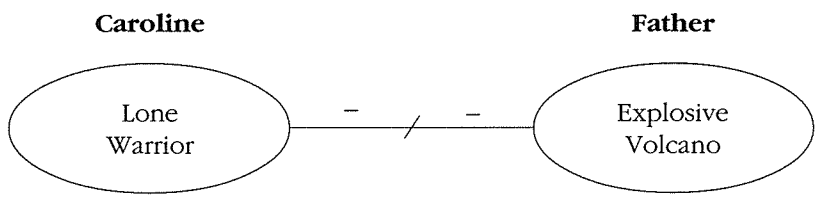
In my own practice I have found similar patterns to the above studies. The client was a young adolescent female of thirteen years of age. I'll call her Caroline. She is the daughter of a Vietnam veteran. Caroline is reported by teacher and parents to have problems of disruptive behaviour at school and to be unhappy at school.

Over approximately eight sessions Caroline indicated that she was very much alone and alienated from the other students. She described her father as a big volcano periodically "exploding" [Refer Diagram 2]. Conflict between the parents was on going. Caroline also indicated that her father was very controlling. There was an overt expression of guilt or responsibility for her father's difficulties. Although Caroline often mentioned that she had a yearning for a "closeness" to exist in the family that was apparently absent, I gathered there was oscillation between too much separation and too much enmeshment. Her older brother had a history of getting into many fights.

In the early sessions Caroline reported to have suicidal thoughts, but these disappeared through the first three sessions. Treatment consisted of mutual story telling, drawings, and psychodrama. It was interesting to observe that, in her drawings when describing alienation from her peer group, there emerged a theme of her being surrounded by hostile school students with guns wishing to do her harm. The students were of different alien facial and body features. For example, she could have a round head and they would have square shaped heads. When asked what would she need to include in her fantasy drawing to make her self safe, Caroline quickly conjured up a helicopter to rescue her from above. The helicopter then transported her to a tranquil safe place with lots of trees, away from the hostility and the treachery. [Diagrams 2, 3 & 4 show Caroline's drawings]

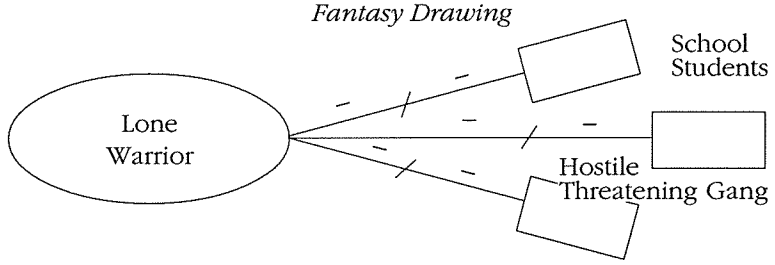
The similarity of Caroline's drawings to drawings of Vietnam veterans that I have counselled was quite remarkable. Although Caroline made no direct reference to the Vietnam war in her drawing or story telling, the studies previously mentioned (Rosenheck, Harkness)

DIAGRAM 2



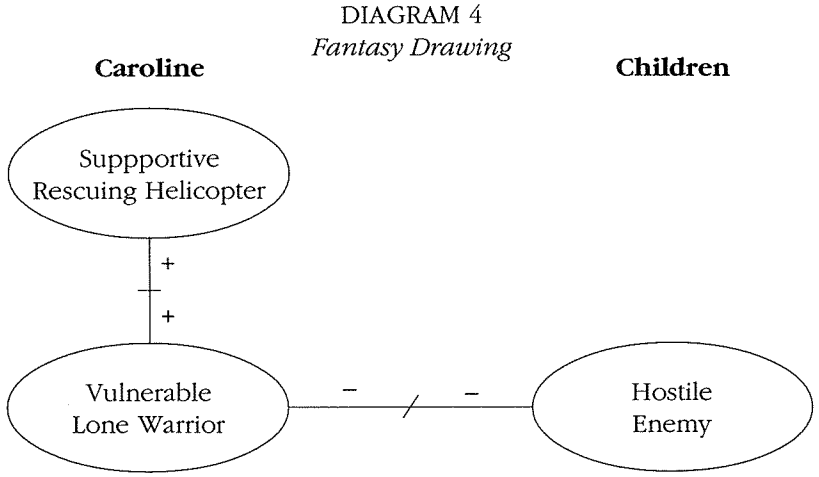
Caroline alone and against the exploding volcano

DIAGRAM 3
Fantasy Drawing



This is a diagram of Caroline seeing herself with her friends

DIAGRAM 4
Fantasy Drawing



indicate that the representation of secondary trauma symptoms of transgenerational war experiences can be unconscious. I make no conclusion in Caroline's case but note with interest the emerging patterns from her trauma. Drawing and story telling are useful means of understanding more about transgenerational trauma issues.

Treatment Using Psychodrama

As I have previously mentioned, psychodrama has been used in conjunction with Art therapy. The themes and scenes emerging in the drawing are readily adaptable to psychodramatic scenes. This is also the case for developing roles and other roles recognised through role analysis [Ref Diagrams 5, 6, 7].

I will demonstrate this interaction by reference to Caroline's psychodrama.

In the first session Caroline indicated that she was suicidal. She felt despairing, isolated, neglected and betrayed by her friends. Caroline said that her parents and teachers described her behaviour as attention seeking, defiant and withdrawing. Caroline said that she often felt hurt and let down by her friends even after trying to help them with their school work.

Through my interview of Caroline she warmed up to conflicted roles. She described herself as alone and despairing in a barren desert. At the edge of the desert was a huge brick wall. The wall had a slight hole, through which she could see a beautiful lush garden. Her trusted pet cat Felix was also in the garden, beckoning Caroline. The cat was the only one that she trusted completely. Caroline said that Felix loved Caroline and she loved Felix.

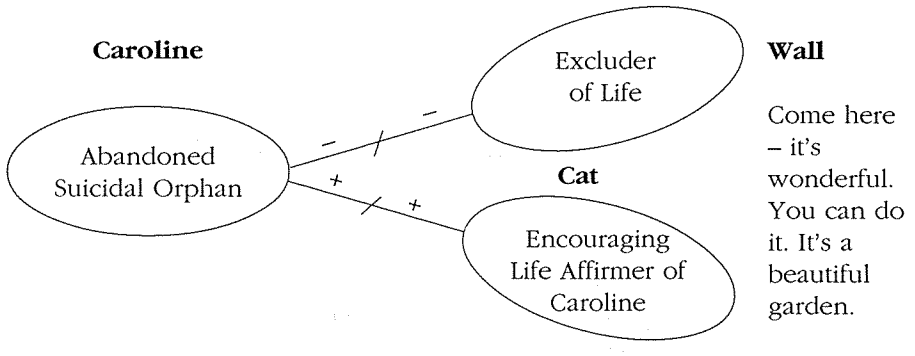
Enactment took place between the roles of Felix the cat in the garden, the wall, and Caroline abandoned in the desert. [Refer Diagram 5].

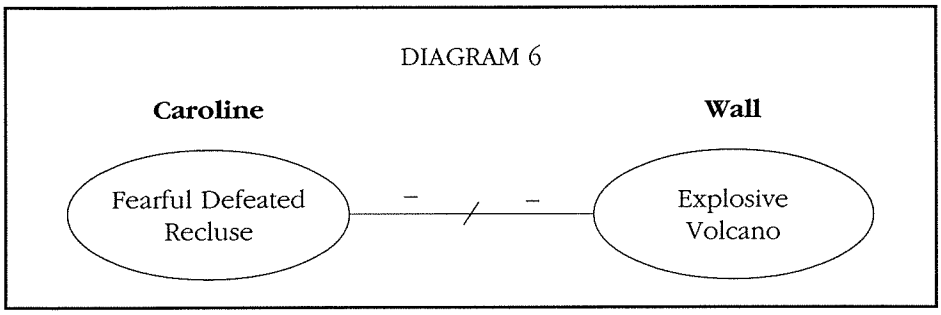
At one point during the enactment while attempting to climb through the wall Caroline retreated fearful and teary. She expressed from that role that she felt that the wall was about to explode on her, a new scene emerged [Refer Diagram 6].

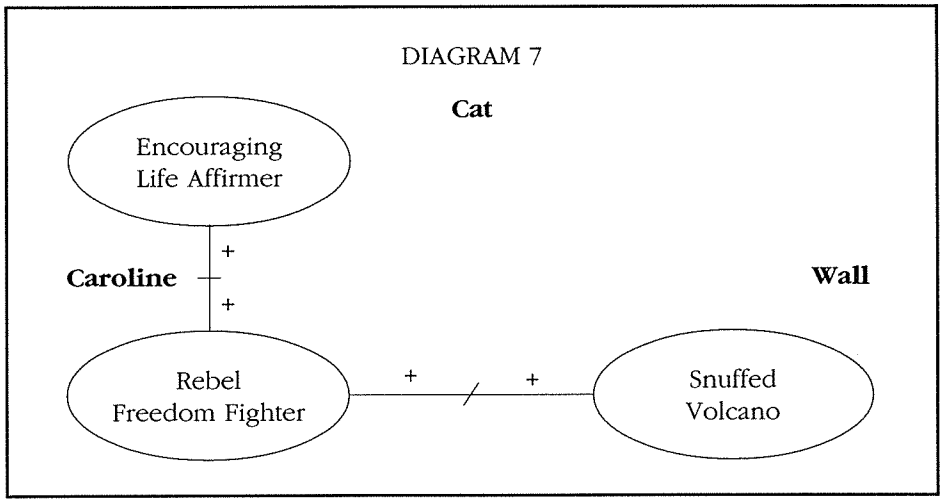
However, through my coaching and role reversals, Caroline became aware of the cat's encouragement and strength. The cat's role evolved taking on magical powers, and gave these to Caroline. Caroline then conjured up a whirlwind and blew the volcano out. These role developments are demonstrated in Diagram 7.

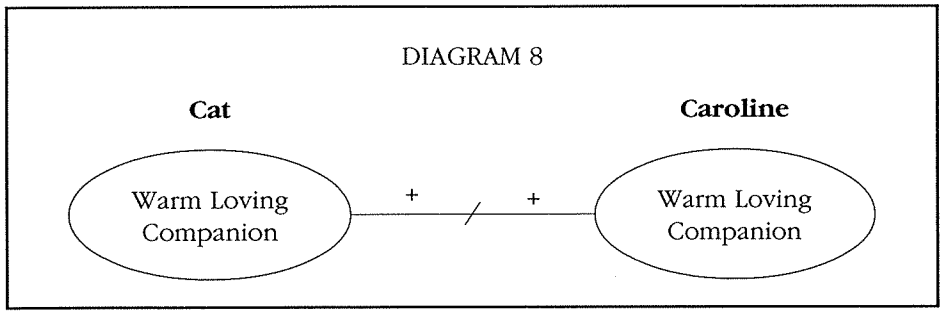
The volcano became a dormant brick wall that Caroline could easily climb through with continual encouragement from the cat. Both Caroline and the cat sat in the beautiful lush garden. The wall and the desert disappeared. The cat and

DIAGRAM 5
You must stay in the desert









Caroline sat in the garden speaking fondly to each other.

At all times I was interested, affirming and appreciative of Caroline in my role as director, producer and coach. I interchanged with Caroline's roles using doubling and mirroring. This helped maintain her warm up to her different roles, and enhanced spontaneity and creativity. When I played the role of Felix the cat I extended that role being particularly encouraging and supportive. That is, providing role training for Caroline, enabling her to choose the roles best able to assist in overcoming fearful and despairing roles. Caroline responded well to me playing her roles, responding playfully and gleefully.

In the following two sessions Caroline reported feeling generally happy, not at all suicidal and was looking forward to overcoming

Figure 1: Role System of Caroline

Progressive Roles	Coping Roles	Fragmenting Roles	
Playful funlover Artist Animal lover Problem solver	Controller Attention seeker Rebel Rescuer of others Hopeful yearner Approval seeker	Suicidal despairing orphan Victim Hurt martyr Fearful child Isolate	**A** 1st Session
Warm companion Problem solver Risk taker Artist/storyteller Freedom fighter Spontaneous actor Self-appreciator Teacher – learner Self-compassionate observer Life seeker Animal lover	Rebel Attention seeker Rescuer of self Hopeful yearner Approval seeker	Hurt martyr Isolate Victim	**B** 6th Session

school and home difficulties. Caroline was feeling firm and solid in herself.

Further work with Caroline may include role training so that she can maintain herself in her family; for example, to be aware when she is having her boundaries violated and how that can be avoided. Training in the role of systems analyst and escape artist would assist Caroline.

Role Development

There is an extensive role development in Caroline through her art and psychodrama work. These are depicted in Figure 1.

Observations of the progressive role system of Caroline indicate that the playful funlover and the artist are her most developed progressive roles. The roles of self-compassionate observer, and life seeker, and spontaneous actor, and teacher would assist in the integration of her progressive functioning.

Observation of Caroline's coping role system indicates that in many situations she deals with frustrations and despair by attention seeking and her powerlessness by rebelling or rescuing others. While these roles help Caroline cope she sets herself up for disappointment and despair; leading to the emergence of fragmented roles. However I noticed that coping roles such as rebel and approval seeker assisted in the emergence of progressive roles such as determined life seeker, story teller and self-appreciator for instance as in Figure 1.

The main role in Caroline's fragmenting role system appears to be abandoned despairing orphan.

Related to these are victim, suicidal child and fearful and defeated recluse.

Greater development of fun lover, self compassionate observer, warm loving companion, self-appreciator roles as demonstrated in Figure 1 B are likely to provide Caroline with the opportunity for better peer relationships and an avenue to a healthier state.

Finally, from my perspective and experience – counselling traumatised Vietnam veterans and a variety of other trauma victims – there is an ongoing effort for the victim to resolve the devastating effects of the trauma experience. Some of these attempts are destructive to the traumatised person and their family, other attempts facilitate healing. There are efforts to resolve the overwhelming feelings of powerlessness and victimisation bestowed upon them by the "perpetrator". The perpetrator may be, for example, an enemy soldier, a rapist, or a bushfire.

The symbolic representation of the resolution process can not be underestimated. For instance, there are many examples of Vietnam veterans engaging in counter-phobic risk taking activities such as enlisting in foreign wars, or seeking dangerous civilian jobs. These are often symbolic of embracing the trauma or may be an attempt to overcome the associated trauma fear. There are also examples of veterans having difficulty with authority figures and government institutions; the classic Rambo series of films symbolises this activity. There are implications here for second generation children of parent trauma victims such as Vietnam veterans as the case of Caroline shows.

Implications

Antisocial, withdrawal or other psychological or social difficulties may be second generation attempts to resolve the primary trauma on behalf of their parents.

The implications for the treatment of individuals experiencing primary or secondary trauma symptoms – including the whole family – could be for the counsellor not to focus on the end behaviour roles; such as trouble maker, racist, uncooperative actor, controller, self sacrificer, or aggressor. It may be more advantageous for the counsellor to focus on symbolic representations rather than the acting out behaviours.

That is, help the veteran develop the role of all-seer or systems analyst in order to differentiate between the past enemy perpetrator and present shadows or reminders. Developing a non-critical, trusting, collaborative, explorative relationship with the counsellor will assist the veteran to gain a broader perspective about the influences on their reactive

aggressive or self defeating emotions and behaviour.

Included in this could be the exploration of triggers such as authority figures, aliens, or government personnel, such exploration could move behind the triggers to uncover representations of earlier traumatic experience.

The benefits of these strategies is to assist the counsellor–client relationship, alleviate obsessive attention to the triggers, create a sense of safety with the particular intervention and to help move the client or family away from restrictive or withdrawn defensive positions towards positions whereby the 'universe' is experienced as a much safer place.

Summary

The purpose of the present article was to demonstrate treatment strategies, and the affects of, for families suffering from direct or indirect exposure to trauma. The cases presented highlighted how trauma, in particular war trauma, permeates from one generation to another. The challenge for the primary trauma victim is to work through the painful and devastating experience in a way that minimises the risk of spreading the terror or despair to his family members. The treatment strategies centred around the power of psychodrama theory and practice to effect substantial resolutions to intrapsychic conflicts and emotional pain caused through post traumatic stress. Through the strengthening of creative life giving roles, the traumatised individual can create peace with themselves and once again feel a part of the universe.

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Letter to the Self

A Technique to Assist Role Assessment and Intensify Level of Warm Up in One-to-One Counselling

by Patrick Fleming

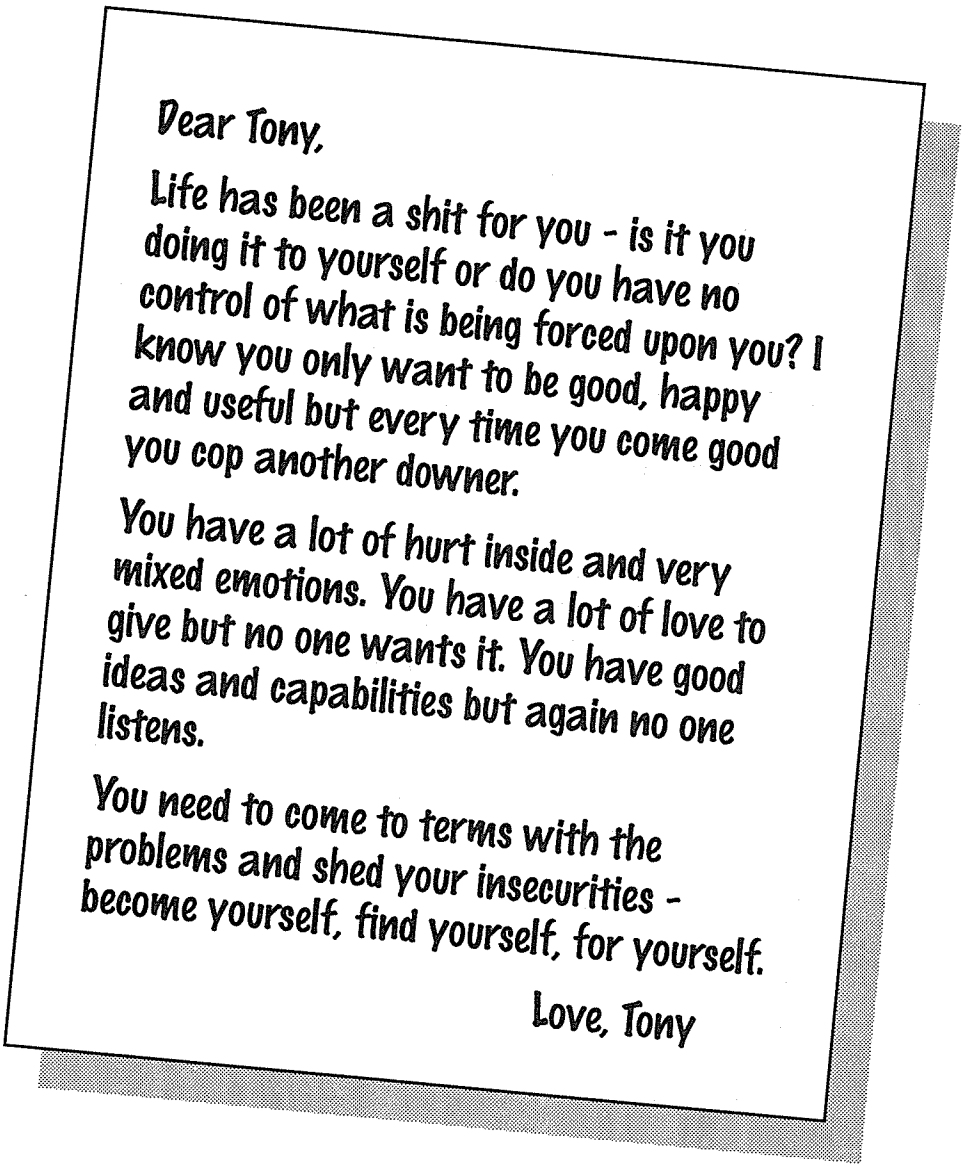
Patrick Fleming is a clinical psychologist working in the Canberra Public Health System and in private practice. He is a staff member of the Psychodrama Training Institute of ACT, he has passed his practical assessment as a psychodramatist and is in the final stage of completing his thesis.

Directing a client to write a letter to Self on the whiteboard during a one to one therapy session facilitates their warm up and indicates paths toward progressive development.

Tony sits deep in the chair. Today his body seems small. He stares mostly at the floor and occasionally glances at me from under his eyebrows. He is deep in gloom. 'I thought I was getting somewhere with you. Now this has happened and it is all back to square one'. We are at the beginning of the fifth session. The air has become thicker and darker, the room cheap and tawdry. Life is mortgaged to despair.

Tony is forty nine. He is a professional photographer on the staff of a university. In the last year he has become increasingly morose, his wife has left and his workplace is being reorganised in ways that he sees as very destructive. An early family environment which was sadistic and punitive had been brought forward in the work and enactments had been produced which have effected some social atom repair. Several days before the present session he drunkenly assaulted a bouncer at a nightclub and he now faces serious charges. He has never acted in such a way before. He is downcast, frightened, ashamed, and blaming.

Assuming on our established positive relationship, I remain dispassionate. I direct him to act. 'Go to the whiteboard. Take a felt tip and write a letter. Write a letter to yourself. Write 'Dear Tony' at the top, 'Love, Tony' at the bottom. 'Now fill in the body of the letter'. Tony at first looked disappointed that I was not sympathising with his position. He then quickly stood up



and, taking a felt tip pen, began to write ...

At the completion of his task I invite Tony to sit down so that we may both ponder upon his letter.

As Tony was writing I made an assessment of his role system and identified those roles which needed to be mobilised in the here and now. Although Tony is despairing there are several positive roles in relation to himself which he indicates in his letter. It is to these roles, in addition to the despairing roles, that we need to address our attention in this session.

I pointed out that in his letter Tony had made generous evaluations of himself, he had displayed a tenderness toward himself, and had expressed a vision of himself toward which he wished to develop. I suggested that his initial movement from defeat into action had become gradually lost as he wrote and warmed himself up in his writing to his personal story of

The Role System of Tony

Progressive Roles	Coping Roles	Fragmenting Roles
generous self assessor	yearning exile	despairing reject
seeker of self	confused ruminator	
	stubborn Eyore	
	woeful martyr	

despair. I invited him to see that his positive expressions toward himself had become overwhelmed by this despair. I then described the various roles that I saw in his functioning (see role diagram).

On the basis of this work Tony set out each of the roles using objects in the room. He was then able to identify the various roles in his own functioning. In the conclusion of the enactment he brought forward the previously underdeveloped roles of *generous self assessor* and *seeker of self.*

The technique of a letter to self offers a number of benefits in the one-to-one setting. Firstly, the intervention offers spontaneous novelty. The second benefit lies in the invitation to the client to become a *systems analyst.* In joining with an exploration of his system Tony developed an overview of a situation in which he was enmeshed. The third benefit of the intervention is that it creates a setting for a self generated mirroring. Tony's functioning was displayed, to himself, by his own projected work without my intervention beyond the initial invitation to write. Finally, the letter to self can provide an excellent warm up to further enactments.

Trick and Treat

The trick
is to seize the moments
for short, sharp action

and the treat is to live between them
'like a river flowing home to the sea'.

Poem: Dinah Hawken / Illustration: Milena Mirabelli

25th Anniversary of the Commencement of Psychodrama Training in Australia

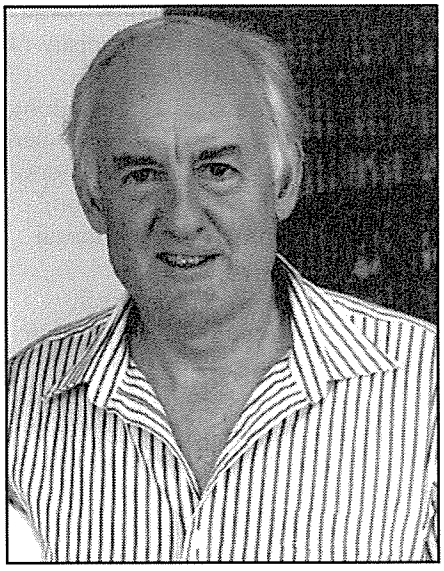
by Max Clayton

Max is the Secretary of the Board of Examiners, ANZPA Inc. He is a Psychodramatist Trainer, Educator and Practitioner and is the Director of Training of the Australian College of Psychodrama in Melbourne.

These few paragraphs are for the purpose of celebrating the 25 years of effective training, the spread of effective psychodrama practice throughout all parts of Australia and New Zealand, the development of ten Training Institutes which have made a great contribution to the lives of thousands of professional people and to the injection of spontaneity into fields of endeavour which had become prosaic and mediocre.

We celebrate the work of the Presidents and Executive Committees of the Association, the work of the Psychodrama Institute of New Zealand, the work of those who have completed practical assessments, theses, articles and books, those who have brought about Training Institutes, training events, Gatherings, Conferences, and all the other innumerable events that have contributed to our training and development.

The Psychodrama Institute of Western Australia was founded in December 1971 by Max Clayton and Lynette Clayton. This marked the beginning of formal training in sociometry, psychodrama, sociodrama, role training and general group work in WA. The first course conducted by the Training Institute was in general group work in early 1972 and was attended by 32 professional people. Subsequently regular weekly training groups were conducted. Standards of training were refined during the 1970s



Max Clayton

leading to the development of the Training and Standards Manual which was accepted by the Australian and New Zealand Association of Psychodramatists, Sociodramatists, Sociometrists and Role Trainers formed in January 1980.

The conduct of national training workshops at the University of New England in Armidale, commencing in January 1974, marked a rapid growth of the psychodramatic method and in particular led to the organisation of the first psychodrama training workshop in New Zealand by Lorna McLay conducted at the University of Auckland in August 1974. The training workshops, conducted along similar lines to workshops developed by Jacob Moreno and Zerka Moreno at the Moreno Institute in Beacon, New York, were definitely unusual, challenging and inspiring to participants, opening up a fresh vision of what could be achieved in work with groups, families and individuals. Participants opened up hitherto unknown or hidden aspects of their being and to their surprise discovered that this was not as frightening as they had previously thought but, on the contrary, caused them to appreciate abilities which had been ignored and to integrate roles which had previously expressed themselves in a fragmented form.

This reference to the 25 years of psychodrama has also the purpose of all of us who are practitioners or trainees building on what has been achieved so far. This is a good time to focus on the end of 50 years of psychodrama training which will come about in December 2021. I wonder what the world will be like at that time. Irrespective of what the world will be like, we are all capable of developing in such a way that our spontaneity will still be a catalyst for the creativity which resides in all of us.

Dissociative Identity Disorder and the Psychodramatist

by Trish Reynolds

Trish is a psychotherapist working in private practice in the southern part of Western Australia. She originally trained as a medical practitioner. This paper is her psychodrama thesis which has been accepted this year.

Everybody dissociates at times and everyone is sometimes amnesic. Who of us has never driven a familiar route and arrived at our destination with no memory of how we actually got there nor of the process of getting there? Sometimes called 'highway hypnosis', this is an example of the process of dissociation and its accompanying amnesia. It is perfectly normal, and all of us do it sometimes. Some of us are fortunate enough to have only ever dissociated because of boredom, others have, in addition, dissociated as a way of coping with otherwise overwhelming trauma. I am one of the latter.

I first became interested in the subject of dissociation after, at the age of thirty-six, I recovered memories of sexual abuse which had begun at the age of two. That was in 1984 and at that time there was very little information about dissociation in the literature. Major works such as Judith Lewis Herman's *Father-daughter Incest* did not so much as mention dissociation. I remember, in my frantic search for validation of my process, writing to Herman. Her blessedly prompt reply included an apology and a copy of a paper she had just written describing the process of dissociation and repression of memories in survivors of childhood sexual abuse. I felt less crazy.

I first became interested in the subject of dissociation after, at the age of thirty-six, I recovered memories of sexual abuse which had begun at the age of two ...

There is a similar paucity of validation available now, in 1995, for people who went a few steps further than I did with their dissociative process, and developed multiple personalities during and after extreme early childhood abuse. Through my reading, and what I have learnt at workshops and by having now worked knowingly as a

therapist with twelve people with multiple personalities I have some understanding of what separates those people from me. It is most certainly nothing to do with superiority in strength of character or anything like that. Rather, truly relevant factors include the following: I was not required by my perpetrator to participate actively in the abuse; I was not subject to sadistic abuse; I was victim to only one perpetrator, and finally, maybe I just wasn't all that good at dissociating! In the words of Herman, people with dissociative identity disorder achieve "virtuosic feats of dissociation" (Herman, 1992:124). From what I have seen with my clients I agree with this description: the dissociative feats which facilitated their continuing function and survival are astounding and deserving of great respect.

As to the aspects of my professional identity relevant to my choice of the present topic for this paper, I was originally a medical practitioner who practised as a medical oncologist until a combination of burn-out and the emerging memories of childhood sexual abuse referred to above culminated in my leaving clinical practice for a total of six years. During that time, I wrote two books, one of which – *Tricia's Song* – was an account of my healing from childhood sexual abuse.

In 1989 I started a private practice as a psychotherapist simultaneous with commencing training as a psychodramatist. I also studied solution focussed therapy techniques and the narrative therapy of Michael White and incorporate the principles of these approaches in to my current practice. For readers who are not familiar with these models, good introductory texts include *Working with the Problem Drinker – a Solution Focussed Approach* by Insoo Kim Berg and Scott D. Miller, *Resolving Sexual Abuse* by Yvonne M. Dolan and *Ideas for Therapy with Sexual Abuse edited by Michael Durrant and Cheryl White* .

I work mainly with clients whose major therapy goal is to resolve symptoms which they attribute to early childhood abuse. Many of these clients, like myself, have used dissociation as a preferred coping strategy. Some – a total of twelve that I have recognised – have developed multiple personalities as part of their adaptation to gross, ongoing, sadistic childhood abuse. For at least eight of these clients the abuse has included abuse by organised perpetrator groups, such as Satanic cults and organised child pornography and prostitution rings.

Both my personal and professional experiences have thus contributed to my choosing to write this paper on the topic of dissociation consequent to childhood abuse. I wanted to contribute towards educating psychotherapists in general and psychodramatists in particular about this process and so help to ensure that people with multiple personalities get the validation and respect for their ways of coping with their abuse that they deserve.

Introduction

This paper begins with a review of the general literature about dissociative identity disorder with respect to its nature, aetiology and diagnostic criteria. The evidence that this disorder is an adaptation to serious early childhood abuse is discussed. A description of dissociative identity disorder in terms of role theory and systems theory follows, with some clinical examples.

The thesis that the separate personalities of the person with dissociative identity disorder consist of role clusters rather than single roles is explained. A metaphor of a house and its internal structure is used to help explain the differing awareness that a client's personalities may have of each others presence and activities and the variable amnesia that these clients can experience. Goals of therapy include assisting the client towards awareness of their entire system and working towards a cohesive, internally consistent world view.

The importance of recognising this adaptation to serious early childhood abuse is then explained, both for the therapist in general and the psychodramatist in particular. Fragmentation must be recognised before it can be addressed. In addition, inclusion of a person with dissociative identity disorder in a psychodrama group is contra-indicated until they have developed enough awareness of their system and process to be able to honour a contract and maintain continuity through repeated role reversals.

Guidelines for recognising dissociative identity disorder in the psychodramatic setting follow, accompanied by an explanation as to why the diagnosis is often obscure and easily missed. Indicators discussed include history of abuse, indications of switching, indications of time loss/amnesia, refusal , reluctance or inability to reverse roles, use of the terms we/she/he/ not me, witnessed disavowed behaviour and evidence of internal voices.

Finally, ways of modifying the use of some psychodramatic principles in order to utilise them safely and effectively in individual sessions with the newly diagnosed multiple are described. Principles discussed include systems theory, setting out all elements of the system, using direct address, concretisation, promoting authentic encounters, role reversal, looking for the health in the system, role analysis, maximisation, and of course, promoting spontaneity in both client and therapist.

A Psychodramatic approach to the management of dissociative identity disorder

Dissociative identity disorder is common. It is usually well disguised, and therefore is often misdiagnosed. These misdiagnoses are tragic because dissociative identity disorder is extremely treatable. This paper will help the reader to understand how and under what circumstances multiple personalities are created, to recognise clues to the presence of multiple personalities and to use the principles of psychodrama to best assist any of these clients that you encounter in your practice.

As I explain in the body of this paper, inclusion in psychodrama groups is contra-indicated for the newly diagnosed multiple. For such clients role reversal typically results in switching from one personality to another, which is physiologically demanding and likely to be accompanied by amnesia, confusion and disorientation. Such a client requires one-to-one work until they have developed both a good enough understanding of their own internal system and enough co-consciousness – personalities having an awareness of the actions and thoughts of other personalities – to be able to sustain continuity through a number of role

reversals. It is only then that they will have the capacity to honour a psychodramatic contract and to benefit from classical psychodramatic group work.

In the meantime, effective work with these clients, while best conducted on a one-to-one basis, nonetheless still demands a sound understanding of systems theory. In this paper I describe some adaptations of psychodramatic principles that I have developed for use in the one-to-one setting with newly diagnosed multiples. I have found it useful to think of the client as a group, all of whose members are within the one body! It's important however, never to lose sight of the last bit – all in the one body – because this is a reality that your client will not always be able to hold.

Review of the literature on dissociative disorders

Dissociation is a normal, and for many children becomes a preferred and habitual, response to overwhelming and repeated trauma. (Bryant et al; 1992:5). A dissociative response is particularly likely when the trauma is experienced by the child as life-threatening e.g. forced fellatio, being beaten to the point of unconsciousness or being silenced by a pillow held forcibly over the face during sexual abuse. The definitive factor is the presence of extreme and overwhelming anxiety in the child. (Bryant, 1992:5) A child victim using simple dissociation, as opposed to creating separate, new parts of the self or alternate personalities, to cope with such trauma-induced anxiety is often subsequently amnesic for the event. When the event[s] is/are later recalled, out of body experiences are often reported, such as watching the trauma from the ceiling or the wall, including seeing details from that vantage point that would not have been visible to their physical eyes. The body is typically seen as having been passive or like a rag doll during the abuse.

In contrast, dissociative identity disorder, formerly known as multiple personality disorder, is a much more complex phenomenon. Like simple amnesia, there is good evidence that in almost all cases it occurs in people who have been subject to extreme trauma. In the case of dissociative identity disorder the trauma has virtually always been repetitive, sadistic and starting before the age of five (Marmer, 1991). Herman (1992:126) argues persuasively that this disorder is best understood as a variant of what she calls 'complex post-traumatic stress disorder. Murray (1994) provides a good review of the literature pertaining to the indisputable link between dissociative identity disorder and childhood, specifically sexual, abuse.

Putnam (1989:49) states that 'the abuse suffered by multiple personality patients tends to be far more sadistic and bizarre than that suffered by most victims of child abuse.' This is true. However, in my opinion, there is an additional key factor which leads to a child forming split off, internally-experienced-as-completely-separate parts of the self, as opposed to simply being amnesic for traumatic events.

This additional factor lies not in the child, but in the requirements of the abuser. Simple dissociation suffices for the child who is permitted by their abuser to be non-participatory. However, a child who is required by their abuser to actively participate in the abusive events in

some way, having dissociated, must then produce an aspect of the self which can do what is required e.g. manually masturbate the abuser, speak or act 'seductively' as defined and instructed by the abuser, kill an animal or hurt other children. These are all examples from my own clients histories.

What exactly is dissociative identity disorder? Here are the official criteria for diagnosis as listed in the *Diagnostic and Statistical Manual 1V* (American Psychiatric Association, 1994:477)

"A. The presence of two or more distinct personality states [each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and self].

B. At least two of these identities or personality states recurrently take control of the person's behaviour.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The behaviour is not due to the direct physiological effects of a substance [eg. blackouts or chaotic behaviour during alcohol intoxication] or a general medical condition [eg. complex partial seizures]. NOTE : In children, the symptoms are not attributable to imaginary playmates or other fantasy play."

I find the following a useful description for conceptual purposes: "The person who develops dissociative identity disorder is not literally comprised of 'many people' but has a normal psyche comprising many different component parts, aspects or facets of the one psyche which have dissociated to cope with trauma or abuse and developed with varying degrees of internally perceived, apparent autonomy and identity" (Halpern & Henry, 1993).

Having now defined this disorder and provided you with the diagnostic criteria, I will refer to dissociative identity disorder from now on by the generally accepted acronym of DID. Similarly, when referring to this disorder by its previous title of multiple personality disorder I will use the generally accepted acronym of MPD.

A description of dissociative identity disorder – formerly multiple personality disorder – in terms of role theory and systems theory

a. A basic description

I want to stress that the "different component parts, aspects or facets" of Henry and Halpern's description are not each single roles but rather, complex role clusters. Look at section A of the criteria from the Diagnostic and Statistical Manual. The description of what comprises a 'distinct personality state' is a description of a complex role cluster, not of a single role. People with DID can also have one or more distinct aspects which consist only of a single role, these are usually referred to in the DID literature as fragments. The more usual role clusters are referred to as personalities or alters, which is an abbreviation of the term alternate personality.

Changing from one role cluster or personality to another is called switching in the DID literature. Switching is physiologically demanding and can result in lassitude and severe headaches. It's not like simply reversing roles is for

those of us who do not have this degree of dissociation. Demonstrable physiological differences between personalities are well documented (Putnam, 1989:123) eg. in response to prescribed medications, alcohol and other drugs, in allergies and in vision and hearing. I have one client who takes her glasses on and off with switches because of the accompanying changes in her vision. Another complains that her hearing goes 'weird' and she is partially deaf while one particular personality is 'out' but has normal hearing the rest of the time. A severe headache can vanish or appear with a switch, as can other physical symptoms such as drowsiness. Because of the accompanying physiological changes, repeated switches over a short period of time can leave a person with DID exhausted. This has obvious implications for the psychodramatist.

People with DID differ from those of us who don't have DID not in their internal complexity but in the degree of their internal compartmentalisation. Clayton (1981:5) describes it thus: 'The person described as a multiple personality has multiple role states or clusters of role states which from the point of initial trauma develop no connecting links between them and have variable connective links with the conscious regulating ego which represents only a partial expression of the creative genius.'

b. A metaphor for guiding therapy and explaining the disorder to the client

I have developed a metaphorical description of DID which helps me to make sense of what I see in my clinic. This metaphor is also useful for explaining the disorder to the client.

People with DID function a bit as if they have a series of complex role clusters, each of which occupy a separate room in a house. Some rooms have open doors and some rooms have locked doors. Some role clusters can roam all over the house, some have access to only a few rooms and don't know the rest exist and some are confined to locked rooms for which they themselves do not have a key. Some role clusters hold a number of door keys, some have none. Or, in other words, some know about the whole internal system, some know about limited parts of it and some only know about themselves, i.e. they are amnesic for the other role clusters and their activities. How you as therapist perceive the system from the outside depends on which role clusters present themselves to you.

Note that amnesia is rarely consistently present throughout a system. Within any one system there will usually be some personalities or role clusters who are amnesic for all the others, some who are amnesic for some of the others and some who are not amnesic at all. In the literature, awareness of the presence and activities of other personalities is called co-consciousness. Co-consciousness, or awareness of the rest of the system is a primary goal of therapy, and obviously must precede attainment of co-operation between or integration of the personalities.

c. A clinical example illustrating the process of development of new personalities

The following clinical example will concretise some of what I am saying. I will preface the example by

explaining that once the ability to develop new personalities as a means of coping with trauma is established, new personalities may be created at any age, including adulthood.

A client with fifteen personalities once described to me the process of formation of one of the chronologically later developed of them. She was being savagely beaten by her father at the age of eight when the thought occurred to her that he only beat the boys – her brothers – in this way. This was immediately followed by the thought " I must be a boy" and with that a new personality was 'born'.

Over time this personality developed a number of different roles – 'he' was the one who endured the savage beatings, who tried to run away from these beatings, who did dangerous things to try to please father like clambering quickly over water-washed rocks on fishing expeditions while trying to keep up with him etc. 'He' was outwardly bold and adventurous although inwardly quite fearful. 'He' was a loner. 'He' didn't cry. 'He' held father in high regard, this regard being facilitated by 'his' amnesia for the sexual abuse which father perpetrated on some of the female personalities. This 'boy' was not just a role but a complex role cluster with different experiences, beliefs, attitudes and behaviours than some of this client's other role clusters or personalities.

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d. Goals of therapy with a client with dissociative identity disorder

I have already stated that a primary goal of therapy with these clients is to facilitate awareness of their entire inner system and from there to help them to develop co-consciousness, which means awareness not only of the presence of the other personalities but also of the thinking, beliefs and behaviour of the other personalities. Once co-consciousness is fully attained the client will no longer experience amnesia and will have a sense of continuity which paradoxically, they may initially experience as quite bewildering.

A further, necessarily subsequent, goal of therapy is the development of more effective functioning of the person as a whole through the achievement of either cooperation between or integration of all of the personalities. This goal can only be reached after the attainment of the intermediate goal of developing a cohesive, internally consistent world

view, something that these clients never have in the early stages of therapy for reasons which I will now explain.

Clayton, (1994:124) states: "A well-functioning person may become conscious of a multitude of pictures associated with each major role in their personality and of the fact that each picture complements the others and contributes to a larger vision." People with multiple personalities are not well-functioning in the sense that before co-operation or integration is achieved it is never true for them that each picture complements the others and contributes to a larger vision. The pictures associated with each of their role clusters are always contradictory. It is precisely these inner contradictions that make the continuation of their internal compartmentalisation necessary and indeed, comfortable, compared to living concurrently with very differing pictures.

The genesis of these contradictory inner pictures lies in the contradictory external world in which they had to live as children. To return to my case example, this client as a child could not tolerate the external contradictions of being treated 'like a boy' e.g. being beaten 'like a boy' and being taken on 'boy's' fishing expeditions and also being sexually abused as the girl which she in fact was. So these contradictory aspects of her life were held, on an on-going basis, in different role clusters or personalities which were amnesic for each other. Each role cluster built up, over time, it's own set of experiences, beliefs ,emotions and behaviours, some of which were contradictory eg. beliefs like I must be a boy/ I must be a girl, dad likes me/dad hates me. This client will not achieve full cooperation between her personalities until they all pool their information about past experiences and dialogue with each to a point where they can recognise and keep external the contradictions with which they lived. For instance, as long as she internalises the beliefs that she is both male and female, she cannot achieve consistency internally and therefore cannot achieve a consistency in how she relates to or views the world.

Here is a clinical example to demonstrate how the use of role theory can assist with achieving the goals of greater inner cohesiveness and elimination of contradictions with resultant more effective functioning.

Within a DID client's system, there are typically one or more personalities whose organising role is that of 'protector'. These personalities are typically experienced by others in the system, and by the therapist , as aggressive, obnoxious, harmful to self and/or others, obstinate and unfeeling . An analysis of the 'protector' personality's roles can help the other personalities to understand that the feared, disliked and unwanted behaviour is based on different beliefs, especially with respect to the outside world.

Phenomena like fogging of thoughts, stopping of speech, and self abusive behaviour, such as drug abuse, cutting and bingeing on food, may then be seen for what they are – attempts on the part of the 'protector' personality to keep the whole person safe. Such phenomena often represent attempts on the part of the 'protector' personality to prevent or punish any talking about past abuse. The 'protector' does this because it believes that this behaviour endangers the whole

system. This motive is typically unapparent to those of the rest of the system who know that talking about past abuse is not currently dangerous. This is a common example of different beliefs and world views within a system creating problems.

Once the rest of the system understands the motives of the 'protector' they can stop viewing and treating this personality as an enemy. It is then relatively easy for them to take the next step and grasp that the 'protector' personality has been choosing certain behaviours in an attempt to achieve safety because they were lacking in the roles of 'independent thinker' and 'observer of current reality'.

The absence of 'the independent thinker' is typically evidenced by statements such as "I fog your thoughts because you're not supposed to talk about this." When asked why not, they may be at a loss, keep repeating "because you're not supposed to" or become very confused at being questioned. It's simply a fact to them, usually, of course, a 'fact' implanted by their abuser(s) in an attempt to keep secret their illegal activities.

As far as the role of 'observer of current reality' is concerned, I have worked with clients where this role was so totally absent from a 'protector' personality that they knew neither that they were in an adult body nor that their principle perpetrator had been dead for several years in one case and lived on the other side of Australia in another. This was so in spite of the fact that other personalities of the same client had strongly developed roles of 'independent thinker' and 'observer of current reality' and knew these facts.

Through a combination of the therapist's modelling and questioning and other personality's role modelling and sharing information about current reality, the 'protector' personality can develop the roles of 'observer of current reality' and 'independent thinker' remarkably quickly. With the inner system and the external world view now more consistent, the previously destructive behaviour arising from traumatic fragmentation of the personality can now be transformed towards promoting genuine safety and truly effective self-protective behaviours.

Implications for the healing of dissociative identity disorder for the psychodramatist

a. Importance for the psychodramatist of recognising dissociative identity disorder

Those of you who, to your knowledge, are not working with highly dissociative clients may well be asking what all the fuss is about. Isn't all this incredibly rare?

In a word, no. Ross (1991) found what he called "pathologic post-traumatic MPD" in 1.3% of his randomly selected sample from the general population of a large North American city. Thus, DID/MPD could be as common as 1:100 of the general population [about the same prevalence as either schizophrenia or bi-polar disorder] and constitute a much higher proportion of survivors of severe, repetitive and sadistic childhood abuse. DID/MPD may be misdiagnosed as schizophrenia in as much as 50% of cases (Bliss, 1983).

This is not just a North American phenomenon. Since becoming aware

of the frequency of this disorder and having a high index of suspicion for it, I have diagnosed DID in over 10% of my clients, the proportion being this high because my clients constitute a selected population – most being survivors of serious childhood abuse.

It is thought that 90% or more of survivors of abuse by organised perpetrator groups such as Satanic cults have this disorder. This high percentage is only partly attributable to the severity of this form of abuse. It is also explained by the fact that these groups deliberately set out to foster the creation of separate personalities in their victims (Neswald, 1994:7). They do this in order to make certain behaviours readily accessible on command and to try to ensure secrecy about their criminal activities.

Secondly, it is important to recognise DID because there is ample evidence that while it remains undiagnosed and the linkage between problematic symptoms and early childhood abuse unrecognised, therapeutic work tends to be lengthy and unproductive. Clearly core symptoms associated with fragmentation cannot be resolved as long as that fragmentation is neither recognised nor addressed. In addition, the origin of the fragmentation in childhood abuse and trauma must be named, because it is only when "survivors recognise the origins of their psychological difficulties in an abusive childhood environment [that] they no longer need attribute them to an inherent defect in the self. Thus the way is opened to the creation of new meaning in experience and a new, unstigmatised identity" (Herman, 1992:127).

Thirdly, here is an incident which high-lighted for me why, in particular, psychodramatists and other therapists using action methods should be alert for indicators of DID. A client once told me of a session with a therapist who used 'voice dialogue' with her some years before her DID was diagnosed. During that session she was asked to repeatedly move to different parts of the room and take up what she and the therapist thought were simply different roles or 'voices'. At the end of the session, she was so exhausted that she had great difficulty in getting home and subsequently was confined to bed for a week with extreme fatigue and headaches. She and I worked out that she had actually been switching between about fourteen different personalities or role clusters during that session! The concern I felt when I heard about this was a major motivating factor in my choice of topic for this paper – the parallels with psychodrama are obvious. Not only was she subject to severe physiological stress as a result of the session I have described, in addition, her fragmentation was neither recognised nor addressed at that time.

Fourthly, what little I have been able to find in the literature concerning the use of psychodrama in people with DID confirms my own belief that it should be used only with clients who have achieved enough co-consciousness and control over their switching to be able to keep a contract and not lose awareness of continuity. (Altman 1992a, Altman 1992b, Hudgins and Wnukowski 1993).

Altman confirms my experience that role reversal in the psychodramatic setting often results in switching for the DID protagonist or auxiliary, and states "some amount of co-consciousness in the

system is desirable to ensure that any emerging alters will have a sense of the psychodrama contract in progress" (1992b). Hudgins and Wnukowski word their caution like this: "Before beginning exploratory, uncovering work with people who experience multiple states of consciousness, the clinician must make sure the client can anchor in present reality if needed – otherwise experiential work is not safe and risks retraumatising the client" (1993).

b. Guidelines for recognising DID in the psychodramatic setting

The diagnosis of DID/MPD requires a high index of suspicion and a knowledge of what to look for. These clients may refer in passing to dissociative symptoms but will very rarely tell you directly that they have multiple personalities. There are many reasons for this.

Firstly, they may not know that they have multiple personalities, or at least the personalities participating in the session may not know, because they are amnesic for the other personalities. Books like *The Flock* (Casey and Wilson, 1993) and *Multiple Personality from the Inside Out* (Cohen et al. 1991) provide useful descriptions of how the diagnosis can gradually become apparent to the client. All your client may know is that they are forgetful, absent-minded, and moody. They may have been told by others that they are all of these , a liar and also unpredictable – "I never know what you'll be like next time I see you". Such descriptions often seem bewildering and unjust to the person with DID. This is how they have lived for as long as they can remember. To them, it is normal to hear voices inside their head, to find clothes in their wardrobe that they don't remember buying and wouldn't dream of wearing, to feel astonished or frightened on seeing their own reflection in a mirror because what they see is not what they expected to see, to suddenly

One of my clients, after marking her questionnaire to indicate that she experienced most of the listed phenomena most of the time commented "I don't know how anyone could 'fail' this test." It was beyond her comprehension that people existed who did not experience these types of occurrences on a daily basis ...

'come to' in strange situations and have to orient themselves without anyone noticing, to 'lose time' etc.

Many clients believe that phenomena such as these and others which are listed in the Dissociative Experiences Scale of Putnam et al. – a screening tool for multiplicity which I discuss at the beginning of [c] on page 56 – are universally experienced. One of my clients, after marking her questionnaire to indicate that she experienced most of the listed phenomena most of the time commented "I don't know how anyone could 'fail' this test." It was beyond her comprehension that people existed who did not

experience these types of occurrences on a daily basis.

On the other hand, if these people do somehow find out that not all people experience what they do, they conclude that perhaps they are crazy and of course must hide this craziness from others for their own safety.

This leads me to another reason why the multiplicity is kept secret. Multiplicity develops as a mechanism for coping with serious ongoing trauma. For the victim the beauty of multiplicity lies partly in that it is secret and therefore unapparent to the abuser. This confers some much-needed, but illusory, sense of control and mastery over their very traumatic life situations. Maintaining an illusion of control can help a person who has been subjected to extreme abuse to keep functioning. For these highly traumatised people letting someone else know about the functioning of their inner world can feel like major loss of control. Revealing their fragmentation may result in an intolerable level of vulnerability. For example, fears that a person who knows of the multiplicity may be able to call out personalities at will, or decide that the client is crazy and get them 'locked up', will ensure that multiplicity is kept secret until significant trust has been built and this can take a long time.

So, as clinicians we must be prepared to look for indicators such as the following:

- **History of abuse**

A history of severe, ongoing childhood abuse of a sadistic nature, starting before the age of five and involving more than one perpetrator or complete amnesia for large blocks of childhood or both should alert you to the possibility of multiplicity. People whom you know to have been abused by organised perpetrator groups such as Satanic cults are very likely to have multiple personalities, as explained in section 6[a].

- **Indications of switching**

At the moment of switching from one personality or role cluster to another a multiple will often avert their gaze, cover their face with their hands or hair, flick their eyes upwards or blink repeatedly. There may be a very abrupt and dramatic change in affect, which can even occur mid-sentence, and may seem inappropriate . They may suddenly appear to become very tired. Their voice, speech – accent, vocabulary etc – and mannerisms may alter suddenly.

After a switch so-called re-orienting and grounding behaviour (Putnam 1989:121) may be seen. This can include glancing round the room or at their watch, shifting restlessly, touching the face or temples and touching their chair if sitting.

These are all clues which would be hard to pick up in a psychodramatic setting when you have just asked for a role reversal , especially as each in isolation is not really remarkable. Of course, switches may also occur when a request for role reversal has not been made and these should be easier to detect. The aspect which I have found most helpful is the abruptness of changes, especially in affect.

- **Indications of time loss/ amnesia**

Glancing at a watch or clock is a classic clue to time loss but one that is so commonplace that it is easy to miss unless you also notice the constellation of other clues to

switching described above. Other indications can also be subtle. For example, a client I was seeing late one winter afternoon commented that it had suddenly got much darker. A few questions from me soon elicited that she had just switched and was amnesic for the preceding part of the session. Other relatively subtle indications of time loss/ amnesia for recent events include statements that seem out of place or inappropriate to the current context. Be alert for terminology like "I must have....." or "I would have done...." or "I probably...." when referring to very recent events. Some clients will even say something like "I seem to have lost the thread", "What were we just talking about/ doing?" Or they might just look blank.

Watch for a client having difficulty in taking up a previously enacted role or other indicators that they may be amnesic for previous parts of the current drama. I can't stress too much that these people are very unlikely to tell you directly that they don't know what has just been happening. They are very practised at hiding amnesia.

- **Refusal/reluctance/inability to reverse roles**

Have you ever had clients who have refused point-blank to reverse roles? Consider the possibility of multiplicity. As I've described above, if accompanied by switching, role reversal is tiring, physiologically taxing and can be disorienting if there is little or no co-consciousness. There may also be a fear of loss of control, of not knowing what they might do in the new role.

Another possible explanation for a refusal to reverse roles is amnesia. If the personality currently 'out' is amnesic for a previously enacted role because it was enacted by another personality with whom they are not co-conscious, they will be reluctant to role reverse for fear of revealing their amnesia. Other amnesic clients may role reverse anyway and be inexplicably bad at taking up the previously enacted role.

- **Use of terms we/she/he/ not me**

The language that people use when describing aspects of their own lives can provide important clues to the presence of multiple personality states. If, as is common, they conceptualise themselves as a group of people, they may use the pronoun 'we' about themselves. Another clue is use of the third person – she or he . This may sound peculiar to you but to them is the appropriate pronoun to use when referring to another personality who is 'not me' – not the personality speaking right now. The term 'not me' is also a clue as in : "It's just not me – I don't think like that/ do things like that/ believe that" etc.

- **Witnessed disavowed behaviour**

This is a strong indicator. Examples would include a client denying an interaction with another group member that you had witnessed the previous week or earlier in the session. This is how these people get labelled as liars

- **Evidence of internal voices**

Behaviour such as appearing preoccupied, gazing fixedly into the distance, tilting the head to one side, and saying a series of unfinished and apparently disconnected sentences are all possible indicators that your client is hearing voices. Of course they may just be 'tuning out' – or in

other words dissociating!, – tired, or watching a fly on the wall. When I suspect that a client may be hearing voices I usually ask directly, stating in a very matter-of-fact way whatever I saw that suggested the possibility to me. If voices are acknowledged, it is important to establish their experienced origin. Voices heard inside the head or experienced as "loud thoughts" and voices heard clearly and distinctly are more likely to mean DID while voices experienced as emanating outside the person and heard indistinctly are more likely to mean schizophrenia (Putnam 1989:62).

c. Use of psychodrama principles with the newly diagnosed multiple.....?

It is not my purpose in this paper to detail how to confirm a diagnosis of DID. Briefly, it is necessary to confirm the criteria listed in the DSM 1V . It is essential that you yourself 'meet' at least two distinctly different personalities.

Tools that can assist in confirming the diagnosis include the Dissociative Experiences Scale of Bernstein and Putnam (1986) and the Dissociative Disorders Interview Schedule of Ross et al. (1989).

The Dissociative Experiences Scale is a screening tool consisting of a self-administered questionnaire that asks the person to indicate, by marking on a 100mm line visual analogue scale, the frequency with which certain specific dissociative and depersonalisation experiences occur. An example: "Some people sometimes find that they are approached by people they do not know who call them by another name or insist that they have met them before. Mark the line to show what percentage of the time this happens to you." All of the questions have the same form and I have found that clients tend not to feel threatened by them. In my experience it's most helpful contribution is in assisting the client to recognise dissociative phenomena for what they are.

The Dissociative Disorders Interview Schedule is a more formal instrument which is administered by the therapist and takes about an hour and a half. It not only helps to make an accurate diagnosis but also provides information on related somatic and other symptoms and history. It will distinguish MPD [as DID was called when the instrument was developed] from other dissociative disorders and identify concurrent somatization disorder, major depressive episodes and borderline personality disorder.

For the rest of this paper I will focus on how the psychodramatist can best work with the recently diagnosed person with DID ie. the client who knows little or nothing about their own system, who has little or no internal communication and little or no co-consciousness. As discussed above, psychodramatic work involving role reversal in a group setting is contra-indicated for such a client. However, this most certainly does not mean you should discard psychodramatic principles. On the contrary, they are invaluable in one-to-one work with these clients.

By trial and error I have evolved ways of using psychodramatic principles with multiples, working on a one-to-one basis without them even changing chairs or moving at all. I have found that in the early stages of therapy they are often very reluctant to move. My policy with these highly traumatised people is

almost never to override their knowing about what is best for them, so I do not push for two-chair work if they resist this suggestion. The 'host personality', who is the one who has "executive control" of the body most of the time and who is usually the one who presents for therapy, (Putnam 1989:107) can be terrified of letting go of internal control and allowing other personalities to appear and interact directly. Allowing the person to stay in the same chair and the presenting part to speak for the others, rather than pushing for switching, is much less threatening and, I believe , may actually be more effective in promoting co-consciousness.

Systems theory

Systems theory, a cornerstone of psychodrama, is vital in working with people with DID. *The Family Inside – Working with the Multiple* by Bryant et al. (1992) is very useful in this regard. Two of the authors are family therapists, so systems thinking strongly informs their work.

It is the therapist's job to hold strongly the reality that in front of them is one person, albeit with a complex and highly compartmentalised internal system, but one person none the less. It is important to use terminology that supports this reality. I prefer to call the personalities parts to reinforce this reality and to assist myself to think systemically. My terminology has at times been strongly resisted by those clients who prefer to call their personalities or role clusters people. I respond by pointing out that I call them parts because they all share the same body, another reality which you may have to repeat often. This is one instance where I do not go along with what the client believes is best for them. I don't try to change their terminology but I do not collude with their delusion that they are separate people.

Set out all elements of the system

Another basic principle of psychodrama is to set out all elements of the system. So, early on, I put a lot of work in to determining the components of the system. I am very curious to explore, through the presenting personality/personalities, any clues to the presence of, as yet unknown to me and the 'host', personalities or role clusters. Helpful questions include the following.

"I noticed that you just stopped in mid sentence. What happened there?"

"You've just acknowledged losing your train of thought. Does some part of you want you to stop talking about this?"

"Who?"

"Why?"

In response to "I don't know" :

"Does any part of you know?"

"Does any inside part have an idea about how we could find out more about this?"

If the 'host' personality reports out any information from another personality/role cluster, I ask for more: "Does this part know about other parts that you don't know about?"

"Can you ask this part how old the body was / what the circumstances were when they first came along?"

"What are they good at?"

"Is there anything else they would like to tell you?"

At times I have really been in the dark as to what is happening 'inside' the client. When the client does not want to report out their internal

communication I accept this. I might say something like "You're the one that needs to know..... After all, it's you that's sharing the same body with this part".

When beginning this work the host personality may be quite distressed to find other hitherto unknown parts, or even at the suggestion that they may be present. I remain calm and reassuring, saying something like "Just relax and listen inside. Everyone has parts, everyone says things like part of me wants to go out tonight and part of me wants to stay home. Your parts may just be a bit more separate than some other people's. If you get to know more about your parts your life will probably run more smoothly."

Direct address

As is clear from the above it is not always possible to use the psychodramatic principle of using direct address – talking to the parts or 'people' most involved rather than about them. (Blatner and Blatner, 1988:151). I do try at intervals to do this and sooner or later it does become acceptable to the client. I might try by saying something like "Is there any way that I could talk directly to this part of you?"

Concretisation

Another basic principle of psychodrama listed by Blatner and Blatner is to "make abstract situations more concrete". These clients are usually pretty good at this. As far as exploring the internal system goes I always encourage them to 'draw a map' or some other concrete representation of what there is inside, as recommended by Putnam (1989:210), Bryant et al (1992:140) and others. This falls short of the usual psychodramatic method of physically setting out the system but even this modified form of concretisation can be very threatening and may take weeks or months to gradually be produced. Another modified, relatively non-threatening form of concretisation is ask the client to use toys or dolls to 'show' something.

Promote authentic encounters

Yet another principle is to 'promote authentic encounters whenever possible' (Blatner and Blatner 1988:152). It has often amazed me how authentic encounters between parts of a clients internal system can occur using the 'staying still' techniques I am describing here. I have often been witness to and facilitated interactions that are very emotional and promoting of future cooperation, the entire process happening inside the client's head, as opposed to through role reversal.

Role reversal

I have spoken of the constraints on doing physical role reversals, as in two chair work, with these people. In my facilitation of internal interactions between role clusters I encourage a mental role reversal or empathy with the other part, who may previously have been seen as the enemy.

For example, when a part has been hurting the body in some way, such as by cutting, drug abuse, binge eating etc., I will encourage the presenting personality to find out from the offending part why they think it's a good idea to do whatever it is that the presenting personality doesn't like.

"What has happened to this part that they want to do this?"

"How could they be trying to help the rest of you by doing this?" etc.

Look for the health in the system

When you are faced with a mute or terrified or self- destructive or abusive part it can be hard to remember that what you are seeing is not all there is. I ask something like "Is there any part who can help here?"

"Are there any parts who see things differently?"

"Is there a part who could help catch this part up with what is true now because I don't think this part knows?"

Initially it may be necessary to model some of the roles asked for by these kinds of questions but it is surprising how much wisdom is present in the system when you are able to get access to it.

Role analysis

The role analysis which is another basic principle of the psychodramatic method (Clayton, 1994) can be very helpful in the person with DID. Both an analysis of roles present in separate role clusters/personalities and an analysis of roles present in the whole system are useful. Solutions to problems may involve both development of new roles within one personality and a diffusion or sharing or modelling of desired roles present in some personalities but not others. I encourage and have often seen role modelling and training occurring within the system, one personality teaching another. A clinical example of this can be found in [d] on page 49.

Maximisation

A word of caution about the psychodramatic principle of maximising through exaggerating or amplifying behaviour. One of the many reasons for these people maintaining internal compartmentalisation is that certain role clusters or personalities hold or contain overwhelming vulnerability, terror, grief and rage. Such personalities are often kept hidden and not 'allowed out' by the rest of the system, who can then proceed unencumbered by these overwhelming affects. The task is not to amplify the affect, which is already of overwhelming intensity, but rather to 'spread it around' amongst other parts of the system and gradually facilitate expression of it in manageable increments.

Remember that in psychodrama the word maximize includes exaggerating downwards or making very small. This can be very useful in assisting personalities who have no emotions to get in touch with the emotions that are in the system and also in assisting the personalities who have overwhelming emotions to express them safely. However, when working with an affectless personality trying to maximise affect in the sense of making it much bigger will either go nowhere or result in a switch to an overwhelmed personality.

Promoting spontaneity

Lastly, and most importantly, the primary, guiding principle of psychodrama is the development of spontaneity. Dissociation is a creative and spontaneous response to a situation the first time the client does it. In the adult client it is an old, worn-out, hackneyed response which restricts spontaneity. Development of new and spontaneous ways of responding to situations is central to the work with these clients, whether this means development of roles new to the whole system or strengthening and increasing the accessibility of present

but hitherto compartmentalised and therefore often unavailable roles.

Spontaneity must also be the cornerstone of therapeutic practice. What has struck me more than anything in my work with these people is their uniqueness and the astounding diversity encompassed by the clinical diagnosis of DID. I am frequently challenged to come up with new and unique ways of working. Formulae simply don't work and exceptions to every principle abound.

Conclusion

Dissociative identity disorder is common in client populations, especially amongst those who have been subject to early childhood abuse. Inclusion of clients with DID in psychodrama groups is contra-indicated until they are familiar with their entire inner system and have enough co-consciousness to ensure continuity through repeated role reversals.

However, psychodramatic principles are invaluable in working with the newly diagnosed multiple. Systems theory is crucial to working effectively with these fragmented people, and can easily be adapted to the one-to-one situation.

In conclusion, I want to say that my highly dissociative clients have been, and continue to be, a source of awe and inspiration for me. It is a privilege to bear witness to such extraordinarily creative, original and diverse means of coping with otherwise unbearable trauma. It is also a privilege to assist these courageous and tenacious clingers to and seekers of life to develop their spontaneity and overcome the unwanted after-effects of their abuse.

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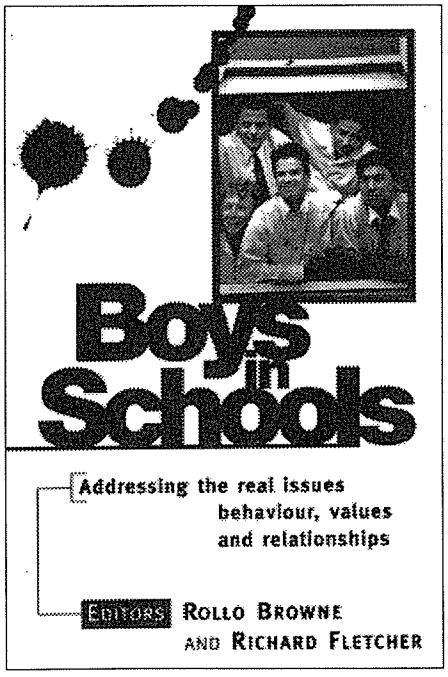
Book Reviews

by Natalie Park



Boys in Schools: Addressing the real issues – behaviour, values and relationships

Editors: Rollo Browne and Richard Fletcher

Sydney: Finch Publishing (1995)

Boys in Schools: Addressing the real issues – behaviour, values and relationships lives up to its title. It is a simply-written, easy-to-read, powerful little book with a punch. Editors Rollo Browne and Richard Fletcher declare at the beginning of the Introduction:

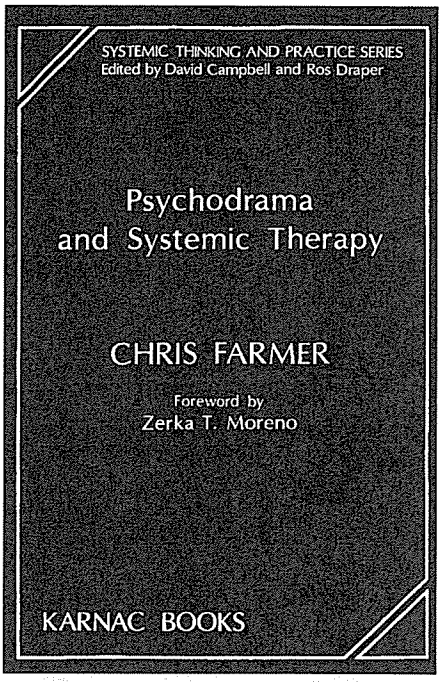
> *We started on this book because it was obvious to us that, as a group, boys are in trouble. Not every boy, not the same kind of trouble and not all of the time – but enough of them across all ethnic and socio-economic groups to know there is a pattern.*

The contributing authors present their own work with boys and it quickly becomes clear to the reader that there is a breath of fresh air making a real impact in these schools. These educationalists are putting into practice, in varying ways, a new and innovative approach that involves taking up and working with the reality of life which emerges right in front of them in the classroom and in the here and now. The issues addressed include masculinity and gender stereotypes, boys' underachievement and non-involvement in school, bullying and school violence, sexism and homophobia, relationships and peer culture, identity and self esteem.

I suspect almost every reader would have first hand knowledge of the widespread undermining phenomena in school whereby boys police each other and keep each other down on a rigid, narrow track of masculinity: "Only poofs read novels". The desperate need to be

"cool" and the fear of being seen as a "wuss" are typical issues faced head on by these agents of change who are successfully building positive relationships between themselves and their students and within the boys own peer groups. As Rollo Browne says: " Boys reassess their options for behaviour when they have experienced alternative ways of getting their needs met... What has been missing is a coherent approach to understanding how the school as a system reinforces gendered behaviour and therefore how to deliver positive change." The effectiveness of a systemic approach is emphasised, and demonstrated, when a whole-school program is adopted. Group work, coaching, modelling and role play are some of the methods used to develop a healthy school culture. Valuing the individual is a principle determinedly practised by these leaders as they gently shift boys towards building one another up, valuing themselves, stretching rigid confines of gender stereotyping and expanding the boys' notions of what's okay in being a boy.

Boys in Schools will be of benefit to teachers, parents and all who are working with boys. Listed in the back of the book, the authors make themselves available for contact by the reader. One is left with the sense that there is a force for good gathering momentum and making itself felt in the education of our young.



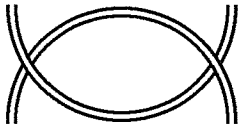
Psychodrama and Systemic Therapy

by Chris Farmer

London: Karnac Books (1995)

This book is written for the mental health professional who is well versed in family systems theory and who may be a newcomer to the psychodrama method. Chris Farmer, a psychiatrist practising in Guernsey, undertakes to describe psychodrama in systemic language as he presents clinical examples of his psychodramatic work with patients. He presents narratives of psychodramas he has directed, along with useful pictorial illustrations, to demonstrate the effectiveness of the method. He follows up these narratives with analysis and explanation from a systems perspective and highlights the common underlying theoretical principles as he describes, for example, the psychodrama director

as a systemic operator. "The protagonist needs another pair of eyes that sees what is missing from his own vision. The director, therefore, punctuates the action. He interupts. He extends. He connects what appears separate. Furthermore, as a true systemic operator, he finds similarities in the apparently different and differences in the supposedly similar..." Farmer demonstrates through the narratives taken from his own work how systems principles are utilized in psychodrama and states that "conducting psychodrama is analogous to operating as a systems therapist in a more general frame of reference." Zerka Moreno comments in her Foreword to the book that Chris Farmer "...has made splendid use of sociometry as well as role theory and presents the kind of systems thinking and operations that form the ground of his own work. Although literature on psychodrama is proliferating in many languages, the use of social systems is still fairly rare, and therefore this book is a contribution to what is still, in many ways, a pioneering effort." *Psychodrama and Systemic Therapy* is a scholarly text that represents psychodrama in an introductory and yet comprehensive manner to the erudite reader.



Bookshop Catalogue & News

You can obtain the following books at the 1998 ANZPA Conference in Christchurch or send an order to the ANZPA Bookshop Co-ordinator.

Books of Interest

Clinical Thinking of Wilfred Bion, *J. & N. Symington*
Psychodrama and Systemic Therapy, *Chris Farmer*
Visual and Active Supervision, *Antony Williams*
Forbidden Agendas, *Antony Williams*
But I'm Only a Social Drinker – A Guide to Coping with Alcohol, *Robert Crawford*
Psychodrama Since Moreno: Innovations in Theory and Practice, *Edited by Paul Holmes, Marcia Karp and Michael Watson*
Psychodrama, Inspiration and Technique, *Edited by Paul Holmes, Marcia Karp*
Drama Games, *Dayton*
Psychodrama, Resolving Emotional Problems Through Role Playing, *Yablonsky*
Leader's Manual for Adolescent Groups, *Clarke, Lewinsohn & Hops.*

A Series of Training Books by G. Max Clayton

- Enhancing Life and Relationships: *A Role Training Manual*
- Living Pictures of the Self: *Applications of Role Theory in Professional Practice and Daily Living*
- Effective Group Leadership

Focus on Psychodrama: The Therapeutic Aspects of Psychodrama, *Peter Felix Kellerman*
Psychodrama, its Application to Alcohol and Substance Abuse Treatment, *Edited by Robert L. Fuhlrodt*
Sociodrama: Who's in Your Shoes, *Patricia Sternberg and Antonia Garcia*
Socioanalysis: Self Direction via Sociometry and Psychodrama, *Martin Haskell*
Psychodrama and Group Psychotherapy, Vol I, *J.L. Moreno*
Who Shall Survive? (Student Edition), *J.L. Moreno*
Acting-In, *A. Blatner*
Acts of Service, *J. Fox*

New Theses Now Available

Dissociative Identity Disorder and the Psychodramatist, *Trish Reynolds*
Sociometry At Work, *Diana Jones*

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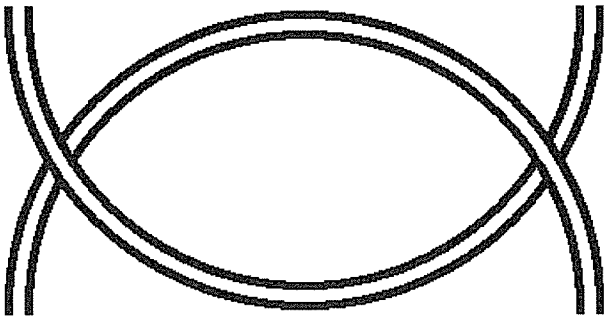

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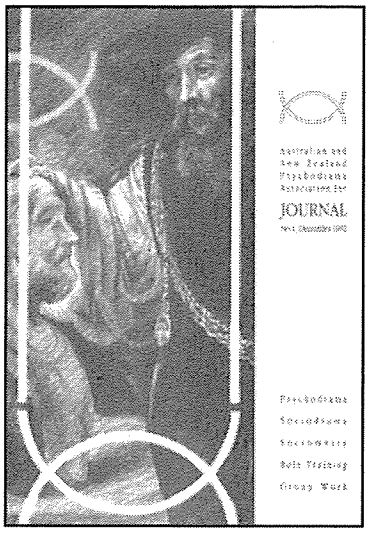

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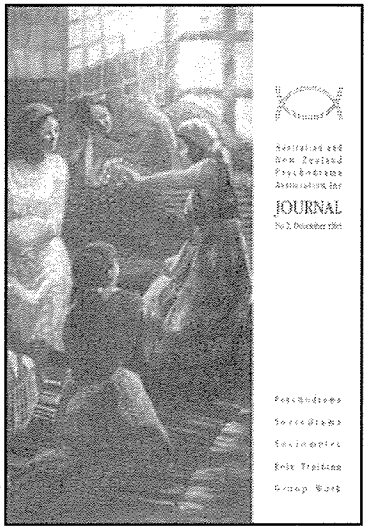

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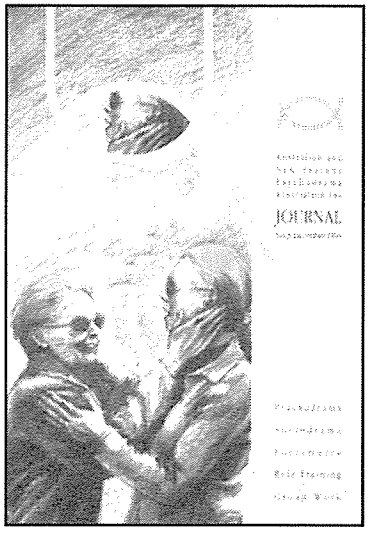

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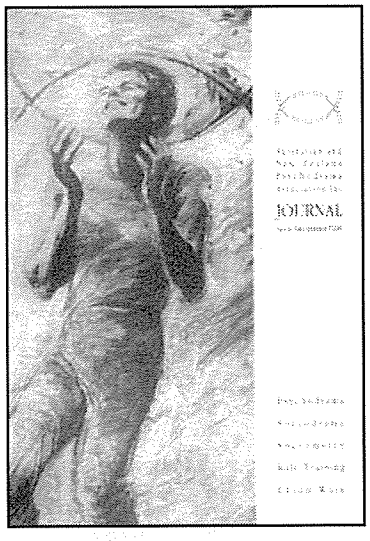

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Australian and
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Psychodrama
Association, Inc

Membership Form

Psychodrama

Sociodrama

Sociometry

Role Training

ANZPA

ANZPA Inc., is an organisation of people trained and certified in the psychodrama method and its applications and developments as a Psychodramatist, Sociodramatist, Sociometrist, Role Trainer or Trainer, Educator and Practitioner (TEP).

The purposes of the Association particularly include association with one another, the setting and maintaining of standards and promoting the establishment and reputation of this method.

Members associate at the annual conference, through a Journal and Bulletins and particularly within ANZPA's geographical Regions.

THE EXECUTIVE AND BOARD OF EXAMINERS

The elected ANZPA Executive appoints a Board of Examiners to set and maintain standards of training and practitioner certification. The Board has established and accredits Regional Training Institutes.

A code of ethics for members has been established and monitored.

The Regions of ANZPA are specified in its constitution. They vary in structure and function from place to place in response to the local situation. Much of the work of the Association is done in the Regions. For instance, ANZPA organises its annual conference and annual general meeting through the Regions.

Regular Bulletins and the Journal are sent to all members.

MEMBERSHIP OF ANZPA

Membership of ANZPA and the appropriate Region are one and the same.

ORDINARY MEMBERSHIP of ANZPA is open to people who hold a current practice certificate from ANZPA on payment of a fee.

ASSOCIATE MEMBERSHIP is open to people who have demonstrated commitment to the Association and its goals and principles by undertaking ongoing training for at least six months. They must be sponsored by an ordinary member who is involved with their training.

Associate Members are not eligible to stand on the Executive Committee of ANZPA or vote at general meetings of ANZPA, otherwise they have the rights and responsibilities of Ordinary Members.

Additionally, from time to time, particular people who have special qualifications or accomplishments are invited to become Honorary Members or Distinguished Members.

See page 72 for details of the new membership structure.

ANNUAL FEES

Full Membership – $130
Associate Membership – $75

APPLICATION FOR MEMBERSHIP

In NEW ZEALAND, send application and fee in New Zealand dollars to:

Membership Secretary,
Bev Hosking,
22 Creswick Terrace,
Northland,
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In AUSTRALIA, send application and fee in Australian dollars to:

Membership Secretary,
Elizabeth Hastings,
78 Edinburgh Street,
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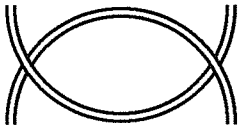

Australian and New Zealand Psychodrama Association, Inc.

MEMBERSHIP APPLICATION

Complete the details requested below. Send with fee to the New Zealand Membership Secretary if you are in New Zealand, or to the Treasurer if you are in Australia or elsewhere.

Surname: _____

First Name: _____ Middle Name: _____

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Status (tick appropriate one): ☐ TEP ☐ Practitioner ☐ Trainee

Certification (tick appropriate one): ☐ None ☐ Psychodramatist
☐ Sociodramatist ☐ Role-Trainer ☐ Sociometrist ☐ TEP

Qualifications: _____

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Occupation: _____

Work Details – Place: _____

Address: _____

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Membership Category (tick appropriate one):
☐ Ordinary Member ☐ Associate Member

Sponsor's Details (required if applying as Associate Member) –

Name: _____

Address: _____

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Phone (include area code): _____

Enclose sponsor's letter of recommendation with this application.

Signature: _____

Date of Signing: _____

NEW MEMBERSHIP STRUCTURE

The new membership structure has taken effect from 1993–1994.

ORDINARY (FULL) MEMBERS

- Ordinary (Full) Members are those holding a current practice certificate or have recently been certified as a psycho-dramatist, sociodramatist, sociometrist or role trainer and have paid the fee.

ASSOCIATE MEMBERSHIP

- Everyone who is currently a member of their local Psychodrama Association will be accepted as an Associate Member of ANZPA under the **Grandparent Clause June 1993** decided by the ANZPA Executive, on paying the Associate Membership fee. This clause will remain current for two years, i.e. until January 1996. After this time all Associate Members will be required to have completed six months of psychodrama training and have an ongoing commitment to training. Application for Associate Membership must include a letter from a person who has been involved in the applicant's training and in the case of a current regional member wanting to become an Associate Member, proof of membership of their local association.
- People who are not members of a local association and who want to become an Associate Member of ANZPA need to have six months of psychodrama training, have an ongoing commitment to training, and their application must include a letter from their primary trainer or someone who has been involved in their training and who is an Ordinary (Full) Member of ANZPA.
- ALL members will receive the Psychodrama Journal and Bulletin.