Short-term Psychodrama With Victims of Sexual Abuse

RAY NAAR
CHRISTINE DOREIAN-MICHAEL
ROBIN SANTHOUSE

ABSTRACT. In this article, the authors describe various methods of dealing with victims of sexual abuse. They show how an approach method, using psychodrama as a treatment modality, can minimize potential risks to the patients and how positive results can be achieved in short-term groups. The article includes theoretical background and 2 vignettes.

STRATEGIES FOR THE TREATMENT OF posttraumatic stress disorders (PTSDs) range from an emphasis on the patient–therapist relationship (Auerhahn, Lamb, & Peskin, 1993; Olio & Cornell, 1993) and story-telling (Gold-Steinberg & Buttenheim, 1993) to analytic groups (Gartner, 1997) and groups relying on an ego–object relations approach (Wells & Glickauf-Huges, 1995). Although most clinicians favor a group modality (Haaken & Schlaps, 1991), some have advocated an individual approach (Jackson, 1994) and others a couples approach (Buttenheim & Levendosky, 1994). All these strategies for the treatment of PTSD patients fall into two general categories—approach and avoidance (Dye & Roth, 1991).

Approach methods of treatment deliberately concentrate on the traumatic experience through talking and thinking about it or reliving it in fantasy. The assumption underlying such methods is that, in order to cope with the disorder (PTSD), the individual must reexperience the emotions associated with the traumatic event and reintegrate them within his or her self-concept and awareness.

Avoidance methods steer the individual away from the traumatic experience through a number of techniques specifically designed to achieve that purpose, such as thought-stopping. The underlying assumption is that coping

becomes easier if the victim learns to distance himself or herself from the experience.

According to Dye and Roth (1991), there are inherent drawbacks in each of the two categories. Approach methods may achieve the opposite effect. Reliving the traumatic event may lead to such flooding of anxiety that, instead of integrating the experience, the individual may reexperience the trauma in all its initial intensity; instead of being cured, the victim is retraumatized. Faulty or incomplete integration of the traumatic experience may result in obsessive worrying and interfere with the victim's ability to function. Caution in the use of approach methods is cited by Blizard and Bluhm (1994), who advocated a go slow approach in dismantling dissociative defenses, and by Gold-Steinberg and Buttenheim (1993), who believed that telling one's story of abuse must be preceded by careful preparation.

Avoidance strategies present a different set of problems. Having dealt only with the symptoms, the individual may not learn to avoid or face other traumatic experiences that may occur in his or her life. Furthermore, repressed memories of a traumatic event may, at times, intrude into the individual's awareness and create dysfunctional behavior and emotional poverty. Olio and Cornell (1995) concluded that avoidance approaches reinforce the mechanism of denial with resulting self-doubts.

In a further discussion of treatment modalities for victims of sexual abuse, Dye and Roth (1991) stated that, without exception, group therapies adopt approach strategies. They also concluded that short-term groups cannot achieve the same benefits as long-term groups in helping the victims positively reintegrate the traumatic experience.

In this article, we focus on the approach strategy and show how such a treatment can be used in a way that minimizes the dangers described above. Furthermore, we describe how that can be accomplished in short-term groups and how such short-term groups can achieve great depth of reexperience and reintegration.

Rationale

The main tenet of the approach strategy described here is to help the individual confront and reintegrate the initial trauma a second time from a position of power and strength that the individual was not aware he or she possessed. This is accomplished by using the concept of *surplus reality*, introduced by Moreno (1965). As explained by Marineau (1990), surplus reality is a more complete and rewarding expression of the individual's reality, as it is expanded through his or her creativity and imagination. It is not a distortion of reality but a reality made fuller.

During a psychodrama in a group run by the first author, a 26-year-old man

was confronting an abusive father with little success. During an *a parte* scene, the therapist directed him to see himself, in fantasy, as a child; he saw himself as a frightened, lonely 6-year-old. He was then asked if the strong adult that he was now could talk to the 6-year-old. In the ensuing dialogue, he realized how he missed the spontaneity, the openness to life of his child self, but he also became aware of his strength and his ability to protect the child in him against all dangers (Naar, 1977). He then went back to his father and was able to confront him with appropriate assertiveness and anger.

In reflecting on what happened, it occurred to the therapist that what enabled the young man to confront his father was his acquired awareness of the strength that made it possible for him to protect a lonely, frightened little boy. He used that new knowledge to protect himself when confronting his father. That knowledge was acquired through the medium of his creativity and imagination when he entered into a dialogue with the little boy.

That same concept could be used to empower and treat victims of other kinds of abuse. In the following case reports, the approach concept was applied to two groups of women who had been sexually abused. Psychodrama was the therapeutic medium chosen.

Participants

Each group was composed of six women, ranging in age from 23 to 55 years, who had been sexually molested in different ways at one time or another in their life. Half the women came from the first author's private practice and the rest from the outpatient Eating Disorders Clinic at Western Psychiatric Institute and Clinic. Diagnoses varied and were not a factor in being accepted for participation. None were diagnosed with schizophrenia or organicity, however, and all were of average or above-average intelligence. An additional criterion for participation was that each member of the group be in therapy or have the available support of, or access to, a therapist outside of the group.

Method

The treatment consisted of 20 hr of group therapy spread out over 9 weeks. The first session was a get-acquainted and introductory session. The purpose of the introductions was to provide a model of openness and affective interaction. (The first author began the introductions.) He stated his name and expressed his trepidation at being the only male in a group of women who had suffered at the hands of men and his gratitude for the trust they were investing in him by their participating in the group. He very briefly alluded to the fact that he had survived a German concentration camp and was no stranger to suffering and pain. He was followed by the coleader, who introduced her-

self in the same vein, and, in turn, by the six participants who described the nature of their sexual trauma, their fears, and their hopes for the outcome of the brief group therapy treatment.

It had been made very clear to the participants that at no time should they feel compelled to share more than they were absolutely comfortable in sharing. At no time was any pressure exercised on any of the participants. We encountered very little resistance, and any reluctance to becoming involved that was displayed by one or two members quickly waned. The example of disclosure provided by the leaders and the first members who volunteered opened the floodgates of sharing and participation.

Interestingly enough, once or twice, when a statement was made that an event in a person's life was too painful even to think about, instead of insisting, the group members became fiercely protective of that person's privacy and expressed their understanding of and respect for that member's need for privacy. Without exception, however, all members eventually self-disclosed and participated. The first session ended on a very high note. It was as if invisible barriers had come down and an unexpected bond of friendship had been established between six very lonely women. In fact, the two leaders wondered whether the bond would be maintained over the life of the group. Indeed, not only was it maintained, but some friendships were forged and were long lasting.

The next sessions were devoted to individual psychodramas involving the abuse. Each of the women took one session. Those meetings were extraordinarily intense and, even though we had contracted for 2-hr sessions, it was a rare session that lasted less than 3 hr.

The way in which the concept of surplus reality was at the core of each psychodrama becomes evident later in the vignette. The drama itself was followed by a long period of sharing, and the support and love that those women—so hard on themselves—were able to give to each other was a marvelous sight to behold.

The Vignettes

Janet, a 45-year-old teacher, was raped by a man with whom she had gone out once and who forced himself into her apartment. Janet was so traumatized by the occurrence that she became a recluse, moved to another apartment, and bought a German shepherd dog, who became her sole and constant companion. When asked to confront her assailant, she laughed bitterly, stating, "You must be crazy. He is 6 feet 3 inches, weighs 225 pounds, wears a gun, and has a black belt in some kind of martial arts. I am 5 feet 4 and weigh all of 113 pounds. What do you think?"

The therapists, stumped for a minute, decided to use a variation of the judgment technique (Sacks, 1965). Three of the women in the group became mem-

bers of a jury, another became the prosecuting district attorney, and another, the defense attorney. The coleader played the part of the rapist, and the first author became the presiding judge. All the anger, bitterness, and hate that Janet could not direct at her abuser was now directed at his defense attorney. The jury found the man guilty and sentenced him to twenty lashes to be administered by the victim. With pillows, we built a dummy of the perpetrator and, with a coat hanger, Janet carried out the sentence. After it was over, she was laughing and crying at the same time. During the sharing phase, she said, "That felt wonderful. For the first time in ten years, I am not afraid. I feel downright powerful."

The second vignette was more dramatic but illustrates the same principle: Empower the protagonist. In the second vignette, the technique was different.

Debbie was a 40-year-old nurse who had been molested by her father over a 1-year period when she was 7 years old. He would enter her bedroom after she had gone to bed, insert his hand under her nightgown, and fondle her. During that period of time, the father was severely alcoholic. When Debbie turned 8, he joined Alcoholics Anonymous (AA) and never touched her again. In all other respects, he was an acceptable father, that is, a good provider who helped the children with their homework, took them away on vacation, and never abused them verbally. The molestation was never mentioned, and Debbie never felt close to her father. Even though he was in his seventies when the group sessions took place, she still felt uneasy in his presence and found it very difficult to talk to him. We endeavored to stage a scene in which Debbie was requested to talk to her father. That was to no avail. This highly articulate and competent nurse was completely tongue-tied. The following interaction then transpired.

Therapist: Debbie, this is so hard for you. Instead of talking to your father, why don't you become a story teller. Tell us what happened.
Debbie: OK, I'll try. I was 7 years old.
Therapist (interrupting): Can you speak in the present tense?
Debbie: I am 7 years old, and it's time for me to go to bed.
Therapist: What time is it?
Debbie: It's 9 o'clock, and I get ready to go to bed.
Therapist: Describe your room, Debbie.
Debbie: My bed is in this corner (she points). There is a window there, chest of toys, a pink bedspread, I remember. I think there are pictures on the walls.
Therapist: Pick someone to be little Debbie.
Debbie: Donna.
Therapist: And someone to be your dad.
Debbie: Janet.
Therapist: OK, Donna, you are 7-year-old Debbie, and Janet, you are her father. As Debbie shares with us her painful experience, you will act it out.
Donna and *Janet*: We'll try.

Therapist: I know it is so hard and hurts so much, but please try.
Debbie: (In a voice choked with emotion) I get into bed and pull my blanket over me. (Donna lays on the floor with her head on a pillow and covers herself with a group member's overcoat.)
Therapist: Are the lights on?
Debbie: Just a night light.
(Therapist dims the rheostat light.)
Therapist: What's happening, Debbie?
Debbie: I can hear him come up the stairs. I am scared. Oh God. I am so scared.
(Janet shuffles her feet to imitate the sounds of an approaching person.)
Debbie: He enters the room and sits on my bed.
(Janet sits on the floor next to Donna.)
Debbie: Please don't, please; he puts his hand under the blanket.
(Janet pretends to insert her hand under the overcoat covering Donna.)
Debbie: Don't, don't, please don't.
Therapist: Will you let him do that, Debbie, she is just a child?
Debbie: (screaming) No, no!!
Therapist: (in a very loud voice) Help her, Debbie, help her.
Debbie: (screams) No, no, leave her alone, you bastard. Leave her alone!
(She runs to Janet, pulls her up and propels her outside of the room. She then returns to the room, slides on the floor, cradles Donna's head and cries, first with convulsive sobs, then more quietly.)
Debbie: (crying, to Donna) Oh! My poor baby, my poor baby, what have they done to you? There was no one to help. But I am here now. You'll see. I'll never, never let anyone hurt you. Never.

By that time, everyone in the group was crying with Debbie. Her father (Janet) then reentered the room, and Debbie confronted him without anger but with assertiveness and firmness. She told him the pain he had caused her, the horror of her experience, the ways in which it had influenced her life; toward the end, she could even recognize that, for the past 30 years, he had been a good father. She finished by telling him that, although she could not ever forget, she would try to forgive.

Many months later, Debbie told the first author that, after her psychodrama, she felt much more at ease with her father. She said, "I don't believe that I'll ever be close to him, but at least we can be in the same room without my wanting to run away."

Discussion

When those groups were conducted, research was not a primary motivation, and no efforts were made to assess formally before and after changes. The participants' comments, however, were telling:

"For the first time ever I don't feel guilty. I don't feel that I have to be ashamed of myself."

"I thought that I was all alone and nobody wanted me. It is so wonderful to be loved. You are beautiful people."

"I feel so much stronger. I'll never let anyone hurt me again."

It should be added that half of the women remained in individual therapy after the group ended. It took approximately three to four additional sessions to process the happenings of the group. After that, the abuse surfaced occasionally in the sessions, but it was no longer the focus of therapy. The other half remained in treatment at the Eating Disorders Clinic, Western Psychiatric Institute and Clinic in Pittsburgh, Pennsylvania.

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RAY NAAR is in private practice and a faculty member in the Clinical Psychology Department at the University of Pittsburgh. CHRISTINE DOREIAN-MICHAEL is a psychologist who is in private practice in Murrysville, Pennsylvania. ROBIN SANT-

HOUSE is a clinical social worker in the Division of Behavioral Medicine at the University of Pittsburgh Medical Center. The corresponding author for this article, Ray Naar, can be reached at the Medical Center East, Suite 540, 211 Whitfield Street, Pittsburgh, PA 15206.