The Use of Psychodrama in Dealing With Grief and Addiction-Related Loss and Trauma

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ABSTRACT. This article is an adaptation of a chapter from the author's book, *The Living Stage: A Step by Step Guide to Psychodrama, Sociometry, and Experiential Group Therapy* (Dayton, 2005). The author proposes the use of psychodrama to help clients in recovery who are dealing with complicated grief issues associated with addiction and addiction-related trauma. She emphasizes the importance of grieving and recognizes the many causes for a client's grief, ranging from death to divorce to addiction issues. She suggests psychodramatic strategies that can help clients to resolve those issues and to move forward with their lives.

Key words: dealing with grief, psychodrama and grief, psychodramatic strategies for dealing with grief

GRIEF IS WIDELY ACCEPTED AS AN ISSUE that needs to be addressed during recovery. Although normal life losses do not necessarily benefit from therapy nor require it, complicated loss associated with addiction issues may be aided by professional help. Those developing treatment approaches are often legitimately concerned about whether addressing powerful issues of grief will undermine sobriety or open the door to relapse. Many addicts are themselves hurt people, who have relied on some form of self-medication to manage their emotional pain. Moreover, the unresolved grief issues that they have been self-medicating with drugs, alcohol, food, sex, or gambling may re-emerge during the recovery process. Clients may need to grieve for time lost, that is, the years that they spent mired in addiction, and for the pain that they have caused those

they love. To complicate matters even further, they are likely to be grieving these issues with a compromised set of psychological and emotional tools. In early recovery from addiction, addicts may not benefit from revisiting painful, historical material that can trigger relapse, whereas in later recovery, the opposite can be true. Avoiding painful material can actually undermine the recovering person's ability to develop a consolidated sense of self, which can also lead to a relapse or a less-satisfying life and relationship. Generally speaking, addicts need to develop a solid enough recovery program along with sufficient ego strength to allow them to tolerate the difficult emotions associated with the grieving process without self-medicating. They also need to have their recovery supports, such as twelve-step programs and professional therapy, well in place.

Grief work in recovering populations can have both present day and developental components. Psychodrama, with its unique ability to concretize virtually any moment along the developmental continuum of a client's life, offers a unique approach to working with the mental, emotional, and behavioral aspects of loss. Psychodrama allows for a therapeutic intervention that involves and engages the full psychological, emotional, and sensorial person in his or her appropriate relational world or social atom. Going to the *status nascendi* of a particular conflict or issue, allows the client to explore the roots of a loss experience and trace the impact that that loss has had throughout their development.

Moreno (1946) believed that the self emerges from the roles a person plays and that the function of the role is to enter the unconscious and give it shape and definition. By using role play to work with loss issues, the therapist has a method that can reach into the conscious and the unconscious mind of clients, meet them at the appropriate developmental level, and allow the shape and definition of the roles that they have internalized to emerge onto the stage. Clients can view a circumstance as it was, explore it psychodramatically, and tease out the web of associated meaning they made of it at the time that they may still be living by. They can integrate their split-off affect and develop new insights as their adult mind witnesses their child, adolescent, or young adult world in its concrete form. They may then reshape their role configuration and practice new, emerging, or desired role behaviors in the here and now of the psychodramatic moment. Moreno (1946) believed that what was learned in action must be unlearned in action. Psychodrama, with its ability to allow the shape of the unconscious to be concretized through role play, is a tool that can reshape the self. It has the ability to reach through time and allow our surplus reality to emerge onto the stage in its many dynamic, cocreated forms.

Gesture as Our First Language

Gesturing is our first language. It is the mind-body communication on which all subsequent language is built. Before language formally enters the

picture, humans have learned a rich tapestry of gestures to communicate needs and desires. The expression of concern or alarm on a mother's face, for example, causes the child to feel alerted to danger. The child's screech accompanied by an arm motion may signal a wish to be picked up and cuddled or command the mother to hand over a favorite object.

All language is part and parcel of gestural communication. Each tiny gesture is double coded with emotion and is stored by the brain and body, with emotional purpose and meaning woven into it. Through that interactive process, we build emotional intelligence and literacy as surely as we learn math in a classroom (Greenspan, 2000). The interaction between the more emotional right and the logical left brain is central to emotional intelligence and literacy. In his article, *The Right Brain, the Right Mind, and Psychoanalysis,* Schore (2004) explained that the cortex, sometimes referred to as the logical left brain, is able to modify intense feeling states associated with the right brain through the use of reason and words. In addition, the right hemisphere is also centrally involved not only in the reception but also in the expression and transmission of emotional signals and affective states. Right cortical functions mediate the expression of facial displays of emotion (Borod, Haywood, & Koff, 1997), thereby facilitating spontaneous emotional communication (Buck, 1994) and spontaneous gestural communication (Blonder, Bowers, & Heilman 1991). These rapid communications are not only sensed by another face, but they also trigger motor responses in the facial musculature of the recipient. There is an emotional contagion between us that is part of how people tune in on another person's unconscious communication and regulate their own behavior accordingly.

Because gesturing is the first form of communication, much of that language is unconscious and surfaces in the form of automatic emotion, according to Schore (2004). Automatic emotion operates in infancy and beyond at unconscious levels and shapes subsequent conscious emotional processing (Dimberg & Ohman, 1996). That web of unconscious gesture, meaning, and word is formed through one's interactional environment with one's family and caregivers (one's first social atom) and lays a foundation for later emotional growth and language development.

Evolution has cunningly made the processing of emotions and their communication to others very rapid. The transmission of facially expressed emotion occurs in as little as 2 milliseconds (Niedenthal, 1990), far beneath levels of awareness. Nature has favored that speed synch for obvious reasons. The mother who could "feel fast," sense danger, and communicate that to her child to get him or her out of harm's way was naturally selected to be the DNA strain that led to us. "Because the unconscious processing of emotional information is extremely rapid, the dynamic operations of the 'transmission of nonconscious affect' is largely unconcious" (Murphy, Monahan, & Zajonic,

1995, p. 600). As Schore (2004) noted, the spontaneous communication of "automatic emotion" cannot be consciously perceived. One might liken that form of instantaneous communication between people to the "hot synch" between computers. Significant information gets transferred from one system to another, but it happens in what feels like an invisible realm. All of these unconscious processes help us to walk, digest, self-regulate, and remain grounded within the self, in relationships, and in our environment. They allow us to operate automatically. Greenspan (2000) maintained that adults who have not engaged in adequate gestural communication as toddlers frequently have trouble with certain abstract concepts. The result of a lack of early experience with the language of gesturing is that gesture, along with its embedded meaning, becomes detached from the word and makes self-reflection difficult, if not impossible.

Many adults have a hard time identifying some of their emotions and their intentions when they enter therapy. They lack awareness about why they do what they do or why they feel what they feel. Perhaps they experience something in their body, such as chronic muscle stiffness or pain in their stomach, back, or head, but they are unable to connect those reactions to their emotional feelings, which may be somatized or split off rather than felt. As young people, they may not have had conversations that decoded their emotional states and translated them into words. Consequently, they respond unconciously and may lack significant personal and interpersonal awareness.

Psychodrama, with its ability to include all of this rich, gestural, interactive language (i.e., "show us, don't tell us"), can recreate the relational context and conditions necessary to attach feeling to gesture at the appropriate developmental level. Roles have physical, mental, and relational components. When therapists work with intrapsychic and interpersonal roles, they enter into the somatic, intrapersonal, and interpersonal world of the client. In the heat of the psychodrama, thinking, feeling, and behavior emerge along with a web of associated meaning. The roles that individuals learn in childhood and later play have a web of unconscious, associated meanings from gesture and word embedded into them. Psychodrama reawakens the sleeping child or adolescent inside the adult. As clients experience their own real-life enactment unfolding around them or witness a protagonist with whom they identify, they enter into a forgotten world. They become purposeful and attending. Through clinical role play, they can modify their early emotional and psychological language and experience. The function of the role, according to Moreno, is to enter the unconscious and give it shape and definition. Schore (2004) believes that the unconscious can continue to expand through new, ongoing, and affectively charged relational or regulatory experiences. Psychodrama allows the affectively charged relational experiences to emerge and be worked with experientially to achieve a more satisfactory resolution and greater awareness.

As clients do, undo, and redo experiences, they move toward more complex psychobiological states and higher levels of self-reflection (Schore, 2004). Initially, they do. For example, a wounded aspect of self emerges into the here and now physically, mentally, and emotionally. In the here and now, the clients feel as they felt then. Then they undo. Through action in a relational context that mimics important interpersonal dynamics, they literally enter their surplus reality and rework what may have been living within them in a frozen state. They allow that part of them to find its form of expression, perhaps to cry the tears that were numbed or thwarted, express anger or helplessness, or shiver with the fear that became frozen. Then they redo; having unfrozen and expressed their pain and fear, they begin spontaneously to experience things differently. The lens through which the client sees the world changes, either ever so slightly or significantly. Insight and understanding replace the knee-jerk reaction, and the client can now respond to life differently.

Researchers have long recognized that in virtually any form of therapy, it is the relationship that heals. By developing trusting, long-term healing relationships that can create a new experience and act as different external regulators, clients learn a new emotional language and the skills of regulation and balance, both within themselves and in relationships. Psychodrama extends and deepens the gestural and relational component of that learning and the sociometry within the group creates a safe container in which learning can coalesce and expand.

The Fear Factor: How Trauma Affects Humans

Neurobiological researchers provide much-needed information for treating clients whose neurological systems have become deregulated through less-than-optimal relational experiences. Those experiences include the relational trauma that comes from familial neglect, abuse, or living with addiction.

The body cannot recognize the difference between an emotional emergency and a physical danger. When triggered, the body responds to either by pumping out stress chemicals designed to impel someone to quick safety or to enable them to stand and fight. In the case of childhood problems, in which the family itself has become the feared object or source of stress, there may be no opportunity to fight or to flee. Children and adults in those systems may find escape impossible, and so they do what they can to survive, which is freeze. They shut down their inner responses by numbing or fleeing on the inside through dissociation. Although that strategy may have helped them to get through a painful situation, perhaps for a period of many years, they suffered within. The ability to escape or take one's self out of harm's way is central to whether one develops long-term trauma symptoms or posttraumatic stress disorder (PTSD; van der Kolk, 2004). If escape is not possible, the intense energy that has been

revved up in the body to enable fight or flight becomes thwarted or frozen (Levine, 1997), and one's nervous system may become stuck on high alert, that is, they become hypervigillant and are constantly scanning their physical, emotional, or psychological environment for signs of repeated insults or rejections. Years later, individuals may live as if the stressor is still present and as if a repeated rupture to their sense of self and world lurks just around the corner, because their body and mind tell them it does.

Early childhood trauma can have long-lasting effects. The amygdala, the fight, flight, or freeze part of the brain, is fully formed at birth. That means that infants and children are fully capable of a full-blown stress response. When frightened, their bodies will go into fight or flight or freeze mode (Aram, 2004). However, the hippocampus or the part of the brain that interprets sensory input about a possible threat is not fully functional until somewhere between ages 4 and 5 yr, and the prefrontal cortex is not functional until around age 11 (Seifert, 1990). Therefore, when small children become frightened and go into fight, flight, or freeze mode, they have no way of interpreting the level of threat or of using reason to modulate or understand what is happening. Their limbic system becomes frozen in a sensory fear response and can remain, without intervention from a caring adult, locked in a sensory memory. Because of the child's natural egocentricity, the threat feels personal and may go to the core self (Aram, 2004). Children are likely to interpret whatever is happening as being about them and may feel that they are the cause. Because they lack the equipment to modulate their experience of fear on their own, their only way out of that state is through an external modulator, that is, the parent who can hold, reassure, and restore them to a state of equilibrium.

If modulating occurs at the time of painful circumstances, the child is unlikely to become symptomatic because the parent is wooing them back toward balance and a sense of safety. If, however, the parent or family environment is the primary stressor, the child is left to live through repeated ruptures to his or her developing sense of self, fundamental learning processes, and relational world on their own. Small children, however, lack the ability to make sense of fear-inducing circumstances, interpret the level of threat, or use reasoning to regulate and understand what is happening. Consequently, in later life, when something triggers their memory, they remember the same unmodulated memory that was locked down initially. When adults are seeking treatment, their memory or recallability of traumatic events may be minimal, and they may have little insight or cognitive understanding associated with the events. When adults become triggered by current life circumstances that mirror past situations—when entering adult, intimate relationships, for example, they may feel that the emotions being triggered are about the situation that triggered them because the nature of traumatic memory is not fully

understood. Trauma is a body–mind phenomenon, not just a mental response. This is why it can be difficult to talk about traumatic experiences. A part of the client was in a fight–flight–freeze mode and so "not there," and when they search in therapy for the memory, it does not necessarily come. What comes instead is a sensorial and emotional reaction (shakes, fear, shivers, pounding heart, and so forth) and a sense of danger, because that is how the memory was locked down in the first place. That is why a mind–body approach to trauma resolution is critical to complete healing. Adults who were traumatized as children do not tend to remember things well or in the order of their occurrence. Memories often appear in scattered flashes and body sensations. While being traumatized, the mind reverts to the basic functioning mode and those parts of the brain that make sense and meaning of events become overwhelmed. Consequently, those adults find a recitation of the traumatic events a difficult task. Oftentimes, the body needs to lead the mind to the truth. The body needs to speak in its own voice, to show rather than tell, or at least to be invited into the therapeutic moment. Then, as the truth emerges through action, journaling, or tuning into what's going on in the body, the adult mind and the observing ego can witness what is emerging through the mature eyes of adulthood and make new meaning of the events being processed.

A similar phenomenon can occur in times of war or intensely frightening experiences, such as rape. The survival parts of the human brain override the prefrontal cortex, and people operate from what is sometimes referred to as the reptilian brain. In other words, they are in fight or flight mode so that the terrifying experience becomes frozen in the brain and body. Because the cortex was overwhelmed, the experience is not thought about or processed normally. Those experiences may live within the self system as act hungers or open tensions; that is, the body and mind want to do something to bring closure to unresolved states of open tension.

Traumatized people are often emotionally and psychically glued to scenes and dynamics from the past. Trauma sears painful scenes into the brain and body where they may live, relatively unchanged, for many years. Traumatized persons' inner worlds can become characterized by extremes, and their outer worlds may mirror that dynamic. They may tend to cycle between extremes of black and white, with few shades of grey, in their thinking, feeling, and behavior. That reaction reflects the intense and overwhelming fear response, when a person becomes flooded with pervasive feelings of fear and then shuts down, numbs out, or dissociates. The clients' limbic systems may have become deregulated, they may become hyper-reactive or hypervigilant. They perceive danger, whether or not it exists, because the limbic system is regularly geared up for fight or flight. Everything feels threatening.

Issues with regulation, both within the self and in the family system seem ever present in that population. Rather than living in the present and tuning

into the natural give and take of the moment, clients' hyper-reactivity may make them feel safer living in their heads, with their own sets of conclusions, stories about what happened, and ideas and ideals about life and relationships, rather than in day-to-day reality. Because they have trouble with self-regulation, their ability to tolerate the vicissitudes of the moment may be compromised. They may have trouble dealing with strong emotion without acting out, blowing up, withdrawing, dissociating, or shutting down. They may lose spontaneity or the ability to respond adequately to a given circumstance, tending to over respond or to under respond. They become caught in a body–mind bind, in which their fearful thoughts trigger states of physiological arousal, and their physiological arousal triggers more fearful thoughts and emotions. That internal body–mind combustion may lead them to respond with behavior that is equally unconsciously driven. They may function, in some ways, through a false self because they have lost access to large pockets of their real selves. The more they respond thus, the more they continue such responses. What is initially a defensive strategy eventually becomes a quality of personality. The reaction is self-perpetuating, and the relationships that they set up with their environment define the parameters of the psycho-social and emotional world in which they operate. For traumatized persons, the past may feel as if it is ever present, even if it is beneath the level of their conscious awareness. Such clients often become caught in repeating dysfunctional relational dynamics, locked in a cycle of unconscious triggering, in which even small gestural cues, such as a raised eyebrow or flashing eyes, can send them into states of physiological and emotional fear that they associate with previous painful experiences.

Grieving Addiction-Related Losses

In dealing with addiction-related losses, clients may find themselves beginning in the here-and-now with their present-day loss issues but experiencing the rumblings of childhood losses that are agitating to come out. In addition to the presenting issues, some clients believe that they have no right to mourn the losses associated with problematic relationships, perhaps because well-meaning people tell them that they are "better off without them," or because they themselves have so often wished for distance from the addict, enabler, or codependent. Pain-filled relationships, however, can be difficult to process, simply because there is so much unfinished business associated with them. The conflicting feelings of love and hate and guilt and relief may complicate the mourning process. Instilling hope and engaging clients with a recovery zeal and helping them to set up a recovery network become important in creating motivation and a safety net to sustain and contain the grieving process.

A surprisingly large number of life's events go ungrieved in people's futile attempt to get on with life or to stop feeling sorry for themselves. Those events, which can become disenfranchised, may include any of the following:

- divorce for spouses, children, and the family unit
- life transitions; loss of job, youth, children in the home; moving or retirement
- dysfunction in the home, loss of family life
- lost childhood, lost security, constant abandonment, loss of parents who were able to behave as parents
- loss of a period of one's own life, loss of potential for what might have been

If people cannot mourn losses, they may experience one or all of the following reactions:

- Staying stuck in anger, pain, and resentment
- Losing access to important parts of their inner, feeling world
- Having trouble engaging in new relationships because they are still engaged in an active relationship with a person or situation that is no longer present
- Projecting unfelt and unresolved grief onto any situation, placing those feelings where they do not belong
- Losing personal history along with the unmourned person or situation
- Carrying deep fears of subsequent abandonment
- Having difficulty staying present in the here and now of relationships

Millions of dollars are often spent trying to locate the bodies of lost loved ones so that survivors can mourn them. Psychodrama allows grievers to concretize lost persons and mourn over them through word and gesture. The need to concretize the object of loss seems to be a deep, psychic yearning, without which the mind and heart remain unsettled and continue searching for an object of mourning. Psychodrama provides a concrete encounter with an object of loss in the here and now.

Grief and Self-Medication—The Connection Between Trauma and Addiction

In his seminal research on trauma, Bessel van der Kolk (1987) found that one of the pervading symptoms of post traumatic stress disorder (PTSD) in soldiers and those who have experienced some form of familial trauma, such as physical, sexual, or emotional abuse, neglect, or living with addiction, is the desire to self-medicate with drugs or alcohol. People abusing substances have

been able to medicate pain associated with grief, often for periods of many years. In sobriety, losses that went ungrieved and were medicated rather than felt, understood, and integrated may resurface. Without the coping strategy of self-medication, sober addicts will need to summon the strength to live through the pain that previously felt like too much to tolerate. Experiencing those losses in recovery may be confusing for recovering clients because often the losses reach back for years or decades. Psychodrama can offer a way to concretize and work with those overwhelming emotions when they surface. It is generally recommended that sobriety be established before those feelings are worked with experientially.

It is not uncommon for those who carry deep grief, which they have not been able to resolve, to feel that their pain is unique among all others and that no one can really understand what they are experiencing. Those clients often withdraw, isolate themselves, and mistrust connections with others. Hence, their path toward the connection as a part of healing becomes fraught with anxiety. Having clients engage with each other can help them to break through isolation, build trust, and begin to engage in the grieving process. Exercises in this article can help grieving persons begin to shed the tears and express the angry feelings associated with grief while simultaneously accepting care and support from others. Work with photographs and use of psychodramatic journaling can also help grieving persons to concretize particular grief issues or stages of life.

Krystal (1984) and Rando (1993) cite the following as warning signs of unresolved grief:

- Excessive guilt
- Excessive anger or sudden angry outbursts
- Recurring or long-lasting depression
- Care-taking behavior
- Self-mutilation
- Emotional numbness or constriction

Stages of the Grieving Process

One can expect to pass through certain, predictable stages in processing loss. I have adapted the stages offered by Bowlby (1969) and added a fifth stage. It is one that I have observed clients move through when they allow themselves to surrender to the process of grieving. Clients' feelings do not necessarily follow an exact course, stages may be leapfrogged or repeated, but listing the stages offers an overall map of the emotional terrain generally covered during the process of grieving loss. Loss, here, refers to the loss of a person, a part of self, a period of life, personal dreams, or addictive behaviors or substances.

Emotional numbness. In this stage, one may go through a period of feeling emotionally numb. The person knows that something has happened, but their feelings may be shut down and out of reach or come in waves. Numbness is part of a natural shock response. It wears off at different rates for different people, depending on such factors as the severity of the loss, the person's support networks at the time of the loss, the person's basic psychological and biological make up, and one's developmental level at the time of the loss (Krystal, 1984). If there is trauma associated with the loss, as may be the case in addiction-related losses, the numbness can become lasting. The natural phase of numbness is self-protective and should be allowed to play its course; it does not necessarily benefit from treatment. The kind of numbness that persists for years after a loss can be part of a complicated grief response and can benefit from treatment.

Yearning and searching. This stage is marked by a yearning for the lost object (person or situation) and searching for it in other people, places, and things. There is deep longing for what was lost—be it a stage of life, a part of the self, or a person—followed by a searching for a way to replace the lost object or experience. People who cannot allow themselves to pass through this stage may attempt to replace what was lost so that they do not have to experience the disruptive and painful emotions associated with this stage. Clients may experience ghosting, or the sense of a continuing presence of the lost person or even a sense that one is seeing the person in a variety of places.

Disorganization, anger, and despair. For persons experiencing loss, life may feel disorganized and normal routines may be thrown off balance. There may be a hole in their lives that feels gaping and empty. Grieving persons may experience feelings of anger or despair, which come and go and can feel sometimes overwhelming. Loses that have unresolved anger and resentment attached to them can become complicated. Clients may experience ambivalent feelings, such as sadness and relief or anger and longing. It may be easier for some clients to feel the anger, rather than the sadness beneath it, or vice versa.

Reorganization and integration. In this stage, one's inner world reorganizes. The loss becomes a part of the client's personal history. In the case of losses that have become complicated, the grieving person is able to articulate and experience the numbed or split-off emotions connected with the loss and integrate them into the self system. Energies that have been blocked become available again. This is a stage of acceptance.

Reinvestment, spiritual growth, and renewed commitment to life. In this stage, one comes to believe in life's intrinsic ability to repair and rebuild

itself. The grieving person experiences this first hand by reaching out and letting in caring and support from willing people, and realizes that one can heal from loss and move on. Although they may always feel some pain associated with their loss, the pain no longer overwhelms their ability to function. Their experience of life and capacity to live fully may expand. Freed-up energies become reinvested in a renewed interest in relationships and life experiences.

Inadequate Attempts at Dealing With Grief

Some attempts to deal with or manage grief do not necessarily lead to satisfactory resolution and integration. Inadequate attempts may include some of the following responses:

- *Premature resolution* occurs when people try to force themselves to resolve grief without allowing themselves to move through the full cycle of mourning. In those cases, the unresolved feelings tend to come out sideways in the form of projections, transferences, bursts of anger, withdrawl from life or relationships, simmering resentments, excessive criticism, bouts with depression, and so on.
- *Pseudoresolution* is a false resolution that occurs when persons fool themselves into feeling that their grief has been resolved, when actually it has not run its course.
- *Replacement* is when people replace the lost person or circumstance without first mourning that loss. For example, divorced persons who immediately marry again may feel that they have solved the pain of loss when, in fact, the loss has not been processed, and they have not learned from it. In the case of divorce, the same issues that led to one rupture tend to reappear in the next relationship. Less of the person is available for genuine love and connection.
- *Displacement* occurs when mourners cannot connect their pain to what is actually causing it and instead project the grief, upset, anger, and sadness onto something or someone else, thereby displacing the pain to where it does not belong. It becomes difficult to resolve the grief because it is projected onto and experienced around the wrong subject. Grief needs consciously to be linked back to what is actually causing it.

Grief Triggers

Some of life's circumstances can trigger grief reactions, and a substantial part of the reaction may be beneath the level of conscious awareness. Bringing those triggers into people's consciousness helps them to understand

where the conflicted feelings associated with the trigger response may be originating.

Anniversary Reactions

Anniversary reactions are common on or around the anniversary of a loss or death. One may feel a vague or even an overwhelming sense of pain related to a loss, a pain that feels as if it is coming from nowhere. One may experience the same type of reaction around the time of previous significant dates, such as hospitalization, sickness, sobriety, relapse, or divorce.

Holiday Reactions

Holidays often stimulate pain from previous losses. Because holidays are traditional ritual gatherings, they heighten our awareness of what or who is missing or what has changed.

Age-Correspondence Reactions

This reaction occurs when, for example, persons reach the age at which someone with whom they identified experienced a loss or they have a child who stimulates an age-correspondence reaction in the adult. For example, a daughter whose mother divorced around age 45 may find herself thinking about or even considering divorce when she reaches that approximate age. The father who had a painful time around 12 years of age may assume his 12-year-old child is having a painful year.

Seasonal Reactions

Change of seasons can stimulate grief or be unconsciously associated with a loss, thus causing a type of depression during a particular season.

Music-Stimulated Grief

Music can act as a doorway to the unconscious. It activates the right brain, drawing out associations and feelings that get stimulated by a particular song or music.

Ritual-Stimulated Grief

Important shared rituals can stimulate grief when there has been a loss. For example, family dinners or Sunday brunch can be a sad time for family members who have experienced divorce or death.

Smells or Returning to a Particular Location

Smells can stimulate memories associated with those scents. Visiting a place that one previously shared with a lost loved one can bring painful recollections.

Creating Living Rituals

Grief rituals are themselves inherently psychodramatic. Psychodrama allows the construction of living rituals that are tailored to the needs of the protagonist. The rituals can address all forms of loss so that those carrying the feelings associated with loss can process them and move toward resolution. Psychodrama is useful in the following ways for resolving grief issues:

- It concretizes the lost object
- It provides concrete closure
- It gives voice to words that went unspoken, reality to emotions that went unfelt, and accompanying psychological awareness
- It allows for catharsis of abreaction to express emotion and engage in the grief process

It allows for a catharsis of integration as emotions, which may have been split off and are out of consciousness, are experienced in the here and now and reintegrated into the self system with new awareness and understanding.

Psychodrama's unique ability to concretize a lost object, experience, or part of self, allows grieving persons to deal with a real, rather than imagined, circumstance. Clients are free to interact with the object of loss and to allow thoughts and emotions that may be banished from everyday consciousness to have their moment of expression in a safe, clinical situation with the support and witnessing of others. Words that were not spoken can be spoken; feelings that were split out of consciousness can be experienced in the present. This process can allow persons who may be blocked emotionally to regain access to their shutdown inner world or conversely to allow persons who are flooded with emotion to revisit the circumstances fueling that intensity in a modulated process that allows for self-regulation. Withheld emotion, particularly anger, can be harmful to one's body and can fuel depression. Through role play, psychodrama allows anger to surface in a clinical environment, where it can be experienced, expressed, and then processed and understood. If the anger is masking sadness, that, too, can begin to be felt.

As emotions are felt in the here and now, the observing ego witnesses and makes new meaning. Current loss often stimulates pain from previous wounds. Particularly when related to addiction, losses that may have gone unprocessed for periods of years become concretized in the here and now,

where they can be understood in the light of today and seen through an adult's, rather than a child's, eyes. That, in itself, is healing. Clients may also hold deep yearnings to understand how they were seen or unseen by a parent. Role reversal can provide a vehicle for standing in the shoes at the other end of a conflict or loss and provide the opportunity to experience the self from the role of the other. Corrective experiences can be built into the drama through reformed auxiliaries who give clients a yearned-for experience. Although the experiences do not occur in reality, they can allow clients to feel what it is like to receive what they yearn for and to have what they want so that if life presents them with a desired object or experience, they will not push the nourishment away because it feels unfamiliar. Thus, the loss is processed, and the self reorganizes to include it.

Psychodrama, through group process, provides sociometric opportunities for clients to learn to relate to people differently and to search for new, adequate responses to situations that used to be baffling. It also allows clients to train for new behavior roles within the group, which they can then take back into their lives.

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APPENDIX A
Grief-Related Exercises

Four basic techniques that therapists can use where appropriate:

Empty Chair Exercise

Ask group members to allow the person, job, or aspect of self to be represented by an empty chair (or a role player). Invite clients to say freely all that was left unsaid, to bring a feeling of closure to the relationship, and to say their good-byes. Role reversal, doubling, and interviewing can extend and deepen the exploration.

Letter Writing

Ask group members to write a letter to the person they have lost. Invite them to share fully any and all emotions and to move toward closure. Their loss issues may require a letter to a part of themselves, to a period in their own lives, or to a substance or behavior to which they are saying good-bye. They may also wish to reverse roles and write a letter that they wish to receive from the person, part of self, substance, or behavior being explored.

Photographs

Photographs are a powerful tool for healing grief. They may be brought to group or one-to-one therapy sessions and used as a near-psychodramatic technique, with the client talking to, doubling for, or speaking as the person in the picture. As a way of working through letting go, a client may wish to make a scrapbook about a lost person, a stage of life that has passed, a child who is going off to college. A scrapbook can also serve as a gift to the departing young person, consolidating their youth and allowing them to hold it in their own hands and take it with them.

Transitional Objects

Transitional objects hold a sense of the presence of a person who has moved on through death, divorce, or departure. Clients may wish to do a vignette or monodrama,

talking to any object that holds the presence of a loved one—a pipe, a golf club, a stuffed animal, or a recording. This exercise can help clients work with those feelings that need to emerge in relation to a lost love.

Four specialized techniques therapists can use when appropriate:

Grief Spectrogram

Goals:

1. To make unconscious, grief-related material conscious.
2. To provide a method of action sociometry that integrates specific goals toward grief resolution.

Steps:

1. Draw an imaginary line dividing the room down the middle, showing group members where it is as you do so.
2. Explain to the participants that each end of the room represents an extreme, with 1% at one end and 100% at the other, and that the bisecting line is the midpoint, representing 50%.
3. Now ask a series of criterion questions that apply to your particular subject, and ask participants to locate themselves at the point along the continuum that feels right for them in response to the criterion question. For example:
   - How much grief is in your life right now?
   - How much anger do you feel?
   - How tired do you feel?
   - How much disruption of your normal routines are you experiencing?
   - How much fear do you feel about your future?
   - How much hope do you feel about your future? (See "Grief Self Test" [Appendix B] for more grief-related criteria questions.)
4. Allow participants to explain why they are standing where they are standing after each question either with the group at large or those standing near them on the spectrogram.
5. Repeat this process for as many questions as can be absorbed.
6. The director may extend the exercise by inviting group members to identify someone who shared something that resonated with them, then to walk over to that person and share with him or her the reasons for their choice.
7. Group members can then return to their seats for further sharing and processing.

Variations: This exercise can be used as a warm-up to empty chair work, letter writing, or vignettes.

Note: The use of a grief spectrogram and the guided imagery for loss are adaptations that were developed by Ronny Halpren, MSW, Bereavement Coordinator for the Cabrini Hospice in New York City.

Grief Locogram

Goals:

1. To allow group members to identify which stage or stages of the grief process, they might be in.
2. To allow group members to identify with and learn from each other.

Steps:

1. Designate each of four corners of the room with one stage of the grief process, as outlined by Bowlby. For example, one corner of the room represents the stage of numbness; one yearning and searching; one disorganization, anger, and despair; and

one reorganization. If desired, the therapist may add reinvestment in another location, but four positions are adequate for the exercise. Designating an "other" area can prevent participants from feeling restricted to only four or five choices.

2. Invite group members to go to the corner of the room that best represents where they feel they are in their grieving process for the issues with which they are working.
3. Ask anyone who wishes to share why they chose to stand in a particular spot. Group members can share individually or in subgroups with those they are standing beside. They will be standing in sociometric alignment, that is, those experiencing anger will be standing next to those in anger, and so on.
4. Next, ask group members if they feel a need to stand anywhere else, and if so, repeat steps two and three.
5. After all who want to share have finished, the group can move into psychodramas with whoever feels warmed up to work, or they can return to their chairs for further sharing.

Variations: This can be used as a warm-up for writing in a journal or for letter writing. Doubling or sociometric choosing can also be part of the process, as the members respond to questions such as "Who can you double for?" or "Who said something with which you identify?"

Guided Imagery for Loss

Goals:

1. To trace past issues, investigate what messages were received, and how one was taught to handle loss.
2. To see how past losses may be affecting current losses.

Steps:

1. Direct clients to find a comfortable position and relax. They are to leave behind whatever outside concerns they may be carrying and bring their attention into the room. Direct them to pay attention to their breathing and to breathe in and out easily and completely and relax. They are to uncross their legs and place their hands on their laps with palms facing upward or have palms toward the ceiling if they are lying on the floor. Clients are to take a deep breath and hold it, then blow it out slowly, as if blowing out through a straw. Clients notice areas of tension and breathe into them, allowing them to release, and then relax.
2. Clients remember a loss, perhaps the first one they can remember, thinking about when it was, where they were, what happened, what they were told to do, and what they learned about grief and loss. They answer the following questions:

   - What are your thoughts?
   - Observe yourself in your mind's eye; how do you look?
   - What is your expression and body posture?
   - What are you expecting, to be true about yourself or about life around the loss?
   - What meaning are you making out of this situation?

3. Whenever they feel ready, they open their eyes.
4. They share what came up, in dyads or within the group. What has this experience and other experiences taught you about loss, and how are the lessons you learned being played out today in the way you currently deal with loss?

Variations: This exercise is a natural warm-up to action. The therapist may wish to put an empty chair in the center of the group. Anyone who has anything to say to someone can use the chair to represent the person, or members may choose someone to play the person or persons involved.

Saying Goodbye—The Empty Chair

Goals:

1. To say goodbye fully to someone who has left one's life.
2. To work through blocked emotions surrounding the loss.

Steps:

1. Allow the protagonist to share information about the person to whom he or she wishes to say goodbye.
2. Allow the client to choose a person or to use an empty chair to represent the person.
2. Allow the client to choose a person or to use an empty chair to represent the person.
3. Ask the client to set the scene.
4. Encourage the protagonist to be specific, saying goodbye to all that he or she will miss in detail.
5. If it seems appropriate or helpful, allow the client to say what he or she will not miss.
6. The protagonist can reverse roles with the person whenever appropriate or double for themselves or the person to whom they are talking.
7. The protagonist can ask for something that he or she may wish to have from the person—a word, a gesture, or an object.
8. The protagonist may wish to give something to the person as well.
9. Ask the protagonist to finish the goodbye in any way that he or she wishes.
10. Allow plenty of time for sharing in the group.

Variations: Scene setting can be very personal. The protagonist may wish to be in any type of setting, either real or imagined. The setting can be a funeral, a deathbed, a park, a field of flowers, or any location that the protagonist may choose. The idea is to say goodbye fully wherever it works best. If life did not offer an opportunity for the protagonist to say goodbye and put closure on the relationship, psychodrama can allow that to happen. Goodbye may also be said in a one-to-one setting, using an empty chair. (Dayton, 1994).

APPENDIX B
Self-Test—Grief Questionnaire

Purpose: This questionnaire is designed to give you more information about your current loss and to heighten your awareness of the role that unresolved grief may be playing in your life.

Instructions: First determine the issue that you believe is your current concern, and then answer the questions by circling the words that most closely represent your experience.

Note to therapists: These questions can also be adapted to a spectrogram.

1. How much unresolved emotion do you feel surrounding this loss?

Almost none Very little Quite a bit Very much

2. How blocked are you from getting in touch with your genuine feelings associated with this issue?

Almost none Very little Quite a bit Very much

3. How disrupted in your daily routines do you feel?

Almost none Very little Quite a bit Very much

4. How much depression do you feel?

Almost none Very little Quite a bit Very much

5. How much yearning do you feel?

Almost none Very little Quite a bit Very much

6. How much sadness do you feel?

Almost none Very little Quite a bit Very much

7. How much anger do you feel?

Almost none Very little Quite a bit Very much

8. How much ghosting (continued psychic presence) of the lost person, situation, or part of self do you feel?

Almost none Very little Quite a bit Very much

9. How much fear of the future do you feel?

Almost none Very little Quite a bit Very much

10. How much trouble are you having organizing yourself?

Almost none Very little Quite a bit Very much

11. How uninterested in your life do you feel?

Almost none Very little Quite a bit Very much

12. How much old, unresolved grief is being activated and remembered as a result of this current issue?

Almost none Very little Quite a bit Very much

13. How tiredness do you feel?

Almost none Very little Quite a bit Very much

14. How much hope do you feel about your life and the future?

Almost none Very little Quite a bit Very much

15. How much regret do you feel?

Almost none Very little Quite a bit Very much

16. How much relief do you feel?

Almost none Very little Quite a bit Very much

17. How much self-recrimination do you feel?

Almost none Very little Quite a bit Very much

18. How much shame or embarrassment do you feel?

Almost none Very little Quite a bit Very much

Note: The author grants readers permission to reprint this questionnaire, taken from her book *Trauma and Addiction* (Dayton, 2000).