

CHAPTER THREE

Group Therapy

Origins of Group Therapy

Many people do not know that group therapy has its origins in tuberculosis sanatoria. Doctors noticed how patient's morale improved when they were encouraged to talk together about their predicament. There were no studies demonstrating improved longevity of life, but this is not the only measure of worth. Death is a very specific quantitative event, but how we get there is also important. Would we rather die happy or sad? Medicine is first and foremost about caring, and until relatively recently there was no other agenda for most conditions. Care was based on assisting nature to do the healing. To a large extent this is still the case, but there are many more ways of assisting nature than ever before. The qualitative questions need to be attended to as well as the quantitative for this reason and also because it turns out that our immune systems function better if we are happy. It is no different for people with addictive disease: 'a problem shared is a problem halved'. Group therapy is one of the most important ways for isolated, lonely addicts to find their route back to the healthy social relationships that healthy people take for granted. Medicine and doctoring are as much about relieving suffering as curing disease. Indeed medicine is often spoken of as an art rather than a science because of this element. If we are asked to attend to the quality of the relationship between the doctor (or nurse, psychotherapist, social worker, psychologist) and the patient, we can see the wellbeing of the latter is affected by far more than cold science. We might dream of one day being our own doctor, with a powerful computer programme into which we feed our symptoms, and out come the diagnosis and treatment. But this ignores two vital facts. 'Symptoms' need interpretation, and no computer programme yet devised or likely to be devised can do this, such are the complex subtleties of human pathology. The patient can fool the machine and themselves. The truth can only be arrived at by human interaction, over time, with the involvement of entities like trust, confidence and warmth in order to deal with anger and grief, dependency and fear. This is especially true when our lives begin to unravel in the face of mental afflictions. Addiction therapy requires a great deal of self-treatment by the patient. Cancer patients, for example, surrender to cyclotron or chemotherapy, but addiction therapy requires the staff to inspire each patient to do his or her own work. We can't do it for them, but we can organise a system that is conducive to producing change.

I began my own involvement in group therapy at the Royal Edinburgh Hospital, sitting in on

large group meetings of chronic schizophrenics. The experience was vaguely surreal, and reminds me now of the film *One Flew Over the Cuckoo's Nest*. We would sit in a huge circle, often in silence. The patients would wait passively for something to happen, like my psychiatrist boss saying something. Usually he was not there, and his place was taken by a very nice senior registrar who applied the same skills to the job as if he were at a cocktail party. If the aim of the group was socialisation, this was no bad thing, but I was never clear what the aim was, and it was never discussed. A vague idea that talking together would do the group members good was what seemed to be motivating us. This was the tail end of the 60s, which saw a big revolution in social psychiatry. I have already described what was happening at Dingleton Hospital, so near and yet so far away from Edinburgh. It was just beginning to dawn on many psychiatrists that our relationships are crucial to our state of mind, and that it was indeed true that 'No man is an island', as the poet John Donne had written in the 16th century. Our attempts to induce institutionalised patients to interact with each other were part of this social revolution. However, I found these groups meaningless and very shallow, seeming to miss the point of self-revelation. I suspect I was looking for abilities that just were not there in these chronically disabled patients. More is now known about the effects of institutionalisation and chronic understimulation, as well as the stunting effects of the psychotic process. Alcoholics are not in this diagnostic grouping. At Queen Mary Hospital I began accumulating experience and rapidly decided that it was vital to use the power of the group to draw in its members to develop a culture of openness and trust, realising that it is this intimacy which is so underdeveloped in the addict's personality, and which isolates them from the support of their fellow men and women.

Alcoholics Anonymous

As far as I know, there was no formal group therapy at Queen Mary Hospital until the advent of Alcoholics Anonymous in the mid 1960s. Oral history suggests that Ian McE., a Nelson businessman, read about AA in *The Readers' Digest* while he was a patient drying out for the umpteenth time in Ngawhatu Hospital, around 1956. Like the founder of AA, Bill W., Ian was desperate to find a way to break the addictive cycle.

Alcoholics Anonymous came into being in the USA a number of years after Bill W. (AA members do not reveal their last names) got together with Dr Bob, a surgeon whose practice of alcoholism had ruined his practice of surgery. Bill was the initiator who discovered the power of mutual support in maintaining sobriety. The movement grew quite slowly with a good many hitches over the next fifteen years, but eventually became a model of grassroots democracy, and is based on the principles of sharing one's own story with other sufferers, and learning the principles of honesty, openness and love for one's fellow men and women. AA works on the method of attraction rather than promotion, and does not seek to be the only road to sobriety. Newcomers hear what AA can offer, and decide for themselves if they like it. Ideally judgements are suspended and advice is not given about an individual's medical condition; this is left for professionals with suitable training. Fundamental is the principle that meeting regularly with other alcoholics aids alcoholics in maintaining sobriety. It is the power of the group that gives AA its strength.

Alcoholism and drug addiction are lonely conditions. Often those folk who are nearest and dearest to the alcoholic (their 'Social Atom', to use a term from psychodrama) are the people who feel this isolation the most strongly. Spouses often feel their alcoholic partner has taken a lover - the bottle - and pushed them out. Honesty is replaced by lies and denial, openness by secrecy.

Inside the drinker a healthy self-esteem is replaced by secret guilt, shame and self-loathing. Personal efforts fail to control drinking (or drugging - the process is essentially the same for any mind-changing drug or process addiction)- Joining a group where every member is aligned to the same goals of sobriety and healthy communication with others vastly increases the chances of stability and emotional growth.

Ian McE. was New Zealand's Bill W. He was so inspired by what he read in The Readers' Digest that he sent to the USA immediately for literature and support. It came readily, in the form of the AA's publication *The Big Book*, and pamphlets on how to form a group. Ian knew Queen Mary Hospital was a haven for alcoholics, and he arranged to call on the hospital's senior medical officer, Dr Tom Maling.

A Hanmer AA group was formed first within the hospital, and later independently in the village, meeting in the Anglican Church Hall, When Dr Wilkinson retired in 1965, Dr Tom Harrison was appointed medical superintendent. He recognised the increasing number of patients diagnosed with alcoholism, and began to research how to institute a special programme involving lectures and groups. At that time formal therapy at QMH consisted of individual sessions with a doctor, occupational therapy, and in particular work maintaining the extensive gardens around the hospital and on the hospital farm.

The original twelve steps published by AA were as follows:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His Will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Developing the Group Therapy Programme for QMH

In 1971, Dr Harrison arranged for Tony Taylor, Professor of Psychology at Victoria University in Wellington, to design a programme of therapy suitable for the existing staff to run. The result was a twelve-week-long residential system consisting of six two-week periods, in which a staff group leader and co-therapist would take daily sessions. The leaders worked with the group for two weeks (or ten sessions), then handed the patients on to the next set of leaders. The daily group time was an hour and a half, from 3 to 4.30pm, weekdays. Saturday was a recreation day,

and on Sundays an open AA meeting was held in the hospital's community centre at 1pm. Members of the public were welcome to attend this meeting, and every Sunday a carload at least of Christchurch-based AA members would attend. Many of these people were ex-patients, and their presence was both inspirational and helped to bridge the all-important gap between leaving QMH and joining in support available at home. At that time, of course, there were no community alcohol and drug centres, and very few doctors, psychologists or other therapists who understood alcoholism and drug addiction. Even today this gap remains wide between leaving in-patient treatment and plugging into community support.

In those days the goal of therapy was a great deal simpler: it was abstinence from all mind-changing chemicals, period. No alcohol equals no alcohol problems. These days the field is beset by multiple options to be selected from by the patient. This is based on the need to attract patients to community alcohol and drug establishments. Even when a patient clearly has a severe addiction problem, if he or she refuses to entertain abstinence, it is their choice to decide. To me this is bordering on the unethical. The first task of a doctor is to diagnose correctly, and the second is to advise the patient on the best treatment. For all degrees of addiction, other than the very early stages, surely the best advice is to not drink alcohol. There are plenty of occasions in medicine where the doctor's best advice is ignored, and this does not result in the doctor pandering to the patient. It does not mean the patient is put down in any way, it just means that the doctor maintains his position in the best interests of the patient. For instance in diabetes mellitus (sugar diabetes) a patient might not accept the advice to control food intake, to exercise regularly, to lose weight and to take insulin as instructed. Usually a few hypo or hyperglycaemic attacks have to occur before the advice sinks in. This is analogous to what happens in addiction. Pandering to the patient's choice when it is plainly not in their best interest strikes me as an example of the daft political correctness that is so bedevilling our age.

The group therapy system introduced by Professor Tony Taylor in 1971 required group leaders to work with the group for ten sessions over the course of a fortnight and then hand the group on to another team, who would work with the group for ten sessions over two weeks, and so on for six successive teams. Patients therefore developed relationships with six different teams of leaders during their stay of twelve weeks. Equally a leader had only ten sessions to get to know up to fifteen patients before handing them on to the next team.

The system was designed this way to avoid one set of leaders having to cope with the transference issues that inevitably arise between leaders and patients over time. For fully trained psychotherapists, transference issues are the therapeutic grist for the mill in which change is gradually wrought. However, to untrained people they can become head-on clashes that are unproductive of change. To deal with prolonged intimacy with others, especially to work with the hidden insanity of addictive thinking, requires a high measure of skill. This skill looks deceptively easy until you find yourself in charge of a therapeutic group yourself, whereupon a whole new set of dimensions asserts itself. As time went by and training became available, staff members were more able to cope with therapeutic intimacy, and the system was changed to profit from this.

In the meantime, when I first went to QMH in November 1972 the twelve-week system was operating, and my preliminary opinion was that it catered more for the staffs anxieties than for the patients' needs. As I shared with fellow staff the group therapy skills I had learnt in my training as a psychiatrist at Edinburgh, the likes of John Craighead, QMH chaplain and vicar of

Hanmer Springs, and Helen Arthur, charge nurse and one time hospital visitor, became supportive of change and helped me to set it in place.

Fear of intimacy is a feature of many people's functioning, particularly when there is a fear of trusting others, and inevitably it is a feature of all people with addictions. It is only possible to recover if this fear is diminished, resulting in the development of a trusting intimacy with other human beings. This is what AA is based on, and AA remains the only scientifically validated therapy that maintains long-term recovery.

Psychodrama

In 1975, while I was still the Special Area Medical Officer and a part time doctor in the QMH programme, Lois Muir (head occupational therapist) popped into my office. 'This looks like something you would enjoy,' she said, and handed me a pamphlet from the University of Otago's Summer Extension Studies programme. It described a workshop to be held later that year entitled 'Introduction to the Psychodrama Method'. The leader was an Australian, Dr G. Max Clayton. From the pamphlet I learned that psychodrama was based on the teachings of Dr Jacob Moreno, a Viennese psychiatrist who had migrated to the United States in the late 1920s. Among other things, Dr Moreno emphasised the necessity for creativity and spontaneity in our lives. He deplored the trend in modern society for control at the expense of vitality. So it is ironic indeed that it is just this dynamic of control at the expense of vitality that eventually resulted in the closure of QMH! Further, he believed that human behaviour could be viewed in terms of roles being acted out in a particular social circle he called the 'social atom'. He believed that we could be trained to be more spontaneous and creative in our encounters with others. One of the most common unhealthy attitudes we can have is the inflexibility to deviate from our planned path. This is a very important principle, both in life, and in recovery from addiction, often referred to as the principle of spontaneity. In fact, the principles of living a healthy life are the same as those for recovery from addiction. The only difference is that addicts soon relapse if they do not follow a healthy path, whereas non-addicts slowly find themselves vaguely 'off course', that is, if they even notice. I enjoy working with addicts because they have faced a crisis and are impelled to seek new ways to live. I dislike when people turn into 'therapy groupies', endlessly navel gazing instead of getting on and living life. If therapy turns into a way of life, then it is unhealthy. In my own practice of supervision of therapists I have often stated that psychotherapy is actually a very unhealthy profession: it has the propensity to isolate people in a closeted relationship in a small room for hours on end. If the only time the therapist emerges is to go to a conference and talk endlessly with others of the same ilk, then we have a condition where life is kept at bay.

The great healers in Christian tradition went out to meet people. They did not sit in offices closeted in aloneness. Too much of anything is detrimental, as the Presbyterian motto 'Moderation in all things' teaches. Buddha advised 'Right Thinking, Right Actions' which amounts to the same thing. Moreno, himself a great teacher by example, taught that we can have any thought we like, but it makes no difference to anything in this world until it is translated into action.

Every generation seems to have to relearn these old truths, and Moreno pointed out that only experience will teach us about them. Reading books helps, but again all the reading is for naught until it is translated into action. Another Morenian principle is that the only truth that counts for anything emotionally is our subjective truth. If this matches other people's, then we

will be in agreement with our surroundings. When it does not, or if we suppress the difference, there is a dissonance that reverberates. We then have the choice of doing something about it, or not.

I can see that these concepts had already taken seed in me when I began my association with Max Clayton, but I could not articulate them. When I left Edinburgh, it was because my subjective truth was shouting inwardly: 'You can't spend your life in this environment.' Luckily my parents had given me sufficient training to stand by my own truth, and I was also lucky that my psychological social atom, in the form of Jan, was willing to trust my spirit of adventure. Entering the world of psychodrama eventually enabled me to find a framework to articulate some of my own truths to myself, as far as this is possible.

Dr G. Max Clayton is a psychologist and former clergyman who had trained in New York under Jacob Moreno. Max had built on the Morenian method to produce a vital Australasian vehicle with several emphases that represented a development on the original. One of these was Systems Theory: the idea that none of us is isolated, and that our actions affect others, and we in turn are affected by the actions of others, including the past actions of people now dead. It seemed to me at once that this would be an excellent theory for alcoholics and addicts to learn to appreciate. Perhaps because of inadequate relationship attachments and certainly because of the nature of the chemical effect of drugs of addiction, the typical alcoholic acts selfishly. Learning that others are affected even by our thoughts, let alone our actions, would be important in recovery. Max also taught an innovative method of roleplay, preceded by a 'warm-up' to action. Warm-up is the creation of a mental state, similar to a sportsman making a mental preparation for a game. If the warm-up is right we can access our spontaneity more readily, we are at the top of our game, as it were. This is a concept readily accepted in sport, but often ignored in everyday life. For example we might wonder why we are ill at ease with someone we want to sparkle with, instead finding ourselves tongue-tied and stumbling for no obvious reason. Often introspection will reveal that our mental energy is being siphoned off by a past event where we were dominated by another - like a bullying incident at school - or frightened - like a childhood event that stayed with us and inhibits a free-flowing 'warm-up' in certain situations. This can be changed by developing insight and refusing to let the past dictate the present. Participating in psychodrama is a good method of learning to understand the generally unconscious process, and substituting new behaviour in its place. When we learn to do this, familiar trip-ups can be avoided. The key word in this context is spontaneity, and in particular the ability to meet an old situation with a new response or a new situation with an adequate response. It is the essence of being human rather than a robot!

Max believes that one reason people often profess to dislike roleplay is that it has been misused to teach rigid roles that amount to no more than learning to act a part. In psychodrama roleplay is about exploring our thinking, feeling and action, and receiving feedback from group members about how we are performing. We are not learning one person's way of dealing with a given situation, as used in law school, for example, where student lawyers are put through their paces in a court roleplay.

At that first workshop in Dunedin in 1974,¹ began to appreciate the joy of learning in a supportive group and the closeness and warmth generated between group members, which lasted outside the group room. The presence of like-minded explorers was in contrast to the rigid customs of the medical profession, particularly in adult psychiatry. I had not realised how my own Guild of Medicine was shaping me to be a cautious conservative. In the years since 1974 this dynamic has become even more rigid for those of us with an interest in personal development,

who also work in psychiatry. I have come to the belief that the average psychiatrist is often very skilled at prescribing drugs for the seriously mentally ill, but is the last person I would consult if I wanted to learn about the possibilities of personal development and healthy living skills. Indeed the average psychiatrist knows next to nothing about addiction, but is all the more dangerous for this because he or she thinks he does know, and acts accordingly. Of course there are exceptions to any generality, but the gulf between psychiatry and addiction medicine has led to very unfortunate consequences, particularly the downgrading and closure of places like Queen Mary Hospital. Doubtless sincerity and science abound in the people who made these decisions, but the lack of appreciation of the Systems Theory we practiced there has, in my view, had disastrous consequences.

I instinctively took to Max Clayton, who spoke with an Australian drawl and seemed to be interested in everything. I have long since forgotten how he warmed us up to action in that first workshop, but I do recall that within a short time I was being directed in a scene with my boss, the then medical superintendent of Queen Mary Hospital, Dr Upham Steven. He was a General Practitioner who had developed poor eyesight due to bilateral cataracts. He had had them operated on, but this was before the days of plastic lens inserts. The sufferer was condemned to wear spectacles with thick correcting lenses, which had a restricted field of vision. This made driving difficult, and Upham had been appointed interim medical superintendent of QMH as an alternative to being a country doctor. He had no psychiatric or psychological medicine expertise, and I suppose his appointment reflected a frustration in the North Canterbury District Hospital Board that the position had been extensively advertised without finding anyone to fill it. The obvious choice was Dr Torn Maling, Senior Medical Officer at QMH since 1944, but he was over 65 and so was ineligible.

Upham was a very determined individual who could never be told anything. Although he meant well, the fact was that if you wanted him to do something for you in a certain way, then the trick was to suggest the opposite, and he would oppose you with all his might. Provided you had played your cards right initially, both parties then emerged content. However, this was not a recipe for good relationships, and I suppose Max must have asked us to think of a relationship we wanted to improve, because I found myself being directed by him in a scene with Upham in his stubborn mode. I depicted Upham resisting a good suggestion. Max asked me what this reminded me of in my earlier life, and we went straight to a scene with my own father, when I was a teenager. My father was resisting what seemed to me, from my arrogant teenage perspective, to be a good suggestion. Now, I had done a fair bit of training in psychotherapy, but I had never really understood the power of the past to shape the present, and this personal demonstration when I had least expected it had a profound effect on me. Indeed it does to the present moment. I found myself wondering how I could find the power to break out of the old way of relating to my dad (and Upham). Well, that was demonstrated next, as we entered the phase in the drama called surplus reality.

I decided to try a new way of relating to Dad, where I took my power as an adult, equal with him, and we had a discussion there and then about how things could be better between us. I was profoundly moved. Note that all this happened on the psychodrama stage. My dad lived 12,000 miles away in Scotland. He was there, and yet not there. By means of enacting role reversals, I discovered what I thought, and what I thought he might reply. As I have just said, this is entering the realm of surplus reality - the reality that is inside our heads all the time, influencing what we say and do. It is also called our subjective truth. Max taught us that subjective truth is the only truth there is when we are dealing with interpersonal relationships.

Many of the group members found this concept hard to understand, let alone agree with. It seemed self evident to me, however, and I ploughed on with my drama, pausing only to reflect that it took about one minute for me to move from working with my dilemma with Upham Steven, to working with my Dad. The connection between Dr Steven and my dad was a demonstration of the force of transference. I could not deal with Dr Steven in the moment without triggering my history with my dad.

I had learned theoretically in Edinburgh about transference, but I had never been convinced that it was real. In other words I was not able to feel it as a part of my subjective truth. In this attitude I was nearer to being an intellectual behaviourist than any other kind of psychotherapist, because behaviourists think in terms of machine-like interaction, just as if we were mere computers reacting according to how we are programmed. I could now see that we are programmed in the sense of being trained by our histories, but that accessing these histories is an immensely complicated and delicate process, influenced by our warm-up to that moment. A behaviourist would say that we have no free will because we are always responding to our past training. This seems to ignore our intensely human feeling that we do have a choice in what we do and think, even though there are many things in which we do not have much of a choice. For instance our physiology dictates that we must eat and breathe, but we do have choices about how we do these things. For instance we can eat 'junk' food or healthy food, or we can breathe to a certain pattern when we are swimming. Moreno believed we have the qualities of spontaneity and creativity to assist this choice-making process, and that these qualities can be expanded by training. The goal of such training is to become a spontaneous actor in the moment, that is, making informed choices in each moment.

I found myself becoming excited by these ideas after my experience of creating my drama with Dad/Dr Steven. So much was emerging in my mind from such a small piece of work: for example, the notion that addicts were stuck in making a repetitive choice of very limited dimensions — to use a drug or not to use a drug - which becomes more restricted the more severe their addiction becomes. Max had introduced me to a way of thinking which seemed at once enlargingly artistic and profoundly true. I particularly liked the tact that all this had emerged from my own experience during the drama. Max had not told me anything; he had unlocked these thoughts by inviting me to act in a certain way to explore what was within me. I was reminded of something I had read about the sculptor Michaelangelo: whereas most people might look at a lump of rock and be aware only of the external appearance of it, Michaelangelo warmed up to the sculpture that was inside the rock, and which merely had to be liberated from its confines.

Human beings could be regarded in the same way, I found myself thinking. How wonderfully liberating! I had a warm-up to the immense possibilities of our lives, instead of to the restrictions. For someone inherently shy and insecure, this was a revelation.

The result of my drama with my dad was that I wrote a letter to him that for the first time came from one adult to another. I told him how grateful I was for the myriad ways he had been a loving parent, and asked questions about his experience of the Second World War, of coping with my mother's illness, and about his own hopes and dreams. It was wonderful, because he immediately wrote back answering my questions as best he could. We had a different sort of meeting to any we had previously had. I also wrote to my aunt, the twin sister of my mother, inquiring about her version of the events around my birth, the postnatal depression that altered my mother's life permanently, for the worse. I can see now that I had been approaching this question for many years, but had allowed myself to be influenced by the family taboos around asking for information about my own history. This insight has had a profound influence on my work as a psychotherapist. It

has resulted in me urging countless patients to ask the questions they feel inside themselves, rather than give away their power to unseen taboos and require permission to find out about themselves. I urge them to ask now about their personal and family history, before important people die and the opportunity is lost forever.

It occurred to me that we can practise asking the questions that are important in the psychodrama room, and get the feedback from the rest of the group - the audience members in that particular drama. Then we can move to life outside the psychodrama room, and put these new roles into practice in reality. Later, when I articulated this to Max, he asked if I thought life on the psychodrama stage was not real. I realised in that moment that I had cut off from the vitality of the moment - by viewing psychodrama as a rehearsal for life. The lesson was that life is here and now, and that this is it. The modern attitude of planning so much of our lives is a peculiar obsession. Sure we have to plan, but we sap our vitality if we live always in the future.

Like anyone, a psychotherapist is constantly seeking insight about how one's personal life is intertwining with one's professional life. Indeed, the two cannot be separated. Many psychiatrists, however bright and well intentioned, often do not allow their own vitality to inform their work. Indeed when I go to meetings of psychiatrists I am often appalled by how defensive they are with each other. This is in stark contrast to meetings of psychodramatists, for instance the annual meetings of the Australian and New Zealand Association of Psychodrama. While I do not for a moment hold up these gatherings as perfect - heaven is not to be found there! — at least there is a vitality and encountering of the other which is not based on fear, but instead on experiencing the now. When we slip back into social niceties, we act according to our dominant fear-based Western culture. But at least we have a modicum of awareness that we are making a choice, and the possibility remains to make a more vital/spontaneous one.

One day at a psychodrama training workshop led by Max Clayton, I found myself investigating my own birth, the history of which I have outlined above. Training of future psychodrama directors is carried out experientially, that is, participants enact scenes from their own lives using the methods of role reversal, concretisation and exploration of surplus reality. The work is then processed within the group, discussing why the director chose to take the pathway he did, and suggesting other ways that might have been equally or more productive.

I cannot recall how I was warmed up to the need to explore my birth, but it was strong and welling up within me. I recall being in my mother's role, labouring to give birth, part of me wanting the child and part of me not wanting it. I felt so angry I had been cast in this role. I did not want to be a mother! I was furious that all this had happened so quickly before I was truly ready for it.

As myself, I felt the dark of the womb, the integral closeness of the mother who nurtured the foetus, of pressure, of horror at leaving the womb. I really did not want to be born. It was frightening to find I would be expelled and then to relate to the woman whose emotions were so strong and likely to be hostile to me — the source, after all, of her future psychosis. No, I realised, that was not correct: I the foetus had no part in her future psychosis. Whatever part hormones, pregnancy, war, separation, anxiety and fear had to play in Mum's future state, they were her issues, not mine. That was liberating. But what was disturbing was to realise how angry she was. Instantly I knew that this was correct. Equally instant was the realisation that in spite of this anger, none of it had ever been aimed in my direction. I had felt loved.

But the anger was nevertheless disturbing. After the drama was over, I continued to feel disturbed by the realisation of how angry she had been. My training in the method and in the importance of we ourselves resolving our own subjective truths, meant that I tackled this from

the point of view of my own need to resolve it for myself. It was my own private, internal issue. It was not one I could make progress with by blaming my mother for my insecurity as an adult. Blaming another actually holds up our personal development. It inhibits our acting in the moment, and being ourselves. And often it is quite unconscious. I became fired up all over again about the potential of the psychodrama method in bringing about this sort of realisation in my patients. This is the wonderfully satisfactory thing about treating addictions. Once a person starts to take responsibility for the way they interact with the world, and stops blaming others, then half the job of recovery is done. The next trick is to go on doing this each and every day — the 'One Day at a Time' approach at the heart of all the great spiritual teachings of our planet.

Instigating Psychodrama at QMH

I attended a training workshop with Max for five days every year throughout the 70s and 80s. The first two workshops were in Dunedin, as part of the University of Otago Summer Extension Studies programme. They were attended by a variety of staff from the psychiatric services locally, both psychiatrists in training and occupational therapists, nurses and psychologists from different mental health hospitals around the country. From QMH Lois Muir decided psychodrama was not her thing, but her place was taken by John Craighead, the hospital chaplain. He became equally enthusiastic, although he never formally trained under the Australian and New Zealand Association of Psychodrama training system. After the second workshop in early 1976 I became a firm devotee, and my wife Jan also started coming to some sessions. After his second Dunedin workshop I asked Max if he would come to QMH to do training, and so began an annual training workshop that continued at the hospital from 1977 to 2003. In fact a five-day meeting of 'Training for Trainers' in September 2003 was the last event held in Chisholm Ward before the hospital was closed.

Soon after I became medical superintendent in 1976, I initiated staff discussions about formally introducing psychodrama to the QMH treatment programme. Opinions were mostly supportive, but some of the more traditional staff members were resistant. To their credit they did not obstruct the development, and were satisfied that participation was to be voluntary and that staff participants who did not wish to reveal aspects of their own life to the patients were not required to do so. As time went by, fewer and fewer staff wanted to be left out of the sessions, as it became clear how well the method worked. The voluntary participation applied to everyone at the hospital, be they patients or staff. It was made clear they need talk only about things that they were comfortable raising, or could see the necessity of discussing for their own benefit. In other words people were asked to be their own judge of what was important, healthy or beneficial. Our guiding precept was 'the truth will set you free (of addiction, pain or guilt), but first it may hurt you'.

Confronting ourselves in a positive spirit of inquiry and wanting to develop a healthier defence than that of denial was seen to be a quintessentially important part of the hospital programme of recovery. Most of us have experienced the lightening and sense of freedom that comes from tackling the big issues we feel guilty about. In addition, we all know when we are avoiding these same issues, deluding ourselves that it's ok to do so.

I began to understand that institutions have memories too, and that these memories gradually change according to the prevailing ethic. We soon had an ethic that did not challenge the utility of psychodrama in the programme. Instead it saw it as absolutely central and compatible with all

parts of the therapeutic endeavour, including Alcoholics Anonymous philosophy. Developing the ability to trust in the group situation is wonderfully healing. QMH visitors often remarked on how open and trusting participants were in the psychodrama group process.

From approximately 1978 to my departure in 1991, we ran three sessions of psychodrama a week, on Mondays, Wednesdays and Fridays, from 10am until Noon. The group of twelve to fifteen people who progressed through the treatment programme together also attended psychodrama together. QMH had two wards, Rutherford Ward and Chisholm Ward, and each ward admitted new patients week about. This meant that a new group joined psychodrama each week, and a group left it. Two groups made up the psychodrama class, which therefore consisted of twenty-four to thirty patients. From 1976 the treatment course was shortened from twelve to eight weeks — occasionally when there were good reasons people stayed for longer, but we found that most were ready and eager to return to the world and put their newly learned skills into practice. Patients spent two weeks in Welcome Group, four weeks in what was known as Stage Two, and a final two weeks in Stage Three or 'Consolidation'. Psychodrama was attended as part of weeks four and five, and was followed by Family Week. This timing was deliberate, because psychodrama so often dealt with interpersonal relationships within the family, and it always sensitised attenders to the dynamics of family life. Any psychodrama group requires a leader: someone trained in the method to a sufficient degree that he or she can cope with any situation that arises. The method comes more easily to those already skilled in group therapy work, who have a mental health background, and who are confident leaders within themselves. Being a director is not for the faint hearted. There is a lot to attend to, as following descriptions of work in progress will demonstrate. When we began, there was only one director — myself. I ran groups within the hospital on a Friday, and invited other staff to be auxiliary group members. John Craighead and my wife Jan eventually felt confident enough to lead a group. Later I advertised in our local village weekly newsheets for people to become volunteers in the psychodrama group, to learn to become auxiliary group members. This proved very fruitful. A number of local residents decided they wanted to be involved in the hospital's work. Since regular attendance was not required, psychodrama was an ideal way for volunteers to be involved. Each psychodrama session stands on its own, and such was the trust of patients in the QMH system that we never experienced any difficulty with non-acceptance of the volunteers. I was always sure to introduce new faces, so that there was no mystery about who was who. Volunteers were required to maintain the confidential nature of the meetings, but it was nevertheless a way that the general nature of our work became understood in the community outside. This was very important to me because there was initially a great deal of ignorance in the local community about what the hospital was trying to do.

Volunteers contributed greatly just by coming along from time to time, and sharing later with their friends in generalities about what they learned. Professionals visiting QMH were amazed to learn about this volunteer programme, specially that it was so positive. The volunteers were expected to stay for a de-briefing session to discuss the work done with the leader over a sandwich and coffee, which was particularly important for trainees visiting the hospital — occupational therapy students, and trainee nurses. When nursing training moved from the general hospitals into the Polytechnic institutions, generations of Polytech nursing students attended my psychodrama sessions as part of their orientation into mental health. They were a young and enthusiastic group. The de-briefing session gave them a chance to ask why the leader had chosen to take a certain line and also to share their own feelings and sometimes their own conflicts, and lastly to properly de-role after participating in the drama. A fundamental rule required of all

visitors and volunteers was that you could not attend psychodrama as an observer.

Another precept was 'Never turn down a role'. Not only would refusing to participate slow the action, but it conveyed the wrong message to patients. In fact, the culture of the psychodrama group was so positive that just entering the room seemed to encourage people in a step up to their performance. I had no idea how special what we created was until I tried to run a group in someone else's hospital. Psychodrama is made for residential therapy programmes. It is far harder to work with distrustful addicts on an outpatient basis. A number of efforts were made at patients' request to run a regular group in Christchurch post discharge, but these always foundered on the trust dynamic. It is just not possible to run groups of the required intensity outside of the residential setting — and it cannot be any old residential setting: it must be one that is organised along a psychotherapy philosophy, not cognitive or behavioural principles. Again, this is rare in New Zealand, and I know of nowhere it is offered at the time of writing. Ex-patients who wanted to explore the method further were encouraged to join the local Psychodrama Training Institute. Some did so, but in general they were really looking for therapy, not training. After I retired from QMH in 1991 I began to run some weekend therapy groups on the hospital premises. This was more successful, but because I was no longer automatically involved in every aspect of the QMH programme, it took time to build up trust - again a good reason to ensure residential therapy is available as an option to addicts: what can be achieved psychotherapeutically at a community level is very limited in comparison to the full QMH experience.

It took me 14 years from my first workshop in psychodrama, to qualifying as a director. This sounds like a long time, but it did not seem that way, and the journey was a great deal of fun as well as a fascinating period of personal growth for me. I conducted psychodrama at QMH all this time, constantly learning new aspects about the method and about myself. Indeed, it was due to running the groups and enabling the method to inform my everyday work that I was held up in finishing my qualification. It seemed not so relevant as the work in hand.

What was involved in the formal qualification was reaching a certain standard in four areas. One was over 800 hours of supervised directing, which I did in residential workshops. Then reading on the subject, particularly the works of Dr Moreno, the American Journal of Psychodrama, Group Therapy and Sociometry, and other books describing aspects of psychodrama. In addition the Australian and New Zealand Psychodrama Association required the production of a written paper on the social and cultural atom of a patient, and the production of a thesis — which was written on some aspect of personal interest. Finally it was necessary to conduct a session in front of two examiners appointed by the Board of Examiners of ANZPA, write a critique of one's performance, and present this half an hour later to the examiners and the group.

This training is not for the faint hearted! But it is an incredibly supportive and intimate journey. Much of it is done in collaboration with a supervisor - another psychodramatist who critiques the work in progress, and ensures that efforts made are in the right direction. In this way trainees who are not academic are supported, and learn what is expected of an academic. Any trainee is a member of a training group, and the core members of this group stay together for several years. It is like having a new family, where many secrets and feelings are thoroughly shared and analysed while being enacted. It is not confrontational, but instead is a challenge in intimacy, love and trust.

In the psychodrama group we dealt safely with all manner of tragedies: sexual abuse - both in adult and childhood - rape, abortion and all types of grief. It was the residential setting which ensured the safety: patients went to a ward with night nurses and their (sober) friends at hand - not some lonely rental flat and the drug underworld, or to prostitute themselves.

Participants enter into the process revealing only what they wish. In this respect trainees are encouraged to 'Do unto others only what they would do unto themselves'. In other words the training process follows the Golden Rule of human behaviour. Everything we expect our future patients/group members to do we will have tried on ourselves.

An Example of a Psychodrama Session

Psychodrama sessions took place in the Garden Room. Imagine it is 10am. The director has popped in at 9.45am and switched on the Zip. He then goes to the central kitchen and picks up a tray of tea and coffee, and the all-important sandwiches for the volunteers' lunch after the session. Keeping the patients' hands off these is also in his job description! As he enters the room, he pauses to tease the group of nervous smokers outside it. He is greeted by some sheepish grins.

The session starts the director having a cup of tea with the participants. After ten minutes it is time to start. Everyone files into the group room, the door is closed, and people sit in a circle on cushions on the ground. This is a deliberate action to set up an atmosphere where the horizons are wider than in formal group therapy, during which everyone sits on chairs.

The director starts by welcoming everyone to the group, and instigating a warm-up to each other by getting to know who is present. He asks everyone to choose someone whom they do not know, and go and sit with them. He writes on the blackboard some questions to ask the chosen person, and says he will ask each person to introduce their partner in five minutes' time. On the board is written:

1. Ask your partner their name, where they are from, and what has brought them to QMH.
2. Ask your partner what they are hoping to get out of the session.
3. Ask your partner what they want to work on during the session.

After ensuring that everyone has had some time with their partners, we share this information, one at a time, in the whole group. Sometimes this is enough to produce several issues that might be interesting to work upon. If this is the case, we make contracts to work with these folk later in the session, or starting right away. I personally am wary of starting right away in a new group, because participants have not had enough time to warm up to the other group members. Starting right away is better in session two and three during any given week, rather than in session one.

So I might now invite people to select another person they want to be with, on the basis of what they have just heard. This request demonstrates that we can respond - or 'warm up' - to different choices depending on what we learn, emphasising the benefit of a curious and inquiring attitude to the world, instead of a passive one. When the new pairs have been selected, I might, for example, ask each pair to sit down together, facing each other. In this case I invite one of the pair to be a listener, and the other to be a talker. I say that the listener is to remain silent for the next five minutes, giving feedback only by non-verbal means. I provide five half sentences for the talker, and I ask them to repeat the sentence, and then go on to finish it, after which they are to let their thoughts roll on until they reach conclusion. If there is still time, they are to repeat the sentence, and carry on with whatever new thoughts occur to them.

As an example, I say: 'I like...old cars; walking in the bush, preferably a three- or four-day tramp in the mountains in clear weather; skiing on a fabulous day on powder snow; being with my children at the local swimming hole in the summer; I like what wonderful young men my sons

have become, and how proud I am of them...' I ensure the group has got the idea, and we are off.

I will usually have made up the sentences while the group was engaged in the first activity, because there is a need for directors to remain spontaneous, and to respond to the atmosphere of each specific group. Care has to be taken that a group feels it is being related to in the moment, that they are not part of a great sausage machine. Dr Moreno stressed the importance of the here and now, the encountering of the present moment, and the effects of trying to conserve anything in a time warp. If I merely produced a list of sentences I carried in my pocket to every psychodrama I directed, then this feeling of observation would be present right at the start. This is one reason why it is hard to write about psychodrama as opposed to take part in it. You cannot really experience psychodrama by reading about it. There is no substitute for taking part in it. The printed word misses so much.

Of course there are limitations to this statement since we cannot do everything, and we certainly cannot do everything well. When I am emotionally moved by a virtuoso musician or a beautiful painting it is because the experience enters me as sublime, and becomes part of me even though I could not create it. Essentially this is a spiritual experience which we can enjoy and be moved by, without giving away any of our own spontaneity or creativity. But we do have to allow ourselves to embrace the new experience and let it suffuse our beings — this is not a passive process but an active, spontaneous one. Indeed the best experiences of this sort actually enhance our creativity. As previously stated, Moreno repeatedly pointed out that thoughts are worthless until accompanied by action. What we were working with in psychodrama is to lead the group members to confront their thoughts, and translate them into actions of which they would be proud.

Many of my friends wonder how I have managed to stay hopeful and vital after a career of assisting the downtrodden. Psychodrama at QMH has made that much easier for me, because it shows how, given the right warm-up, anyone, even the most downtrodden, can act in kind, loving ways. This is something we can forget when we are caught up in the rush of modern life. It is a lesson I learned when I lived in the Gilbert and Ellice Islands. There, people had very little, but if they lived regularly, they could feed, clothe and provide shelter for happy families on four hours' work a day. I often wondered what on earth we Westerners were teaching the local people that they could possibly benefit from.

To return to the Garden Room: here are some specimen sentences that I might use.

I love...

I know...

Today, I feel...

I want you to know that...

One of my favourite things...

I remember when...

My mother...

My father...

My grandparents...

When I first went to school, I...

At secondary school I...

My first love...

I hope...

I felt very spiritual when...
The closest person to me...
I hate...
I get angry when...
I was influenced by...
My addiction is...
etc., etc.

Nearly all QMH patients had experienced a recent crisis in their lives that had brought them face to face with their problems and the need to seek treatment. The natural defence in addiction is to deny the significance of this crisis, how it is linked to the events of a person's life. Conversely, to make progress in recovery, therapists need to organise opportunities that undermine this natural tendency to denial. It is a big step to seek admission to a hospital, and to agree one's life is out of control. This is part of the 'set and setting' that influenced patients. They were, to borrow a phrase from Outward Bound (see the section beginning on page 128 on the QMH Outdoor Programme) 'impelled into experiences' willingly by the whole process. Often people would be astounded by what they heard in response to a simple activity like the 'Sentence Completions'.

As director, I would be looking around to see if folk were observing the instruction to divide the talking and the listening roles. Often I would have to have a quiet word with participants who could not comment non-verbally (e.g., smile, make a gesture, maintain eye contact), and were having a conversation instead. I wanted the listeners to learn that they did not have to ask questions or impose themselves on their talker. After five sentence completions we would swap roles, and I would ask people not to discuss their experiences until this next part of the session was over. The idea here is to produce an act hunger for sharing, but to do this in such a way that it was not just an ordinary conversation.

Once both parties had had their turn, I asked them to talk freely with each other about what the experience had been like for them. There is usually a pent-up burst of sharing as people talk to each other about their revelations. I find that when we allow our less than conscious thoughts to emerge, we are generally excited, simply because we are connecting with our inner truth. However we manage it, recognising our own truth produces a solidarity that is uplifting and clean. This is the case even when it is an unpleasant truth that emerges.

I listen carefully to the 'buzz'. When it starts to drop slightly, I ask everyone to share with the whole group something about what they have been sharing with each other. Typical remarks are: 'I wanted to ask lots of questions, but I wasn't supposed to. So I waited, and usually the questions got answered anyway', 'I learned more about my partner in a few minutes than I have in being with him in group all week', 'I felt very trusted by my partner', 'It was really exciting - I could have gone on for ages'. 'It seemed so natural just to talk, and yet I rarely do that with my partner at home', 'I thought about my parents for the first time for a long time'.

When someone says something like the latter, I'm alerted to what may be a warm-up to action. I might ask that person: 'What did you get in touch with?'

'I thought what sad lives they led, and how my life needn't be the same.'

Ah ha! I think to myself. That sounds like a warm-up to a drama. So I decide to carry on with my interview. 'Would you tell us some more about your parents and what you got in touch with, or better still would you come out here and we can have a short vignette about them?'

He comes over and sits in a chair next to me, and I ask the group to sit on cushions in a half circle, on the edge of the part of the floor we have designated the stage. 'Now, let's decide what the

purpose of our vignette is: so far we have you reviewing your life with your parents, and feeling sad, but coming to the conclusion that there is no need for you to live the same. Who do you tell this to?'

What I am doing here is exploring the system around the protagonist, and with whom he has to share this feeling.

'I'd like to tell it to my ex-wife.'

'Choose someone from the group to be your ex-wife. Do not choose just any old person to take this role, look around carefully, and choose the person in the room whom you think is the best for the role. Don't say why you have chosen the person, just choose them.'

He picks a good-looking young woman who is one of the volunteers - a farmer's wife from nearby Waiau village.

'Where are you having this conversation?'

'At our home, the one we lived in together after we got married.'

'Create the room in your home where you are having that conversation.'

Psychodrama uses whatever props are available, but mostly we use our imagination. Moreno developed the concept of psychodrama while playing with children in the public parks of Vienna, around the time of the First World War. He marvelled at the vitality and ability to act in the present that children have. He wondered where all that vitality disappeared to as we grow up and become more self conscious, cowed by the world, or beaten down by it. He developed the method because he believed that we have far more choice over our responses than we tend to think. 'It all depends on the warm-up' was his vital maxim. Another way of looking at this is to consider that there are 'no ordinary moments'; there is only the present moment, and all the opportunity it contains. If we learn to act within this moment with spontaneity instead of searching for a blueprint from former times to apply right now, we will release our creativity. Imagination has such an important effect on our warm-up at any given moment. Imagination can make us ill: imagining the worst leads to anxiety, depression or neuroticism, while imagining the best leads to confidence, trust and faith in the world. Some researchers into mind/body medicine teach that imagining our bodies fighting cancer beefs up our immune system and leads to a higher rate of cure. Certainly most doctors agree that if cancer patients 'give up' and imagine dying soon, they increase the likelihood of this fate overtaking them. So we need to make our imagination our friend or its power will overwhelm us. Much of psychodrama technique involves harnessing the imagination to enlarge and strengthen our worldview and become more conscious and creative about the choices we make.

We usually become anxious and/or depressed precisely because our Imagination propels us in that direction. We can, with suitable encouragement and warm-up, recognise the habitual warm-up that keeps us behaving in this repetitive manner. We can train ourselves to warm up differently. This seems simple and self evident, but many simple things are not easy and many addicted people have an over developed tendency to give up early, especially when things are difficult or harder than expected. Perhaps one of the great gifts we can be given by parents is to keep going at tasks that we decide are important, even if they are difficult or we do not think we are very good at them. One of the functions of psychodrama is to guide people into confronting difficult situations in a new way, using 'surplus reality', as I have already alluded to. We often find ourselves having conversations in our head, often in the form of a play script - such is the common gift of imagination that goes hand in hand with consciousness.

In the psychodrama session I am describing we are about to have a conversation that has not been had before. Psychodrama is not about enacting what has already happened. It is about

exploring situations more fully, playing with them, savouring them, reflecting on them, exploring surplus reality, and coming up with new solutions and new roles so that we are better equipped in the future. It is also good for working with unresolved grief. I think this present drama is going to explore all of these aspects, but I don't know, obviously. I am following my leads as they appear. I am following the protagonist's warm-up, in other words. This is a hard skill to learn, and takes trainees many hours of supervised directing of their fellow trainees to learn it.

These days psychodrama training is well established. When I began there was only Max and his annual workshop, and nobody to ask in the meantime, except my colleagues at QMH: John Craighead and, later on, Helen Arthur and my wife Jan. Still later there were lots more people, and I ran my own training sessions at the hospital. Luckily, at the start of my directing I had already had group therapy experience in Edinburgh, and was a confident leader, striking a balance almost instinctively between support and probing. I had also done some supervised directing with Max Clayton.

The protagonist sets up a lounge room in his house. I ask where the windows are, and what we can see through them. He describes the garden, a fence, and the view into the neighbour's kitchen. 'Do you get on well with your neighbour?' I inquire.

'Quite good,' he replies. 'They're a lovely family. Sometimes I wish I lived there instead of at my place.'

I sense the regret and sadness in this remark. Has his warm up turned into grief? 'Reverse roles with your neighbour,' I say. 'Who are you?'

'I'm Jim. I'm a mechanic, work at the local garage. I live here with Cathy and my two kids. We go to the river to swim, camp at the beach for a summer holiday, pretty humdrum really.'

'What about your neighbour across the fence.'

'John? He's a bit of problem, is John. We get woken by their screaming matches after he comes back from the boozer. I've tried befriending him, but he keeps me at arm's length. Decent enough joker when he isn't drinking. I feel sorry for his wife, Karen. She's real nice. Far too good for him, I reckon.'

'Did you know John has gone to QMH for treatment?' I ask. My idea here is to ensure we keep working with surplus reality and do not get bogged down with a litany of "Poor me's" rooted in the old role of guilty self-blamer. This is an overdeveloped role in many addicts' systems, and is unproductive of change for the better. Instead it anchors the person to their old repeating script of Guilt—Apology-Relief-Temptation-Relapse—Repetition-Guilt.

'Has he?' says John in the role of Jim. 'I hope he makes it. What I overheard isn't any way to bring up a family.'

'Reverse roles.'

My intention is also to strengthen the role of Spontaneous Actor, reminding John that he has taken a big step towards changing his responses to life by recognising his addiction and broken relationships, and that it is possible to be different.

John returns to being himself. I ask the role player to repeat what he has just heard.

'So John's gone to QMH, has he? That's good to hear. Decent enough joker. What we used to overhear wasn't the way to bring up a family.'

'Now say what you want to say to Karen here.'

'Well. Karen, you were quite right to leave when you did. I miss you so much, and little Carrie too. I've heard you've remarried, and I'm glad you've found some happiness at last. You certainly deserved to after the hard time I gave you. I've learned about addiction as a disease, and of course my dad had it too. I guess I never knew any different. Here at the hospital they're

teaching us how to stay sober. I've been off the turps for three months now. I feel so different. And I'm really sad about how we split up. I wish it could have been different.'

'Reverse roles.'

John now takes up Karen's role. The role player playing her is now in John's role. I ask her to repeat what she has just heard. She does so, in her own words, not trying to remember word for word what has been said, but instead paraphrasing the gist of it, following the instructions given in the preparatory warm-up to the action and at the same time using her own creativity to enlarge her own experience of such a role.

'I miss you so much, Karen. The more I go on with the sober life, the more I realise how different it might have been, if only I had come to my senses earlier. Still, I'm here now, and I want things to be different.'

John as himself replies: 'I'm glad you're happy. I guess I will always love you. I'm sad that you're not available to come back to me. I guess that does hurt.'

I see tears in his eyes as he says this: here is a manifestation of his warm-up to grief. I think that I am on the right lines.

'We had such dreams when we began.'

There is so much grief associated with addiction and recovery: sometimes it is so easy to see why patients relapse, when they go on paying for their addiction even when they get sober. This is why grief resolution is so important for recovery, and why shirking ownership of the bad things that have happened only produces a brittle recovery, easily disturbed, because there is no ability to use insights to form new roles. So often, we can see that the addict is still practising denial of the past as the preferred defence structure. The 12 Step Programme in Alcoholics Anonymous discovered (perhaps that should be rediscovered since these teachings are age-old!) that this coming to terms with the past was unavoidable. So it recommends writing a 'Fearless and moral inventory of our wrongs', known as the 4th Step. This is then to be shared with another trusted human being, often a minister of religion, so that the recovering person starts out with as clean a balance sheet as possible - called the 5th Step.

In addiction, guilt inspires relapse, not recovery. This is contrary to received wisdom, where we are taught that guilt should inspire us to better behaviour in the future. So it may in someone who experienced a secure childhood, where communication between parent and child was uncomplicated by disruptions and internal inconsistencies of the "Do as I say, not as I do" variety. In people who have gone on to become addicts, this was not usually the situation. In our current example John says he has a family history of the disease of addiction, so it is no surprise to me that grief resolution will be a big part of his recovery, and without it his positive self-esteem will not return. Usually children from alcoholic families — often called adult children of alcoholics, or ACOA for short - have resolved in their youth not to behave like their parent alcoholic when they grow up. Despite the sadnesses that accrue and the drink/drug-laden culture in which we live, they feel one way or another that "it will never happen to me". Such is the power of denial that it indeed can happen, and when the disease of addiction has finally wrought the crisis that penetrates denial, the patient may be devastated. Countless people have told me that they swore to themselves never to let what happened to their father happen to them - and yet it had happened. The guilt and shame that go with this can be overwhelming. Unless these feelings are resolved, round and round on the merry-go-round of denial the addict will go. For recovery it is necessary to develop a way of working through both old feelings and new ones, as they are generated. It is often a puzzle to therapists why a particular addict cannot see this pattern. I do not know the explanation for this, and wonder if it is some deeply embedded defence of the

developing mind, now enshrined in a brain pathway that is extremely difficult to change.

'We had such dreams when we began,' John continues.

I say to him, 'Is there a scene which is typical of these dreams?'

He thinks for a moment. 'Yes.'

'Then take us there. Clear the stage.' The role players take their seats; the group members are expectant and interested. (One of the tasks of the director is to ensure the audience are attentive. The more self centred and concentration impaired the audience, the harder this is to achieve, but by and large it was not a big problem, so long as the action kept coming.)

'Where are you?'

'I'm seventeen. I've just left school. I'm about to start work on my father's farm. Karen and I were at school together.'

'Was she your first love?' I ask, intuitively.

'Yes,' he replies,

'Set the scene, please.'

'There are two scenes,' he says.

'Start with the first.' (Note how this heightens tension and interest. Nobody knows what he will set out, least of all the director. We are following the warm-up.)

'It's summer, and we're down at the swimming hole on the river, towards evening.'

'Set out the river.'

He indicates where the riverbank is.

'Use these pieces of coloured material to make the riverbank,' I suggest.

'Well, it's a pool caused by the winter floods, and in the summer it's cut off from the rest of the river. There are these rocks, limestone, all smoothed out by the water.'

'Choose people to be the rocks, and set them in their proper places.'

He looks around the group, and picks both men and women to take the role of the rocks, arranging them on the floor in various postures. When he is finished, I ask what else there is around. He picks further role players to be trees and, of course, the sun, beaming down from the west, sinking towards sunset.

'Where is Karen at this moment?' A director seeks to expand a moment, in the fullest way, and not to allow ordinary narrative to narrow the exploration.

'She's swimming in the river.'

'Pick someone to be here at this time in your lives.' He picks a younger person than in the earlier scene.

'And where are you?'

'I'm swimming with her.'

'Go and join her.'

He does so. They both lie on the floor and make swimming motions. Our psychodrama studio is equipped with coloured lights to aid in setting atmosphere. I switch on the bright yellow lights, simulating strong sunlight. The group laugh spontaneously at the romantic atmosphere that has been created. It is a happy, light-filled moment we are taking part in: as if all the hopes of two lives are about to be revealed.

'Say what you have to say to her, right now.'

'I'm sorry...'

'Pause,' I say. 'Let me remind you that you are seventeen years old, with the whole world at your feet, and a girl you love and want to marry. Tell her what you are dreaming of.' I say this

because it is part of a director's function to keep the protagonist focused on their contract and purpose. In this case we have a contract to explore John's dreams for his marriage, rudely shattered by his addiction. We know they were shattered: what have been lost are his ideals and hopes for a different life. His warm-up to hopelessness is most likely overdeveloped, and my job at this moment is to warm him up to other possibilities. There is no good in a psychodrama that merely re-enacts the past, or that reinforces roles that are already overdeveloped. You could say that recovery for John depends on reconnecting with the positive side of himself, which has been suffocated by addiction. His self-esteem will improve if he can reconnect with his positive aspect, and when he can again see that his shadow side (to use a Jungian term) is but part of him, not the whole of him. This tendency to 'all or nothing', whereby if the addict is not perfect he must be all bad, is very undermining of balance. It is the basis for the 12 Step slogan, 'Progress, not Perfection'. Perfectionism is an impossible defence against the chaos of the world, doomed to failure since we cannot expect perfection either of ourselves or of the world. Sooner or later we will make a mistake, simply because this is how humans function. Then, if we expect to be perfect, we are injured. Whereas if we can own our imperfections and struggle with them, making amends where we can, and sincerely trying to learn from our errors, then our self-esteem improves.

John tries again, as he swims in the river with Karen: 'It's lovely here, isn't it?'

'Yes,' replies the role player, spontaneously.

'I wish we could always be as happy as this.'

I say: 'Tell her how happy you are, and show her while you're about it.'

'I want us always to remember this moment, when it's a perfect day, we don't have any cares, and the whole world lies at our feet. I love you, and I want you to marry me. We're going to have a very different life from the one I grew up with.'

'Reverse roles,' I say.

Karen (role played by John): 'I want to be with you more than anything else in the world.'

'Reverse roles.'

The role player repeats this for John to hear. 'What is your response to that?' I ask, as he is silent, obviously reflecting on something.

'I'm thinking that, even as I speak, the addiction is somewhere inside me, working to destroy my happiness.'

'Choose something or someone to be this embryo addiction.' He looks around and sees a big man whom he does not know, a local farmer who is one of the volunteers.

'Him.'

'Reverse roles with Addiction, and show us how you are acting right at this moment, and you, Hugh, take up John's role.' Hugh comes and speaks John's words to Karen. John (as Addiction) stands in front of him, between him and Karen, and places his hand on John's chest, over his heart.

'This is what you do, now put words to it,' I say.

'You may think you're happy,' John as Addiction says, 'but I will ruin it for you.'

'Will you now?' I say. 'Tell him how you are going to do that.'

What I am doing here is interviewing for the new role, to warm up John to the particular nature of his addiction, and how it is operating at this point in his life. This expands his notions of addiction, and erodes denial further, because he has to enter this role fully. It is also one that the audience knows well, and is the focus of their QMH stay. All visitors, whether addicts or family members, have to learn the nature of the beast that is addiction, and take steps to live with it.

Maximising and concretising the addictive process assists awareness of each person's unique manifestation of the syndrome. Awareness is the first part in the process of altering one's life to take account of this process within ourselves - in fact, of any developing trend in our lives. Awareness has to be followed by action, and the action has to be based in reality. Incremental steps or goals are the important ones, so that they are achievable. Just making a resolve is usually not enough. At this point the psychodrama is about deepening acceptance of what has happened, exploring its inevitability, grieving it, and resolving not to let the process continue wrecking new relationships that John may enter into. For what is it that makes life worth living? The answer is the relationships we form, and the way they sustain us. Moreno called the circle of relationship around us the social atom. It is defined as the smallest number of significant relationships that maintain our psychological equilibrium. We include our spiritual relationships in here too.

In the drama, Addiction looks at John, and pushes in with the heart pressure. He pushes Hugh-as-John over.

'Is that what you want to do? To push him over?' I ask.

'No. I want him to carry on but to feel me here, ready to get him when he's not looking.'

'Put your other hand behind his back, so you can exert pressure without knocking him over.'

John-as-Addiction does so, then says, 'I don't want you to fall over just yet, that comes later. I want you to know I'm here, waiting to get you. You don't deserve to be happy.'

'Reverse roles.' The role players take up their new positions, so John as himself can listen to Addiction speaking. It is always an extra impact to hear one's own words spoken by someone else. Sometimes we cringe when this happens, and sometimes we are amazed by our wisdom. Typically we hear our young children uttering our words, often the ones we are quite unconscious of— and very humbling this can be at times!

John listens to Addiction speaking, looking past him to Karen, still standing in the river in the summertime. We are verily in surplus reality now! I observe him stiffen as Hugh speaks the words of Addiction. 'Whose voice is that?' I enquire.

'It's my father's.'

'What scene does this bring up?'

'I'm about five years old, and I'm in bed, listening to my father rowing with Mum.'

'Clear the stage,' I say. The role players do so. 'Now, John, re-create your bedroom here, when you are five years old.'

He puts some large cushions, part of the psychodrama room equipment, in a corner to be his bed. He puts another lot of cushions to be his older brother's bed, opposite his. He describes the room: cramped, not many possessions or clothes because they are poor, no pictures on the wall. The family has not been here very long, in fact the house is one of many that John has already known in his short life. They are constantly moving. 'Choose someone to be your dad and mum, and place them where they are in the scene.'

He looks round the group. He chooses Hugh to be his dad, and a female patient to be his mum, and another patient to be his brother.

'Who is speaking at this moment?' I ask. This sort of question keeps us in the surplus reality space, warming him up to the next phase of action.

'Dad.'

'Reverse roles with Dad.'

Dad then shouts at Mum. 'You useless old cow! Always on my back, always asking for more money. What do you think I'm made of? What do you think I do all day - lie around, like you? God, if I had a half decent wife I wouldn't be like this. You're responsible for this, d'y'hear? If it

wasn't for you I'd have taken that job in Fiji and we'd be rich by now. Stupid old cow. It's a good belting you need.'

'Reverse roles with your brother.' They do so. 'Tell me about yourself,' I say.

'There's nothing to say, really. I'm a straight sort of joker. Don't think about my childhood at all.'

'What are you thinking of as you lie here?'

'I don't think anything. I just sleep.'

'Have you anything to say to your brother here?'

'Yes. He thinks too much—'

'Don't tell me, tell him. Address him here.' I say this because psychodrama is interactive and immediate. Patients take time to understand this. They tend to lapse into reporting to the director, and this is less effective than being embedded in the drama, in the here and now - in life, in fact. The whole point of having a drama is to maximise the Spontaneous Actor within, and move on from the expectations of our past training. It is to actualise the vast range of choices that we can make, instead of running along tramlines. As I have already mentioned, we were spontaneous actors as small children, and this gets beaten out of us as we encounter a hostile world. But it does not have to be permanent: nothing in life is permanent, not least the choices we make. I recall being very moved, for instance, by an account of a blind man at Auschwitz concentration camp. He retained his sense of humour, and was inspirational for many with whom he came into contact. The notion of human potential, of which we at QMH were ardent supporters, also subscribes to this optimistic view of human nature.

'Go to sleep, John, there's no point in listening to all that. It's just them. They carry on like this. Dad's a boozier. Mum never learns not to upset him. There's no need for us to be involved.'

'Reverse roles.'

John, now as himself, replies: 'But Tom, in a minute he'll hit her; she'll scream. I'll get up and try to stop him.'

'Reverse roles.'

'What's the point. You'll only get thumped yourself.'

'Reverse roles.'

John returns to being himself. 'What is emerging within you at this moment?' I ask.

'I want to thump him.'

'Is this a new response, or the same old one?'

'He and I are always having fights.'

'So it is the same old one. Do you have any new feelings or understandings, different ones to your usual?'

'Yes. I see him' - indicating Dad — 'as an alchy just like me. That job in Fiji he was talking about. He used to bring that up as the cause of all our family troubles. But it was really the booze that was his trouble, just like me.'

'Can you tell him about this now?'

'He won't listen. He never listens.'

'To get someone to listen, we first have to get their attention. How can you get his attention?'

'I could call out.'

'Good idea. You call out, only this time remember you are an adult child calling out. How old are you in this scene?'

'About eleven.'

'Ok. You are eleven going on - how old are you today?'

'Thirty-seven.'

'Eleven going on thirty-seven. Let's try that. We are not re-enacting the past: we are exploring how you can bring a new role and a new experience to an old situation in your head.'

'Dad!' says John. 'Don't treat Mum like that. You know you're an alchy. Do something about it.'

'Reverse roles with Dad.'

'You shut up, boy, or I'll give you something to teach you not to speak to me like that!'

'Reverse roles with Tom.'

John-as-Tom says, 'I told you not to upset him. It'll be worse than ever now. Shut up, John. Let's get some sleep.'

'Reverse roles.'

John is now himself again. I say to him, 'What are you going to do? What did you do?'

'I shut up.'

'So where is all that rage now?'

'Rage?'

'Yes. You've been rendered silent all these years. Doesn't that make you angry?'

'Yes. It does. I wanted to give him a dose of his own medicine. But if I started, I think I'd kill him.'

'Well, we don't want any actual killings here this morning — it would give the hospital a bad name. But we are going to have to express this rage safely. And you can kill an old role in him and in yourself. Look at him. What comes up in you?'

'I still want to thrash him.'

'You want to thrash him, and yet I have to protect the role players. I tell you what, how about we select some of the men here to hold you while you express your rage. They will allow you to struggle against them, but not to hurt anyone or yourself.'

'Sounds all right. Provided they don't let go. I might hurt someone if they do.'

'Choose some of the strong people here to help you express your rage.'

He selects six men.

'Now, lie here on this mattress, and you guys, one to each arm and two to each leg. Hold on until I tell you to stop. Do not let go. I'm relying on you.' The role players agree and take up their positions. The rest of the audience look apprehensive.

'Come over here, Dad and Mum, and stand in front of John. Re-enact what you say.'

The role players do so. Dad begins: 'You stupid old c—'

This is as far as he gets, as John suddenly erupts with a huge wrench and a shout. He struggles and the restrainers struggle with him.

'You big bastard, you c*nt! You f***ing arsehole! You made our lives a misery, made Mum's life a misery, don't you have any realisation what you do to others? Christ, you're supposed to love us. Is this the way you show your love? Why, I'm coming to get you—' he makes a super-human effort to throw off his restrainers— 'Arrgh, arragh, waw urr, you...'

'Reverse roles with Dad!'

The point of reversing at this moment is to allow John as Dad to appreciate John's rage, to see with his own eyes what has been lurking since childhood, and no doubt affecting his relationships with Karen and others. A lesser point is to demonstrate that warm-up to a role can be chosen as an act of will. I often think of psychodramas at this point as a type of "trance" intervention. The protagonist has so entered the scene in his imagination, that he is oblivious to the surrounding

world. This is no different to the experience of the average theatre goer. When we go to see a play, it succeeds to the extent that we enter into the world portrayed before us. We could resist entering, and see only the tinsel and completely miss the romance, for instance. If we do this, we have a lousy experience and probably blame the director! But the failure was not the director's, but a failure of imagination on the part of the audience member.

John is now in Dad's role. I instruct another role player to re-enact the rage and struggle he was portraying, to exactly the same level that we experienced when John was in the role. This is very important. I want John to see his rage exactly as he enacted it. No more and no less. The role players do this as John-as-Dad looks on.

'Well, Dad,' I say, 'this is what John has been feeling all these years. What is your reaction?'

Dad begins to weep, silently.

'I wanted things to be so different,' he says.

So here is a symmetrical role system. Both Dad and John are enacting the same roles: on the surface there are a cluster of roles around the central organising role of Selfish Addict; beneath it, less developed, are a cluster of roles around the central organising role of Loving Husband. It is a classic conflict between Shadow and Light, Yin and Yang, Selfishness and Nurture. This type of conflict is often present in the addictive family system. This is why spiritual development is so important in recovery: spiritual development emphasises that love is ultimately more powerful than hate, anger, selfishness, self-centredness etc. In fact it emphasises that a positive emotion can displace a negative one, if we give it the correct warm-up. The recovering person has a responsibility to see that the correct warm-up is in place. And it's essential that they seek the company of people striving to be equally positive. Very few patients at QMH relapsed after becoming embedded in the therapeutic programme. Most of the approximately 10 per cent drop-out rate for treatment occurred during the early days - as if those people, even if they saw the positive possibilities for themselves, took fright at the work involved! My follow-up studies demonstrated that some of the early leavers did, in fact, remain in recovery - a finding that surprised me. It is to be hoped that the same effect is being felt by John in this drama: a sort of psychodramatic shock therapy (to borrow a term used by Moreno in the 1940s), which reveals the power of an underlying role system. He will do well if we can bring about a permanent role system reversal, so that the awareness of others and seeing them in a positive light displaces the self-centred needs of active addiction.

At this point in the drama, it seems that John has two separate fathers: a Harsh Self-centred Pirate on the one hand and, less well developed, almost an embryo, a Sensitive Lover. My next task is to concretise this system.

'So, Dad, there are really two of you: a small loving person, and a giant ogre who terrorises John over there. Which role are you in at the moment?'

'I'm sad at what has happened through the years.'

'Choose someone to be that person.' He chooses a young woman patient. I ask her to stand behind John-as-his-father. 'Now reverse roles and be yourself.'

The role player who was John goes back to being Dad, for which role he was originally chosen. I ask John to warm up to being himself again. 'Look at your two fathers. Are they standing in the right place?'

'No,' he says. 'The soft Dad should be much further away.'

'In the corner of the room?'' I ask. 'Soft Dad, go and stand in the corner, please.' He/she does so. 'Like that?'

'No. He should be almost hidden. It's like I don't really believe he's there at all, I can only see

a small bit of him.'

I ask two group members to hold up a piece of curtain material, behind which most of Soft Dad is hidden. 'Like that, perhaps? Have we got the right colour of material? There are different pieces to choose from.'

John considers the contents of the materials basket. 'Use this one,' he says, choosing a black piece of curtaining. We set all this up on the stage area. John goes back to his position in his bed, in his childhood bedroom, with his brother nearby, and the restrainer folk in readiness next to him.

'Look at your dads,' I say. 'Which one are you attending to?' And I instruct the restrainers: 'Be ready to grab him if he explodes. I am relying on you.'

There is silence and tension builds up in the room. I note John's shoulders stiffen. I ask the two fathers to speak their roles again. The negative father begins but he has only said the first word, when John utters a cry.

'Grab him!' I shout to the role players who are the restrainers. They do so as he launches into a tirade of anger, hate and grief, shouting and weeping at the same time, fighting with all his might against the restraining folk. A number of women in the audience are weeping and being comforted by fellow group members. I am close to tears myself, moved by witnessing this recreation of the pain of childhood, which has been submerged by an anaesthetic of mind-numbing drugs for so many years. When he has exhausted himself, I say: 'Talk to your other dad now.'

John looks over to the woman who is playing Soft Dad. 'I don't believe you ever existed,' he says. 'Reverse roles.'

John-as-Soft-Dad: 'Oh! I exist all right. I never had the chance to be myself. No coming to Queen Mary for me. So I got squashed. But I'm here now. I love you. I wish things could be different.'

'Well they can be different in psychodrama,' I say. 'Reverse roles, go over there and do what you wished you could do.'

Now we are in a very important part of surplus reality. I am coaching John in a new role to become a Loving Father to himself. He will have the experience of being loved by his father, which he instinctively finds within himself, but has had difficulty in expressing to his own children. By re-enacting this role we get a double whammy winner: he fills in the act hunger of wanting to be loved, and he practices the role of giving love, which will be important in future relationships with his own children. It is my hope that such an expression will interrupt the cycle of perpetual grief maintaining the transmission of addiction from one generation to the next. It is an extraordinary fact that, unless we make a great effort to avoid it, we re-create in our adult lives the relationships we lived amongst as children. We seem to be built to re-create our familiar pattern of intimate relationships unless we work hard (and insightfully) in some other direction.

Back to the psychodrama: John takes up the role of Soft Dad. The female who played this role before now takes up the role of John as a kid.

'I wanted it to be so different: I wanted you to be secure and to feel loved,' he tells little John.

I say, 'Show him this love, don't just tell him. We learn from actions, which speak far louder than words. Look at him. What comes up in you?'

'I want to hug him, and keep him safe.'

'Hug him, then.'

John goes over to Little John, and stands in front of him. After a moment he opens his arms, and hugs the role player, weeping wordlessly. This lasts for a few minutes, during which time I

look around the group and find many are also in tears. After John-as-Father has expressed himself fully, I ask him to role reverse, and to experience what he has just portrayed.

In the role as himself as a kid, he hears his Soft Dad tell him he is loved. He feels his father's arms around him. As he enters the role more thoroughly I ask him if there is anything he would like to do with this loving Dad.

'I'd like to go fishing,' he says.

'Set up the scene where you are fishing,' I say.

We go to the banks of a trout stream, where Dad is showing John how to fish with the dry fly.

This is enacted with much tenderness and understanding. There is hilarity too, when John's first attempt at casting hooks his Dad! I decide to capitalise on the fun, because this is a natural human antidote to the pain we had earlier, and we are still in the space of surplus reality.

'Do you catch any fish?' I ask.

'Yes, Dad does, and I help him get it into the net.'

'Choose someone to be the fish, and get a net handy,' I say.

A role player is deputed to be the fish, and a jandal serves as a net.

'Reverse roles with Dad, and let's see you catch the fish!' I say.

We see Dad stalking along the riverbank, with Little John in tow.

'See that eddy there, John? That's the sort of place a fish lurks. Look, I can see him down there. Can you see him?'

'Yes, I can,' says John looking at the role player in the water.

'Reverse roles with the fish,' I say.

He does so. 'What's passing through your mind, fish?' I ask, interviewing the fish for the new role.

'I'm very content. I've just had a good feed of water beetle, and there's more to come. Look, there's an interesting-looking fly. But wait, sometimes those human beings put flies in the water and they have a string on the end, and fish like me get caught. I wouldn't like that to happen.' 'Can you see any humans around?' 'No. So it must be safe to eat then. I'll eat it now.'

In the role of fish he lunges forward to take the imaginary fly. 'Reverse roles with Dad!' I say.

Dad tells John: 'Look, he's taken the fly. We've got to play him now, or he'll break the line. Gently does it. Let him swim away, then reel him in again, gently, so that you exhaust him.' The role player of the fish enacts this to the general amusement of the audience. There is a lifting of the sombre mood of the drama so far. 'Get the net, John, we've nearly got him.'

'Reverse roles and be Little John, and do what you do with the net,' I say.

Little John wades into the shallows, the 'fish' gives a flip and makes as if to swim off. Dad yells 'Get him, John!' and John uses the net/jandal to lever the fish onto dry land.

'Reverse roles with Dad,' I say.

'Well done, lad,' says Dad. 'Now isn't he beautiful. He's too beautiful to kill. I think we should let him go, don't you?'

'Reverse roles!'

Little John replies: 'Can't we keep him to eat? He'd taste good, Dad!'

'Reverse roles with the fish!'

Fish: 'Ye Gods. That hurt. Now they want to eat me. Help!'

'Reverse Roles with John.'

John, after the fish has said its piece: 'You are beautiful. Maybe all beautiful things should be let

free to find their own destiny.'

I note that his hand has strayed towards the fish: 'What is this?' I ask, indicating his hand. 'Make more of this.'

John looks at the fish, and begins to stroke it. I encourage him to maximise this, and to put words to it, if there are words. The fish is now in the role of a powerless prisoner: there is the possibility of a metaphorical release, connecting in some deeper way with John's own release from the tyranny of the past - these are the impossible to predict moments that emerge with a well directed drama that allows the protagonist's creativity to flow.

'You are so sleek and shiny, but you don't look happy out of the water. Would you like to go?'

Now John has entered fully into the enactment - remember how Moreno noted the creativity of little children as they played in the woods of his native Vienna, and had the intuition that there was no need for us to cut ourselves off from this just because we grow older. We could harness the optimism of children and relearn how to be fully in the moment, unfettered by harsh self-judgement.

'Reverse roles with the fish!' I say.

Fish, replying to the question repeated by the role player of whether he would like to be released: 'Of course I would. This is my life, to cruise around here in the deep river. It's wonderful. Want to come?'

'Reverse roles.'

John: 'Will you show me the river?'

'Reverse!'

Fish: 'Yes!'

'Reverse!'

John: 'Here, I'll let you off and we'll go for a swim.' He unhooks the fish, and slides him out of the jandal/net, back into the water.

'Pause,' I say. 'Does Dad come on the swim too?'

John: 'Yes, he does. We all go.'

I say: 'Off you all go then, do what you do.'

The fish flips around a bit, getting into deep water. The role player is enjoying her role as the fish. The director's job is to encourage creativity in the role players, but ensure they do not get carried away and do John's work of discovering his own playfulness. Some role players need coaching that we are not after magical change, but change occurs when the protagonist enacts the emerging roles from within themselves. Our own work is far more meaningful than neat solutions supplied from outside. Trainee directors have to be coached not to supply solutions, however elegant, because solutions are not the point. The point is to enact a Catharsis of Integration of the emerging roles, as the next stage on from the Catharsis of Abreaction, which we saw earlier when John was expressing his rage in a safe way for the first time.

The role players Fish and Soft Dad take John's hand and slide into the water.

'Reverse roles with the fish!' I say. 'Carry on, Fish.'

John is now the fish, and it is important he indicates how we are to proceed, and not have another person's notion of what should happen now.

'Come with me,' says the fish. 'We'll go exploring. See this overhang here? This is where I hide when I see a fisherman. I can see the beetles floating in the water, and get my feed easily. When I want to swim for fun, I push out into the current, get carried down the river, and then swim

back up it again. Let's go!

All this is enacted with maximisation and a lot of fun. The group enjoys this lightness, in contrast to the anxiety and tension of the earlier scenes. Meanwhile we have the Harsh Dad looking on.

As I feel the innocent merriment of the fish-swimming scene beginning to pass its peak, I know it is time to move to the next part of the drama, taking this new energy and developing role to the next scene. I recall the original purpose of the drama is to assist expression of grief and loosen the ties with the hurt of the past, and to maximise the expression of love where it needs to be found.

'Reverse roles with Harsh Dad,' I say. 'The rest of you, please enact your roles in that last scene. What is happening with you, Dad?' I ask.

'He's happy over there. Why can't I be happy?'

'Where are you, Dad?' I ask.

'I'm imprisoned here, surrounded by my addiction.'

'Choose someone to be your addiction.' He does so. 'Reverse roles and show us what you do to Dad, Addiction.'

John takes up the role of Addiction, and wraps himself tightly around Dad. 'Put some words to that, Addiction,' I say.

'You will never escape me, and you'll never be happy.'

'Reverse!'

John takes his father's role, and hears addiction's words. Before I can say anything else, he replies: 'You bastard, don't call me an addict, I know what I'm doing,' and he gives a heave: a fight is developing.

'Reverse roles with yourself over there,' I tell John. There is no point in developing this stuck system any further. Dad is not here. It is John we are working with, and his addiction, his grief, his history and his future.

I say to the reorganised role players: 'Dad and Addiction - enact that last part.' They do so. 'Now, what, John?'

He looks sad, tears begin to form in the eyes of this 37-year-old macho gentleman. The 'fish' moves to comfort him - but I hold her back. These are healing tears, and must be expressed before we can go anywhere else. He sobs, grieving the dad he never knew, held by addiction and a lack of awareness of other possibilities. 'He denies it to the end.'

The end?'

'Yes. He died after his car hit a power pole one night.'

'Where is he now?' I ask.

This is a deliberately vague question. It is worded so that we can enter the spiritual domain. Psychodrama may be used to explore ideas about what happens when we die, and thereby our spirituality, not because that provides a definitive solution for the person, but because it is good to think and explore and become more aware. Later the audience will share some of its responses. Still later, at QMH, patients will talk amongst themselves without staff being present, and share their own feelings, fears and new resolutions.

'What do you mean — where is he?'

'Where is his body, and where is his soul?' I say.

'His body is in the cemetery.'

'Let's go there now.' The stage is cleared, and we go to a village cemetery in a country district in rural New Zealand. 'Set up the new scene.'

John arranges chairs for the headstones, and I ask him to choose role players for the people in the graves next to his father. Again we are in the territory of surplus reality, going into the imagination and extending it, exploring how it relates to the here and now inside our heads.

'Here is Dad's grave,' says John.

'Tell him what you are experiencing now,' I say.

John stands in front of the grave, and looks down at the role player. His eyes fill with tears, not the so recently expressed rage. No words emerge. He is making his statement with tears.

'Reverse roles,' I say, once he has expressed himself fully. The audience are totally involved. Some are weeping again, quietly.

John takes up his father's role in the grave. I coach the role player to produce distress in John's role. Dad contemplates his son. 'Well, Dad,' I say, 'here is your son, John. He is silent and sad in front of you. Have you anything to say? Where is your addiction now?'

I ask the latter question because that is where we last saw Dad — with his addiction wrapped around him. It is part of Dad's 'system' — we cannot imagine Dad without his addiction. Yet there is often the concept of the dead at rest from their earthly struggles. If Dad is now 'at rest', then this may assist John to let him go, and with it the grief and terrible "conflict bonding" that is so negative a force in human life.

'I don't have addiction here. I am at peace at last,' says Dad. 'It's gone.' 'Where is your soul?' I ask.

'My soul is in Heaven,' he replies, without hesitation.

'Reverse roles with your soul,' I say. I instruct the role player at present in John's role to return to the grave as Dead Dad; John to pick another role player to be himself standing in front of the grave, and finally to take up the role of the Soul. He does so. 'Show us what you do,' I say to Soul.

Soul wanders round the room, looking at people, and finally comes to stand behind John, looking over his shoulder at Dead Dad in the grave. Tut words to that now,' I say.

But no words come. Instead there is an action. Soul puts out its hands and lays them on John's shoulders. The words come. 'I'm sorry,' says Soul, 'life was not good. Where I am now is good. Feel my love for you now, and I am sorry I couldn't tell you or act properly while I was on Earth. I am with you now, in the proper way.'

Notice how, in this relatively long speech, all these notions come from the ether into the psychodrama room. It is so easy in our civilisation to pour scorn on these simple ideas. But they have emerged today from a macho man who probably was unaware he had these thoughts within him. He was someone who started the day filled with rage, which he expressed violently. And now he is filled with love, and is expressing forgiveness and peace. There is something solid and enduring about peace and love, whereas anger and grief are fraught, bursting qualities. Peace descends over the psychodrama room.

'Reverse roles,' I say, 'and be yourself.'

He does so, and hears his father's soul speaking these healing words. He feels the hands of love on his shoulders. The Catharsis of Integration is complete. The morning's psychodrama action session is over. It is time for the sharing session, which is the last component of any psychodramatic work.

There are a number of reasons for the sharing session. Every 'classical' psychodrama such as the one described above has a protagonist, who is usually chosen because he or she acts as the carrier of the group issues. So in a sense the protagonist is enacting everyone's drama. However, it is quite lonely being a protagonist, with, in our case, the focus of twenty or thirty people on

you. The sharing session allows the group to come together after a long period focusing on one person - the protagonist. The director is taught to ensure group members - the audience - share, but do not ask for more information, do not ask questions or give advice. This is in itself useful for patients to learn: that there are different ways of communicating, and the allowable ones in this environment are those that share something of the speaker with the protagonist, so that the latter knows how his work has connected with the rest of his group. I usually start with a guideline speech, something like: 'Now we have the sharing session, after which we will end the morning. Please be aware that you have had all the information you need this morning. There is no need to ask any further questions. If you want to share some of the feelings you have had during the session so far, this is the time to do it. Please do not give advice or make judgements: what we are doing here is sharing our feelings with John, supporting him really, because he has put himself out on a limb to share his innermost feelings with us. This is our opportunity to balance up the account, so that he is not the only person sharing deep feelings. I would like to hear something from every member of the group, and particularly from those who had a role to play, so that we can be sure you are de-roled before you go to lunch. Who would like to share first?'

'I will,' says a tough-looking young man, who did not have a role in the drama. 'John, mate, you did my drama for me! That's my dad you had up there. He shot himself three months back. I went to the funeral, but I couldn't feel sorry for him. Now I can see he needed help just like me. It's a pity he couldn't have come here years ago, and seen what we can see. Thanks, mate. That was great.'

There is a short silence while the group ponders this. Another voice pipes up - it is the woman who was the fish.

'I was the fish in the river,' she says. 'It was an amazing experience. First I was captured. That felt dreadful. Just like addiction captured me. Then I was set free. It felt so wonderful. I wasn't going to swallow any more hooks again. I felt I had learned my lesson. Then we had that play. I haven't played like that since I was a kid. It felt so free, no troubles, no cares. It felt so clean, not like when you have fun taking drugs, knowing they will have to be paid for. Thanks for all that.'

'Are you de-roled now, back to being yourself?' I ask.

'Yes,' she replies.

'My father died a few years ago,' says the man who role-played John's father in the drama. 'The bit in your work that made me think was when you were standing in front of his grave, and you were asked by Robert where your father's soul was. I've often wondered what I'd reply if I was asked that. It was very moving just then. When your dad was looking down from Heaven, somehow everything was all right. It felt very peaceful, like something was complete. I think I'd like to have that experience with my dad, to feel that I was loved by him instead of always being a nuisance. He never told me he loved me, and I never felt he did. But I realised today that it doesn't matter how much bad has gone before, if the person says they're sorry and means it. If he fronted up here now, and told me he was sorry, I could forgive him, and we could start all over again. Thanks for helping me realise that.'

Buddhist tradition recognises that 'all evil lies in wanting things'. We create pain for ourselves, as adults, if we rely on other adults to meet our own expectations. Of course we know that the world would be a better place if everyone were kind, loving and gentle all the time. But it will never be this way. Perfection does not exist. So we must have a way of living that takes this into account. For Buddhists it is a concentration on the Right Ways of living including not expecting people to behave in the way we might like. Instead, Buddhists look inwards and reduce their

expectations of the outward world to fulfil their desires. In this way they are protected. I am not Buddhist myself, but I can see how this reduced outward expectation and increased inward orientation can bring about acceptance. If we add the other 'noble truth' of compassion for all sentient beings, then the necessary warmth towards others is expressed.

In Christian tradition we are asked to be more proactive: actually to pray for our enemies, and to confront ourselves with the need to show love first, and to forgive those who hurt us. I teach that the opposite of love is not hate - for if you hate a person you are locked in an intimate battle with them. The opposite of love is indifference. In that state we do not mind one way or the other what happens to another person.

Both traditions encourage compassion and suggest avoiding judgement of others. Christianity asks that we leave judgements to God, and we practise forgiveness as a form of love. Of course this does not mean we have to become martyrs, forever putting up with nonsense and bad behaviour in others. We may take a stand, based on Tough Love, for instance, where we stand up for what we believe is good behaviour, and ensure the consequences of bad behaviour are felt by the perpetrator of it. 'How can anyone do this without making a judgement?' you may well ask. The answer is that we do make a judgement, but it is not focused on the badness of another person, it is focused on the good or bad nature of the behaviour. To get this sort of judgement right it is often necessary to discuss the whole thing with another trusted person whose opinions we respect. We are directing our attention at the behaviour rather than the other person and this is the crux of this approach.

Another way of articulating this approach is: 'I love you, but I do not love this behaviour.' In the psychodrama I, as director, separated the father into two roles, one loving and one self-centred, and this enabled the protagonist to separate behaviour from person. There is a great wish in humans to believe in people's inherent goodness. Separating the roles allows the goodness to be seen and worked with. Some protagonists cannot see any good at all in their parent: in this case I am left suggesting that the parent gave life to the protagonist, and this was a gift, and if it is the only gift, then we can still be thankful for it. I am of the belief that we enter this world from another place with a certain spark of our own. While we are trained by our experiences, particularly early in life, this is, thankfully, not the only thing that shapes our lives. We have this spark from elsewhere that seems to give us a measure of independence from our upbringing. As mentioned previously, some studies of childhood development also suggest that if children form relationships outside the family circle, e.g. with a neighbour, teacher, or the like, then this can provide a different sort of modelling that protects the child from the worst effects of being raised in an abusive environment.

In this psychodrama we had a spiritual moment, which the last speaker highlighted. His words 'When your dad was looking down from Heaven, somehow everything was all right,' are one of the hallmarks of a Mystical Experience. The spontaneous appearance of these mystical moments is very satisfying to me as director, and also to many in the audience. We can set up conditions where mystical moments are likely to occur, but of course they cannot be produced to order. It is the spontaneous quality that makes them special. There will be members of the audience who are unable to appreciate them. There will be members of the audience who overplay them. However, as William James repeatedly says in his classic book *Varieties of Religious Experience* these moments have a peculiar power. They are the stuff of spiritual conviction, and are an example of how emotions are a far stronger motivator of human behaviour than rational thought or logic.

It is nearly lunchtime so I ask to hear from all the people who have not yet spoken who had a

role in John's drama. I want to be sure everyone leaves de-rolled.'

'I was your dad,' says the man who role-played the father.

'You were the abusing dad,' I remind him. 'Very important you leave here as yourself and not carrying that role!'

'I hated playing that role. It was only because I've seen other psychodramas and I know how good they are in the long run. But I've never had to play a role like that before. It was terrible. To think I could treat you like that. But I know I have behaved pretty badly towards my partner and kids when I've been drinking, and I want to make up for my past. So playing that role helped me to see how recovery can change things around me.'

I address the protagonist, who is sitting in a chair next to me. 'Is he back to being himself again? He no longer is in the role of your dad?'

'Yes, he's back to being himself.'

'How about you give him a hug, then, to thank him for playing that role, which was not an easy one.'

'Sure.'

So these two men give each other a hug, and this manifestation of comradeship settles over the group. Other role players share their experiences, and I note that there are still some people who have said nothing for the entire morning.

'To finish off today, please talk to the person next to you for one minute about something that profoundly affected you in John's drama. Then think of one word or phrase that conveys something about this, and I will ask the group members to each say their word, after which we will finish.'

The group is a-buzz for a few minutes, until I ask everyone to contribute their word. 'Peaceful,' someone says. 'Powerful,' says another. 'Sad.' 'Anger.' 'Fear.' 'Love.' 'Spirituality.' 'Generation to generation.' 'Breaking the cycle.' 'Forgiveness.' 'Grief.' 'Joy.' 'Hatred and confession.' 'Togetherness.' 'We are all the same.' 'Loving social atom.' 'Envy.' 'Loneliness.' 'Denial.' 'Closeness.' 'Trust.' 'Addiction is terrible.' 'Beauty.' 'Nature-' 'Why do you say that?' I ask.

'Because in the scene with the fish swimming I was reminded of how clean and simple the pleasures that are natural are.'

'Good stuff,' I say. 'Anyone else? Who hasn't said anything yet?' We finish there for the day, with a last reminder that participants can talk to anyone they like about their own feelings and story, but that they must not discuss with people outside the group what they heard today. That requires being sensitive to who might be listening to a conversation, not talking loudly in the commonroom, etc. I emphasise the value of talking amongst each other about their experiences, and raising the session in their afternoon group. We must maintain our confidentiality and trust.

The group breaks into spontaneous applause, and John finishes by saying. 'Thank you, everybody. That was awesome. Gives me lots to work on. I feel terrific right now!'

It is 12.15pm as the patients file out of the room. With the remaining volunteers, students and staff we settle down to a coffee and a sandwich, and to process the morning's work. This is the way psychodrama's finish for the staff. They get a chance to raise questions, and to reflect on the session. This is a warm down from the emotional intensity of the morning. The patients have an afternoon group to do this in formally (if they wish) and, of course, they have all gone off to lunch in the ward together, talking animatedly about their experiences.

