Centar za Psihodramu, Diplomski rad:

TREATMENT OF PSYCHOSOMATIC PATIENTS BY PSYCHODRAMA PSYCHOTHERAPY

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SAŽETAK

Moj osjećaj radoznalosti za psihodramu dolazi istovremeno sa osjećajem radoznalosti za fenomen psihosomatike. Općenito težak pristup do skrivenih i na prvi pogled beznačajnih simptoma, za psihosomatiku specifične osobne crte pojedinca, specifične disfunkcionalne uloge u kontekstu obitelji i drugih konteksta i teorija i prakse psihodrame kao i teorije drugih psihoterapijskih pravca, su otvorili cijeli novi svijet za mene. Osjećao sam, kao da sam u ruke dobio dugi roman kojeg nikad više ne bi želio pustiti. Zna se, da psihoterapija koja za cilj ima dublju promjenu na razini strukture ličnosti, je proces koji ne traje „seansu ili dvije“. Kad je u pitanju psihosomatika postepenost, dosljednost i umjerenost je realitet. Ako je psihoterapijski proces dugotrajan i često težak, bolje je, da je ponekad i zabavan. Nadam se, da će vam ovaj rad koji je pred vama pružiti nešto od oboje: dozu oduševljenja i ozbiljnosti ali također i veselje. Moje mišljenje je, da kako pacijent, tako i terapeut ne bih mogli izdržati dovoljno dugo koliko bi trebalo za duboku promjenu, ako oboje nisu prisutni u terapeutskom procesu.

U ovom radu pokušat ćemo opisati područje psihoterapije i psihosomatike sa fokusom na: različite definicije psihosomatike, izvorom i liječenjem. U smislu teorije i prakse pogledat ćemo kroz oči psihoanalize, sistemske/strukturalne obiteljske psihoterapije i posebno psihodrame.

U prvom poglavlju vidjet ćemo kakav je bio povijesni razvoj ideje o psihosomatici, pokušat ćemo postaviti koherentnu definiciju psihosomatike i opisat glavne karakteristike pacijenta sa psihosomatskima bolestima.

U drugom poglavlju istražit ćemo etiologiju psihosomatike kroz tri poglavlja: individualni teorijski pristup, međusobni teorijski princip i karakterni obrambeni mehanizmi.

Treće poglavlje bavi se liječenjem psihosomatike uz pomoć psihoterapije sa posebnim fokusom na psihodramu. Poglavlje je podijeljeno na tri glavna pod-poglavlja: psihodramsku spiralu, opće posebnosti kad je u pitanju rad sa pacijentima sa psihosomatikom i koraci u psihodramskoj psihoterapiji. Liječenje uz pomoč drugih dvije psihoterapijskih pravca, psihoanalize i sistemske/strukturalne psihoterapije, je već nekoliko obilježeno u drugom poglavlju uz glavne razloge psihosomatskih oboljenja.

Četvrto je poglavlje sažetak glavnih važnih specifika psihodramske psihoterapije kad je u pitanju rad sa psihosomatskim pacijentima a koji nisu bili posebno opisani u prethodnim poglavljima.

Peto je poglavlje rezervirano za primjere iz moje psihodramske prakse u kojoj sam kroz dvije, tri godine imao privilegij upoznati se sa nekoliko pacijentima sa psihosomatskim oboljenjima.

SUMMARY

My curiosity for psychodrama came together with my curiosity for the phenomenon of psychosomatics. The generally difficult access to the hidden and on the first impression meaningless symptoms, the specific psychosomatic personality traits, the specific dysfunctional roles in family and other social contexts and the theory and practice of psychodrama along with the other psychotherapeutic theories have opened a whole new world to me. It is like a long novel that I cannot wait to read and read. As it is well known, psychotherapy that goes for deeper structural changes in the personality is the process much longer than "a session or two". When it comes to psychosomatics gradualism, moderation and patience are a reality. If psychotherapeutic work is long and often very difficult, it better be also fun - I hope that through this work the reader will receive something of both: enthusiastic seriousness, but also fun. In my opinion neither the patient nor the therapist can hold on long enough to see a substantial progress if both is not present.

In this work we will try to describe the field of psychotherapy and psychosomatics with a focus on different definitions of psychosomatics, the aetiology and the treatments of this phenomenon. Regarding the background of theory and practice we will look through the eyes of psychoanalysis, family systemic/structural psychotherapy and especially psychodrama.

In first chapter we will see how the ideas around psychosomatics were developed during the history, try to make a coherent definition of psychosomatics and look at the main characteristics of psychosomatic patients.

In the second chapter we will examine the aetiology of psychosomatic illnesses through three main chapters: a more individual approach theory, a more interpersonal approach theory and the character mechanisms of defences.

The third chapter is regarding the treatment of psychosomatic patients by the use of psychotherapy in general with a special focus on psychodrama. The chapter is divided into three main sub-chapters: psychodramatic spiral, general peculiarities when working with psychosomatic patients and steps of psychodramatic therapy. The treatment by other two psychotherapeutic modalities, psychoanalysis and family systemic/structural psychotherapy, is already briefly described in the second chapter along with the main causes of psychosomatic illnesses.

In the fourth chapter we summarize the important points of psychodramatic therapy when working with psychosomatic patients that were not especially described earlier in this paper.

The fifth chapter is reserved for examples of psychosomatic patients that I have had a privilege to get to know during my psychodrama practice in the past two to three years.

INTRODUCTION

The subject of this paper is treatment of psychosomatic patients by means of psychotherapy with a focus on psychoanalysis, family systemic/structural psychotherapy and psychodrama. Although there are several authors and sub-shades in all three fields mentioned and we cannot truly talk of the real homogeneity within each of the fields, we have made three groups as doing otherwise we would fall out of the scope and meaning of the paper.

My thesis is that psychodrama is the most inclusive as theory and as practice / therapy when it comes to the definition of psychosomatic illnesses, the cause of the illness and the treatment of it. Throughout the paper these three chapters will be discussed in detail revealing the ideas and examples of each of the psychotherapeutic theories and practices.

1. HISTORY, DEFINITION AND GENERAL CHARACTERISTICS OF PSYCHOSOMATICS

1.1. HISTORY AND THE DEVELOPMENT OF THE TERMINOLOGY

In antiquity body and mind were not yet explicitly viewed as separate entities. First distinction between body and mind (soul) was made by Heraclitus in 500 BC. In 5th and 4th century BC Hippocratic's medicine natural explanation of disease took over the older explanations that were based on divine origins. However, regarding the treatment no line was drawn between psychological, biological and social aspects of the symptoms. Physical symptoms of an intrinsic sexual quality were attributed in Ancient Egypt and later in Greece to a "wandering womb" where a disease labelled Hysteria was invented. Symptoms such as loss of appetite, loss of voice, and on occasion unconsciousness were describing this disease and the cause was the so called "displacement of the womb". The disease entity of hypochondria also dates from antiquity where symptoms such as depressed mood, anxiety and physical symptoms were described. The cause of this disease was a surplus of black bile. Common to both Hysteria and Hypochondria is that all the symptoms were attributed to the body.

In the second half of 17th century a key conceptual shift was introduced by the Descartes with his notion of systematic scrutiny of mental processes. Soul issues that were previously a subject of the clerics entered into the scientific field with his methods for the use of mind. Sydenham followed in 1682 with his suggestion that hysteria and hypochondria were the same diseases only that the first occurred in the woman and the latter in the man and claimed for the first time that the main cause was "the animal spirit": a cause that we would now called psychological. Another example described by Cheyne was "English malady" - a disorder with physical symptoms, such as nervous pains and vapours, as well as psychological symptoms, such as low spirit that derived from the strains that the modern society is putting on the individual - a disease with social aetiology.

In 19th century there were two major streams: first, "The somaticists", believed the soul was free from the body and it could not become ill, and that mental disturbances are caused by somatic factors, and second, "The mentalist", that believed that the aetiology was mental.

In 20th century thought the conceptual gap between body and mind seems to be less deep: body and mind are regarded as separate but related entities that influence each other (Felitz-Cornelis, 1997).

Nowadays more contemporary ideas go towards the notion that body-mind-environment are so interrelated that we must look at the individual in the context where he/she grew up, where he/she lives, works, plays, etc. The word *mindbody* (and not mind-body) has been suggested in order to convey the real state of things, as in reality there is no separation of mind and body: there is no body that is not mind and no mind that is not body (Mate, 2004).

1.2. DEFINITION OF PSYCHOSOMATICS

After having followed a complex history and development of ideas connected to the body, mind and malfunction/disease, setting a definition of the psychosomatics is not a simple task. For it to be useful, it has to be simple and clear enough in order not to lose the main focus in the context where we move, the context of psychotherapy. Certainly, the definition and the use of it will become clearer at the end of this paper when the cause and the treatment, along with some clinical examples will be described. As described at the end of the previous chapter the definition has to include the whole individual in the context, so it has to be more than simplistic: the influence of the mind on the body is emphasised more in the individual approach theories, for example in psychoanalysis. Consequently, a person with psychosomatic illness should in my opinion be defined more as one who during his/her development has co-created a chronic stressful mindbody state due to his/her dysfunctional personality traits formed in an unfavourable context. What all is meant as a personality trait and unfavourable context will be revealed during this paper.

1.3. GENERAL CHARACTERISTICS OF PSYCHOSOMATICS

During years of research and treatment of psychosomatic patients, some general characteristics have been commonly found, to name some:

general tendency for not expressing feelings on one hand and a tendency to repress and supress them on the other (most commonly the feelings of anger, but also fear and sadness); incapability to say “No” and to set boundaries to others (in a way the body says No instead); compulsively taking responsibility for others while forgetting about own needs; rumination of the same

thought patterns inside as a main strategy for conflict resolution without communication on outwards; rigid and powerful self-judgement and self-examination (felt blamed for what ones is); tendency towards perfectionism; excessive emotional involvement with parents and a lack of psychological independence; hidden overwhelming need for love, affection and approval; trying to keep the identity of a strong person that doesn't have a needy softer, vulnerable side; escaping in work.

2. THE CAUSE OF THE PSYCHOSOMATIC ILLNESSES

2.1. MORE INDIVIDUAL APPROACH THEORIES

2.1.1. THE SYMPTOM FORMATION

"One of the main points in defining the term *symptom* is to understand that the symptom is the end result of a series of events that begins with the consideration of a wish." (Kellerman, 2007:12).

Symptom formation by Henry Kellerman:

In the context there is an object that is (or we perceive that is) preventing our wish fulfilment, so we become frustrated and hopeless and to regain the power for wish fulfilment we become angry. As the anger is in some way prohibited / not allowed / not socially desirable and we cannot express it directly to the object (especially due to survival, self-interest and fear factors), we repress it. Still, the anger wants to be expressed, but since it cannot be expressed to the object it turns to the self. The subject (the self) becomes the surrogate for the original intended object of the anger. Finally, the repressed anger turned against the self, forms the symptom. The wish, the anger and the object are accompanied into the unconsciousness, only the wish fulfilled in the symbolic way, the symptom, remains.

"What this means is that the anger remains in the repressive unconscious repository of the psyche and sustains the translated wish as symptom". (Kellerman, 2007:18). "In this way, the transformed wish into the symptom satisfies Freud's discovery that in the psyche no wish will be denied – so that since the symptom is the wish (albeit in perverse or neurotic form), than indeed, we all love our symptoms (including those that are unpleasant or even painful), because they are informed in the unconscious as gratified wish." (Kellerman, 2007:24).

"Now the axiom is formed: *if the anger is not repressed there will be no symptom. If the anger is repressed, not only will there be a symptom, but there* ***must*** *be a symptom."* (Kellerman, 2007:145).

The cure of the symptom according to Kellerman is becoming conscious of the anger and the object toward who the anger was originally directed further reinforced by identifying and addressing the original wish in the context (Kellerman, 2007).

Often the symptom is in a way more bearable than the confrontation with the situation that the patient is trying to avoid – mainly because confronting the situation would mean to redefine the way the patient is thinking of himself (seeing himself) and the way the patient is presenting (and want to present) himself to the important others. Another mechanism that is preventing the symptom to be resolved is the so-called ruminating – being in "communication" with oneself when the only functional ways to resolve the conflict would be to turn the communication towards outside, towards the object (with expressing, negotiation, etc.). Henry Kellerman is talking in terms of "The line withdrawal state, or being/staying behind The line" vs. "in front of The line doing state". (Kellerman, 2007:163). "The symptom only exists because its host, the subject, when reacting with the symptom, is basically in a state of withdrawal." (Kellerman, 2007:26). ".. pretending to be listening, but really only turned to the self, only listening to the inner dialogue with someone the subject is thinking about. Or the subject may be listening to the ongoing monologue/dialogue-self to self." (Kellerman, 2007:27).

2.1.2. FROM SYMPTOM TO PSYCHOSOMATIC ILLNESS

The so-called "inaccessible symptoms" are according to Kellerman the ones that have joined the patient's repertoire of character traits. These symptoms operate in the personality as though they were character traits and not only within the domain of the psyche concerned with the wishes where the symptoms remains ego-alien: apart from the personality trait structure (Kellerman, 2007). The other difference is the presence of palpable signal anxiety in the case of accessible symptoms acting to motivate or induce change, while at psychosomatic illness there is often a total unawareness of the body except of the physical dysfunction and/or pain.

What happens?

It might happen to the person whose anger towards the object is so repressed that the memory of *The who* is detached from the anger and loses track. In this way the anger has been left aimless (and perpetuated!) without the true target.
"This endless search of who by the repressed anger means that such a symptom will resist all attempts to be reached. The symptom becomes the moving target, all of its energy being consumed by this never-ending search for something, perhaps the true who." (Kellerman, 2007:150-151).

The perpetuated, accumulated, repressed, in-expressed and aimless anger (detached from the original object) for too long and on too many occasions becomes too much for the psyche to handle. So, also the other defence mechanisms (besides repression) come into play and the symptom transforms into the character traits. ".. a symptom that is visible as a symptom, but has become a trait, requires an understanding of the structure of character formation along with character defences.." (Kellerman, 2007:153). It is proposed that the end of this process is a specific psychosomatic illness (Mate, 2004).

2.2. MORE INTERPERSONAL APPROACH THEORIES

Moreno saw people as essentially relational and encouraged the exploration of systems people live which influence the patterns of choice, role development and interpersonal relations. "His concept of individuals building interpersonal networks is given shape in his theory of the social atom – the minimum number of supportive relationships that give one's life stability and encourage spontaneity." (L. White, 2002:3).

Minuchin, whose orientation was structural family therapy, talked about psychosomatic families, rather than psychosomatic patient. His patient was always the whole family system and the definition of dysfunctional family for him is one that fails its function of nurturing the growth of its members. Specifically he saw psychosomatic families as over-organized families with certain specific traits: undefined boundaries, overprotectiveness, rigidity and absence of conflict resolution. The main challenge for psychosomatic families is to "destruct" this over-organized and excessively stable structure and to build more functional parameters, such as clearer

boundaries, increased flexibility in transactions, conflict negotiation and detriangulation of the identified patient. His premise was that social context is the most powerful organizer (or disorganizer) of families and its individuals. That so, also the therapy focus must be on family structure and organization: on transactions and dynamics between family members, how the members relate to individual problems, rather than focus on an individual patient – in short: the problem and the solution lie in the family structure and context rather than in an individual. His therapy is understood as realignment of the family structure of the transactions with a major focus in the present rather than the past. By structure it is meant some form of internal organization that dictates how, when and to whom to relate. These transactional patterns that operate as a set of rules make up the structure of the family. Structural family therapy understands the family as a living organism, constantly developing and adapting to a changing environment with its structure and adaptability as a major components of the system where family context has the power "to organize the data and to maintain definitions of self and others" (Minuchin & Fishman, 1981:144-145).

"Adaptation to one's family, far from being surrender to individual identity, is its main condition. Unlike Laing (1976), who saw in the family an enemy of individual differentiation, Minuchin sees the family as the matrix of identity: the individual becomes such as a result of participating in multivariate family transactions. One differentiates within, rather than against, the family group; individual and family are not contraries, but different cuts of reality." (Colapinto, 1991:422).

The roles of individual family members are always played in relation to others and are often build around some daily routine context (for example kitchen) without an explicit negotiation. The origins of these "automatic role contracts" between family members can be for sure forgotten; however, they can always be seen on a psychodramatic stage. Moreno talked about *robopathy* and lack of the spontaneity (below see more for robopathy). A failure for trying new roles in real life - playing roles by inertia - range from unawareness (that ideas for possible new ways of behaviour and thinking simply don't emerge, because either the need is still not urgent enough or the general level of spontaneity is so low that nothing new comes) to fear for change (the imagined consequences of trying a new role are catastrophic). Conflicts between members within a subsystem are often avoided by either redirecting the attention from the problem (for example by humour or by entering of the third party for other subsystem – often child or grandparent) or by perpetually playing the conflict, but without real confrontation with resolution and resulting change.

In the next two chapters we will describe more in detail the more functional, fluid role formation cycle and then more dysfunctional roles.

2.2.1. FUNCTIONAL ROLE FORMATION CYCLE

2.2.1.1. DEVELOPMENT OF THE INDIVIDUAL THROUGH ROLE THEORY

Moreno defined roles as: "the actual and tangible forms which the self takes" (L. White, 2002:4). From the roles individuals play the personal development occurs. Each individual encounters social constraints where some of the roles are more desirable than others. Anyhow, our task is to encourage ourselves to choose the roles that suit us more, to be creative and to find ways of interaction that enhance our role development. Throughout our life our repertoire of roles expands and if we were able to develop roles of higher value for us our "act hunger" is well managed. The process of role development can be divided in different stages:
1.) Role perception (an idea occurred in our mind or we saw somewhere someone in a particular role); 2.) Role expectation (we imagine ourselves in this role); 3.) Role taking (giving a try in the new role – here guidance and/or encouragement from the others might be helpful or our inner strong and curious part); 4.) Role playing (this is the period we are already starting to own the role, to master it – the level of initial anxiety already decreases at this stage. However, the person already starts to redefine himself with a new level of responsibility*); 5.) Role overdevelopment (we become increasingly unspontaneous as if the life is asking us for change. Many times other people that are involved with us and our role have pressuring expectations. However, we are now defining ourselves with this role and to leave or change the role might not be simple even though they have already outlived their usefulness); 6.) Resistance to balancing roles (we perceive not to play the role as it is unsafe, undesirable or even unimaginable. For example: if we were always playing a helper, we might perceive a balancing role of relaxing as pure laziness that is not allowed to us); 7.) Role relief (the last stage is the letting go of the role balanced with development of some complementary roles. The stage is specific by our recognition that the old role was overdeveloped, overplayed and unspontaneous (L. White, 2002).

*Responsibility is to have the ability to respond with the awareness to the circumstances of our lives rather than reacting and it also has to be clearly distinguished from self-blame and feelings of guilt (which are emotions, not an ability). Responsibility is knowing that we are the

authoritative person in our life and are able to take authentic decisions that affects us (Mate, 2004).

Many times our bodies can come in action if we don't listen to ourselves and recognize the need for a change of role. On the other hand, we become more resilient and skilful when expanding our role repertoire, which in other words is the collection of responses / "response-abilities" needed for our different life situations. In the end we learn how to simplify, expand or better select our roles.

In this chapter we have learnt about the role development cycle and how we can either get stacked or develop new roles. When directing psychodrama we must pay attention of this flow of increase and decrease of the spontaneity and know how to support the protagonist to find his own sources of it.
In the next chapter, we will have a look at the typical life cycle developmental stages and the developmental needs of particular stages. It is important to note if the client is perhaps playing a role within the family composition that is "developmentally obsolete".

2.2.1.2. DEVELOPMENTAL STAGES IN A LIFE CYCLE SPAN

Each person normally goes through certain developmental stages and corresponding roles (from an entirely somatic role of an infant: eating, sleeping, defecating; through more complex and wider roles of activity and intention) in his life cycle span. The transitions are always to some extent challenging and are source of an individual and family stress; if coped with successfully, they are only of a transitional nature.

- Independent adult:
The person has gained new differentiation and liberty of his/her primal family and begun the independent life.

- Couple formation stage:
The new made system with rules made by mutual agreement between two adults.

- Family with young children:
The arrival of each new child asks for new specific roles, rearrangements of closeness and distances, renegotiation with extra-familiar relatives and friends.

- Families with school-age/adolescent children:
New responsibilities for each member of the family: issues of autonomy and control have to be renegotiated. The domination of powerful extra-familiar systems of peer groups is in focus.

- Families with grown children:
The roles between parents and children, this time all as adults, are further renegotiated. Parents are faced with becoming again a twosome (possibility of empty nest syndrome).

- Solitude in old-age:
One of the couple has died and the other has been left alone. Institutionalized (third age home) and other peer group gain more importance again like in adult independent stage.

2.2.2. DYSFUNCTIONAL ROLES

Dysfunctional roles in a family system result from various combinations of inner and outer stressors that the family has difficulties to cope with. The source of dysfunctional roles can be tracked generations back. The main components of dysfunctional roles are: undefined boundaries of a role, roles that have missed its normal/functional place in the system and rigid/fixed roles or roles that lack spontaneity.

2.2.2.1. UNDEFINED BOUNDARIES OF A ROLE AND ROLES THAT MISS THE APPROPRIATE PLACE

In a family system we can observe certain subsystems, such as husband/wife subsystem, parental subsystem, children subsystem, sibling subsystem, father/son subsystem, etc. that need to have well-defined boundaries to function in a healthy way.
Well-defined boundaries can be mistaken for rigid boundaries that on the other hand can result in isolation and “coldness” of one subsystem from the wider system. The result of this rigidity is the so called disengaged family, where the emotional distance is excessive and problems such as

failure of mutual support, delayed responses between members, underdeveloped nurturing and protective functions, a sense of nonbelonging, excessive tolerance to deviation are common characteristic. In my opinion well-defined has more to do with awareness of the boundaries of the roles (the responsibilities and the authorities), while rigidity more with the doing (the reactivity between subsystem members). A well-defined boundary can, for example, be the awareness that the parents' room is the arrangement managed between spouses and that the children's room is the arrangement managed between siblings (this differs also according to age) and that the privacy of these two subsystem's private places has to be approached with some form of respectful behaviour: for example knocking on the doors, or communication through the closed doors before entering the room, (soft form) or calling each other on the phone before visiting (rigid form).

Undefined boundaries, on the other hand, can produce a real malfunction in the individual and the family and can often be found in psychosomatic families. Another parameter of dysfunctional roles is a kind of "displacement": a member of one subsystem enters into the field of another subsystem playing the role, first: in an unappropriated place in the system, and second: in the way that is abnormal / dysfunctional to be played. This phenomenon is also called *triangulation.* The example is the daughter that is "helping" her father by listening to partners'/couple problems that he is having with his wife (daughter playing the wife of her father), or a mother that is always present as a mediator between father and son affairs, or a mother that is "helping" her two teenage sons by interrupting their sibling's conflicts.

Especially harmful forms of triangulations are *cross-generational coalitions* that are considered the main element for psychosomatic illnesses by structural family therapy. The example is one partner trying to enlist the support of the child against the other partner when arguing their couple conflicts (Minuchin et. al, 1978 in: Colapinto, 1991). This happening, the child is playing a role of an ally, a kind of a personal lawyer of one client against the other. Coalitions can be played when all three are present in the same time, but also secretly when a child or one parent is absent.

Another very similar dysfunctional role that a child often unconsciously plays is the role of "a family healer" (M. White, 1979). Here the child is again in a triangulated position, but his function is not necessarily of an ally to one or another parent, but more of the healer/mediator of the parent's subsystem and also an "important" member of family homeostasis / status quo. The child symptomatic presence is like a distractor away from couple problems between parents: when potential threat for disturbing the spouse subsystem is felt, the child appears thus reducing the threat by focusing the attention on him/her. The child so regulates the distance-closeness

issues of parents with its engulfment and abandonment anxieties underneath. If the couple is threatened by engulfment anxiety, the child enters in such a way that distances the parents from one another and if the couple fears abandonment, the child intervenes with some of his issues (illness) and so draws the partners together for mutual concern for a child: in either way the child conserves the standard cohesion of the family. Further, when the child enters (or also the other way around: when the child is invited) into parent's subsystem, it usually happens that one parent becomes overinvolved with the child, while the other parent becomes disengaged both from the marital and parental relationship. The child in relation with the overinvolved parent and the absent parent also experiences many more difficulties with his/her development, growth, autonomy and independence. This composition has again a fruitful ground for cross-generational coalitions to be born, but it also manoeuvers another very common characteristic of a psychosomatic family: the fight for control. Partners in psychosomatic families apart from distance-closeness issues often have dominant-submissive relationship patterns: one partner usually rigidly plays only one extreme. As a child is habitually in triangulation, his dysfunctional psychosomatic role-play is a part of a family drama again; the drama where, due to strong under-overdeveloped roles of dominant vs. submissive parent and the child in coalition, conflicts are usually avoided or in some other way not dealt (M. White, 1979).

The child as a saver of the parents' marriage is a very common phenomena. Mostly we can find two symptomatic phenomena in "children saviours": children's delinquent behaviour (that redirects anger away from within the parental subsystem by joint parental anger towards the child) and ill child (parents join in concern for a child instead of concern for conflict between them) - in both parental conflicts are avoided.

The undefined boundaries on the other hand have again to be distinguished from the phenomenon of enmeshed families, which is the other extreme from the disengaged families. Here the family is characterized as excessively interrelated with an excessive proximity between subsystems: the response of one member of the family results in immediate and many times emotionally full response of the others. The level of individual differentiation is very low and we can observe specific dynamics, such as exaggerated concern and protectiveness, mutual demands of loyalty, an attempt for change in one member is accompanied with huge resistance of other/s. Generally children coming from enmeshed families depend often exclusively on their families for a sense of support and identification usually at the expense of their ability for creative response to various adult life challenges. However, it is true that the family with a psychosomatic illness is often also an enmeshed family with its characteristic transactions; the undefined boundaries are a different phenomenon with different consequences.

Again, the awareness and the clarity of the boundaries and a corresponding responsibility hierarchy are the important and not the specific end-agreement: a grandparent can manage a part of a parental role as long as it is directed by parents, for example.

2.2.2.2. COMPLEMENTARY UNDERDEVELOPED AND OVERDEVELOPED ROLES

Complementary underdeveloped and overdeveloped roles that become fixed, rigid and imprinted in character trait can be observed when larger family context is on the stage. Roles that could have existed flexibly in each member of the family or could have been deliberately chosen exist only at particular members as fixed, automatic roles with their complementary role in the other member of the family system. The examples are divisions like harsh vs. soft, the active vs. passive, the doer vs. thinker, the manager vs. executor, the talker vs. listener, the emotional vs. rational, the chef vs. helper, etc. When we note "the complementary role phenomena" on the stage we can observe a kind of general/permanent lack of creativity. Anyway, complementary roles can be observed not only between one member and another, but also between one member (often an identified psychosomatic patient) and all the rest of the family, the latter being very typical for psychosomatic families. It can be observed how the whole family takes more fixed than not complementary roles organized in relation to the ill child and with this cement any possible chance for a change.

Similar, but still very different to the complementary role phenomena is what the system therapy theory calls "circular causality". This is when certain behaviour of one person "causes" the behaviour of another person and vice-versa. Here the malign rigidity also can be observed. However, it doesn't take the form of a whole role, but more of behaviour component (Colapinto, 1991). In psychosomatics families we can observe a circular causality between the ill child and the rest of the family, not only between two members. "… the dynamics of overprotection, showing how the involvement of the whole family with the sick child, the heightened concerns regarding the physical welfare of the child, and the constant eliciting and supplying of protective responses helped to submerge potential conflicts." (Minuchin & Fishman, 1981 in: Colapinto, 1991:428).

Anyhow, fixed complementary roles between the members are more rigid and malign, because the present component of identification with the role has become a character trait: it is not only that a member has a rigid and preferable pattern of behaviour in relation to another member, but

its sense of meaning is derived from the identification with the role (later we will discuss identification between character mechanisms of defences). These complementary roles have also the component of co-dependency: the role of saver, helper doesn't exist without the role of sickly and weakly. If one role is to be changed, the other must consequently also change. Making a permanent change of the dysfunctional role the identified psychosomatic patient owns would mean to consequently force the change of a complementary dysfunctional role of the other pair of a co-dependent member. In case the role of a complementary pair doesn't change (and if the role has been played over a really long time this is to be expected), while the pair of psychosomatic role has been left, the surrogate person must be found. In the worst scenario, this can be the other member of the family and in more desirable scenario some form of sublimation in help professions can take place. Many times "the psychosomatic role" is interchanged within the family members (in this case the complementary role also travels to someone within the family) just to maintain the same "type of drama" in the family and to further avoid real conflict emergence and resolution.

2.2.2.3. DYSFUNCTIONAL ROLES IN LIFE CYCLE PERSPECTIVE

An age specific role is another theme that can result in various degrees of good/mal-functions and psychosomatics illnesses. When facing the transitions between life cycle stages the family systems experience a certain degree of (hopefully transitory) crisis. The responsibilities within subsystem and for particular individuals are different at different ages of the children and so the roles ask for the right adaptability and restructuring of the family system during the life cycle span. Rigidity and impossibility to readapt to the new age-specific roles and slowing down or even stopping the transitions between life cycle stages are important elements for appearance of psychosomatic difficulties. The lack of capacity to modify patterns of transactions that are becoming obsolete and have ceased to meet the developmental needs of its members is in psychodramatic terms called "role overdevelopment" (L. White, 2002:6).

For example: a caring mother in the relation with her child might on one hand be helpful and functional at a certain pre-adolescent age of the child, while on the other hand she is overprotective and growth preventing when the child passes certain age and the relation should change consequently.

Colapinto mentions the overprotective, anxious and helpless mother and the absent father as a frequent example of a psychosomatic family:

“In the enmeshed family profile any evidence of loss of control over her children makes the mother anxious. The predominant fear is that of becoming helpless, rather than of becoming “mean”… She has an overwhelming need for a continued hold on the children. These families usually do not include an adult male, but if there is one, his power is clearly restricted and controlled by the woman.” (Colapinto, 1991:427).

2.2.2.4. OTHER SOCIOENVIRONMENTAL CHALLENGES

Apart of developmental changes the source of crisis are other socioenvironmental idiosyncratic changes, such as: a move to a new town, change of jobs, sudden death of a family member, a major shift of financial situation, a beginning of chronic illness, etc. When facing these changes the family and its members are again under a test for functional/dysfunctional adaptability. Temporal changes such as: physical injury, temporal absence of one member of the family, etc. can sometimes be a good source of information regarding role under/overdevelopment and the degree of rigidity/spontaneity.

2.2.3. ROBOPATHY AND ZOOMATRONS

In spite of the significant importance of the spontaneity in human overall health, it is very common that people too often rely on habitual roles even though they ceased to be functional in current lives. Moreno used two terms to describe the human tendency towards rigidity: fix/conserved roles and repetitive habits that people inhabit. “When people become actively attached to conserved modes, social and psychological, when they live accordingly to fixations and habits, they act as if they are programmed like a machine called “robopathy”. (Another term Moreno used was “zoomatrons”, living automatons.)” (Blatner, 2000:82). This role inertia and the lack of spontaneity can function as a common denominator of many types of neurotic, personality disorders and other individual and social pathologies. In milder words it means overusing the “lazy role” we all have in ourselves. Otto Rank talked about the unconscious desire to return to the womb-like state of existence (Blatner, 2000). Putting this in a wider interpersonal context: where there is one that is overusing the lazy role, there must be one overusing the complementary role of an active provider or problem solver. The examples vary from more simple “two-dimensional” (a lazy teenager and a providing parent, a lazy husband and an active wife, a lazy client accompanied with a “supportive” therapist), to more complex “three-dimensional” (a lazy unemployed husband being “cared” by the mother-like wife, both

avoiding to confront each other and the situation by joining together in their collective fury against the unfair political situation in the country – the latter being a clear example of the *scapegoat*).

2.3. CHARACTER MECHANISMS OF DEFENCE

Defences are mental operations that restore or maintain psychic equilibrium when people feel that they cannot manage emotions that stem from conflict; they remove components of unpleasant emotions from conscious awareness (Blackman, 2004).

The ego/emotion defences are defences that manage more transitory states, such as basic emotions, or even more subtle mixtures of the emotions (these will be mentioned briefly in the end of the chapter), while character defences are more utilized in the fortification and cementing of character traits. These personality traits profiles come to exist as more permanent arrangements of the personality (Kellerman, 2007). These character defences, or to say early programming, are so imprinted into the self and for such long time that they are felt like a part of the real self (Mate, 2004).

2.3.1. IDENTIFICATION

Although at first impression the ability to identify with another seems benign or even a needed social learning orientation and skill, we can regard many cases of identification as motivated by needs to avoid anxiety, grief, shame and other painful emotions and to restore a threatened sense of self-cohesion and self-esteem. Many acts of identification contain elements of straightforward taking in of what is loved and at the same time a defensive becoming like what is feared (McWilliams, 2011). One example is identification with aggressor (you act abusive to someone, because in the past someone acted abusive to you) and identification with a victim (a phantasy that we will be rescued and the manoeuvre to avoid feelings of anger and guilt).

2.3.2. INTERNALIZATION

Internalization is an unconscious process when a person absorbs and imprints values and attitudes of the role models/objects/figures in an undifferentiated, undigested and unselected

way. The influences of these role models are much more important and weighty than all other influences from the surroundings.

2.3.3. SPLITTING

To avoid the ambiguity of the objects this character defence enables self-contained compartmentalisations to exist in the psyche. The result is to split the world/objects/part of the objects into either black or white and not to perceive them as they are: black and white or so to say, “grey”.

2.3.4. TURNING AGAINST THE SELF

This mechanism enables the subject to direct the hostility primary meant for others towards the self (which is more tolerable for the subject), and so avoid or more easily tolerate the conflicts to the external world. The main emotion is anger that was originally meant for someone other than us; however we turn it towards us instead. So, the result is that much of the energy goes in a way for “fake” care of others, while self-care and self-acceptance have shifted to self-judgement and self-hostility. The conflict with others is so “resolved”, but the price is permanent self-blame.

2.3.5. SYMBOLIZATION

As already explained above, the wish, the repressed anger and the object are accompanied into the unconsciousness, only the wish fulfilled in the symbolic way, remains conscious. The symbolization as a character defence mechanism permits an indirect or substitute satisfaction of the unacceptable and/or thwarted wishes (Kellerman, 2007).

2.3.6. SOMATIZATION

Rising in the environment where we are not supported by our caregivers to express our feelings in words, we tend to either act them out (acting-out mechanism of defence) or express them in camouflaged bodily states (McWilliams, 2011). “Part of maturation is the slow mastering of language to describe experiences that are originally felt as inchoate bodily arousal. If one has

little help on making this transition, the automatic physical responses may be the only language one has for states of emotional activation (Gilleland et at., 2009 in: McWilliams, 2011:100).

2.3.7. OTHER MECHANISM OF DEFENCES

There are other mechanism of defences that are very common at psychosomatics and we will most certainly meet them during the therapy treatment: denial (in spite of many evidences of reality, we deny it, so we won't have to see it), repression (that what I think and feel is shameful or otherwise not allowed, so it is repressed into the unconscious), suppression (if I expressed what I think and feel, it wouldn't have good consequences, so I must forget it – in comparison to repression this is a much more conscious manoeuvre), isolation of affect (the feeling of emotion lacks), rationalization (we make "rational" excuses to avoid and/or relieve emotional tension, usually after denying some reality), rumination (we overanalyse and turn around same thought over and over again trying to solve a problem), intellectualization (instead to feel and express we engage in some abstract theories), humour (we joke in order to avoid painful feelings) (Blackman, 2004).

3. TREATMENT

In general Moreno was not obsessed with diagnosis and pathologies, but rather with potential for development of higher level of spontaneity and creativity. In psychodrama the director focuses on here and now emotional flow (the so-called emotional smoke) and with the help of different techniques supports and promotes the appearance of creativity. When "talking cures" try to reconstruct the patient's stories to be able to offer help for change by talking and listening, psychodrama through the enactment reveals the story and patient's context with the possible origin of symptomatic, rigid roles in the psychodramatic stage.

At the end of his book, *The Psychoanalysis of Symptoms*, Henry Kellerman, the psychoanalytic author, proposes that the symptoms involve a kind of common, broad cluster of concerns compound of themes that are related to attachment/separation and its corresponding emotions, such as separation anxiety, dependency, sorrow, depression, abandonment and loss, which he calls an epigenetic trigger (Kellerman, 2007).

3.1. PSYCHODRAMATIC SPYRAL

At classical psychodramatic full length protagonist centred sessions the work normally starts with here and now current situations/issues, progresses towards earlier past experiences (by following the emotional psychic energy of the patient) where a reparation takes place and finishes by re-entering into the starting scene, but this time with new inner powers and a heightened level of spontaneity and creativity where a new respond and ideas emerge. This process was named a *psychodramatic spiral* (Goldman & Morrison, 1984 in: Kelerman & Hadžins, 2001). This very vivid, plastic and structured way has many advantages, most of all a feeling of control and safety. It enables the patient to regress into painful past experiences in order to contain, repair and integrate it without a feeling of chaos.

3.1.1. THE HOLLANDER CURVE

Carl Hollander introduced a diagram in 1969, now widely recognized as the Hollander Curve, to see the progression of a particular psychodrama session from beginning to end in a more structured way. In the two dimensional graph the vertical dimension is the intensity of emotions starting with zero to mild emotional intensity from the axe and growing in intensity going up the vertical line. The horizontal line has three points: *warm-up* point in the axe and then going right by the horizontal line in the middle *the psychodramatic enactment* and ending with *sharing*.

3.1.1.1. THE WARM-UP PHASE

The warm-up phase establishes the readiness to work on ourselves and move the whole group into a working mode. As psychosomatics are less aware of their body, the warm-ups constructed around exercises that include some body movements and focusing on bodily sensations is a good choice. For rising the awareness of how we deal with our bodies exercises that include mirror techniques (somebody plays us by taking our exact posture and behaviour gestures instead of us, while we look at “ourselves” from the outside) can also be of help.

3.1.1.2. THE PSYCHODRAMATIC ENACTMENT PHASE

The enactment phase is usually made up of the first scenes that are more of recent occurrences (issues that occurred just moments ago in the group, issues a week old, issues of the last period) and as emotions intensify during the scene the connections with some older archaic situation is

recognized which brings up the next scenes that are of more past occurrences (in the childhood, in teenagers years). The climax of the drama can be accompanied with catharsis of abreaction where raw, repressed, suppressed and unexpressed emotions are relived and finally expressed and/or by catharsis of integration: the "aha" moment where we see the wider picture of the situation we were in years ago, but this time with a fresh view that helps us to leave old patterns and defences that don't serve the current situation any more. This is also a moment for reparation and for trying new ways of being and relating, a so called surplus reality: an enactment that would have been better if it had happened then, but it didn't; now there is a chance to try it out and give back to ourselves what once was taken away from us or what was missing. Before the end of this middle enactment phase we return to the first scene of recent occurrence and feel how it is now. Usually we see the situation very different and with wider range of possibilities: this is actually already a new role. Many times we enter in much more spontaneous state and respond to the situation in new creative ways (L. White, 2002).

However, this flow of the enactment phase is not so typical for psychosomatics, at least not at the beginning of the psychotherapeutic treatment. Normally psychosomatics are aware only of the general body sensation (pains, aches, some limitations, etc.) and not of the particular emotions and the corresponding context. The other problem is the particular psychosomatic way of seeing the emotions: they don't see them as a valuable partner that helps us become aware of what is important for us in our lives, but rather as a disturbing intruder that we must get rid of. Last, but not least is the fact that the body and the overall psycho-physical capacity is very low and that shorter enactments, enactments with one scene (also called vignettes) and enactments with slow progression are desirable.

In the coming chapters we will describe in more details the peculiarities of working with psychosomatics.

3.1.1.3. THE SHARING PHASE

In the last phase the protagonist returns to the group and receives feedback. During the enactment phase it was the protagonist who shared his/her part of a self, now it is time for him/her to rest and listen to how it was for the others to be in the roles of important persons and to the other elements in protagonist psychodrama (sharing from the role) and how their personal experiences and lives connect with protagonist's shared parts of life (personal-life sharing). Sometimes some painful themes from other members of the group open during psychodrama, so

it is important that we leave enough time for the closing session. When working with the psychosomatics, the sharing phase is very important for additional integration. Of vital importance is also the final check if the client has closed his topics in sufficient extent for the moment and will go home in a more reinforced state. The sharing is particularly powerful for the psychosomatics in itself as a treatment: many times a psychosomatic client that "only" participated in other's psychodramas or was "only" in the group as the observer can get for himself a lot with sharing.

3.2. GENERAL PECULIARITIES WHEN WORKING WITH PSYCHOSOMATICS

3.2.1. GENERAL AVERSION AND/OR MEANINGLESSNESS OF THE EMOTIONS

Patients in general fight with the symptoms and so become aversive towards themselves (anger turned against oneself, general hostility towards the self, self-judgemental attitude) and first need to understand the positive function of their body and the feeling of the emotions (which basically inform us about what is important to us). As the "fight" slowly turns toward "listening", the main shift is achieved: the relationship with their body, and so with themselves, goes from general hostility towards a friendlier attitude.

3.2.2. SYMPTOM AS THE ALARM

Analogically, the relationship to the symptom has to be shifted from the dominated wish to fight and erase it to the one of finding the meaning behind it. As already stated in earlier chapters, the symptom contains hidden repressed material of our original unsatisfied wish – as per psychodynamic theories - and also contains the information of the dysfunctional ways we are relating towards self and the others – according to more interpersonal approach theories. If we say that the symptom is actually the alarm for us to embark on a program of change, we are not far from the truth.

3.2.3. GENERALIZED SENSATIONS VS. EMOTIONS

The difference between the body sensation and the emotion is substantial: body sensation in itself can be of a totally physical nature, and so without additional personally important meaning, or it can be a part of the emotion (more accurately - an emotional reaction). Emotions can be defined as psychological meaning we invested into something important to us that is felt as sensation in the body when big enough change occurs (the change can occur on a merely material level: we gain or lose an important object for example, or on a meaning level: we change the perception of the object, or the combination of the two). Generally, if physical sensations are in range of normal, that maintains a healthy function of the body, and the body feels pleasurable, then most probably we are talking about the sensations. However, if the body is in chronical pain or is starting to lose the healthy function, we are talking about body symptoms: at psychosomatic the symptoms are in form of body dysfunction with hidden/masked meaning. So, when only sensing bodily sensations without the recognition of the connectedness with the meaning (the example of masked, undifferentiated emotion), the main problem is that we don't have our main compass for orientation in the world. Without this awareness of the emotions we cannot access the original meaning, so what and/or who is important for us, and so we lose the opportunity to re-adapt ourselves to the changing circumstances towards more meaningful position. On the contrary: if sensing the emotions lacks, it is the same with the meaningful deliberately chosen adaptation (the adaptation happens only as an automatic neurotic one).

3.2.4. GOING SLOWLY AND BEING MODERATE

With psychosomatics in therapy going slowly and being moderate is a must. It is wise to check the illness situation itself with the client regularly to know the capacity for particular session, as psychodrama can be very intensive for their body. Paying attention to the body posture, gestures, movement is also a part of the role of the therapist.

As per previous chapters, due to the general aversion towards oneself, in addition to this vicious cycle of fighting the symptom instead of listening to it by means of mechanisms of defence (inner fight), the symptoms that have hidden important personal meaning are suppressed or removed by drugs and/or operations (external fight), so the chances for meaningful healthy re-

adaptation are even smaller. The big challenge for psychosomatic treatment is also finding the right equilibrium and dosage of usage of drugs while being in psychotherapy treatment: if the dosage is too big, besides of heightened probability of side effects, the symptoms are more hidden, and if the dosage is too low, the physical body in itself can suffer additional damage.

To sum-up: small steps in listening to the body, recognizing the hidden emotions and what they are connected with are mostly all we can do.

3.3. STEPS OF THE PSYCHODRAMATIC THERAPY WITH PSYCHOSOMATICS

3.3.1. FEELING OF RELATIVE RELAXATION AND THE BASIC HUMAN RIGHT TO FEEL

There are different approaches to getting the first two steps of relative relaxation and the basic right to feel (this includes gaining the knowledge of important functions that emotions have in our lives) in the psychosomatic client meet. Some therapists first give the clients and the group concrete tools of different relaxing techniques. It is possible to take first part in a few initial sessions for group meditative, breathing and/or slow body-awareness movement structured exercises. This helps the clients to get in touch with their body and to learn how to calm down when needed. What can follow is an open discussion in the group and sharing of the experiences about different unpleasant body-mind manifestations we all have experienced. It needs to be said that within the group it is normal and absolutely ok to cry, weep, shout and scream and to feel whatever the feelings are. This discussion can be made by sitting in the group in the circle and talking or already by the use of some *sociometric** tools, such as standing in line between two points marked with chairs - one chair indicating zero per cent, the other one hundred per cent - measuring the extent of anxiety at different common life events (in psychodramatic terms this measuring line is called *Spectrogram*), or grouping people together by some common keys like the type of emotion and rearranging sitting positions accordingly. Also we need to explain that one of the powerful characteristics of psychodrama is that there we can try new behaviours without the fear of being punished or humiliated. This connects the group and prevents hiding personal concerns and secret fantasizing about the fears and shames in lonely isolation – this sharing what we feel is also in itself a powerful way to feel more relaxed. Sharing of the

therapist can be also a good group cohesion and safety builder, but with right dosage and timing. Another more indirect approach is to work on the comfortable, warm feeling in the group by using our own personality as a role model for the clients to feel more relaxed: having a flexible, relaxed, unperfectionist and accepting friendly relationship with our own body and behaviour. At the same time when we learn how to achieve a certain state of easiness, we also learn that this particular emotional sharing in the group connected us in a new meaningful way and by this we consequently learn that feelings have a positive function in our lives. Such context of well-connected, relatively relaxed group where all the emotions are allowed, welcomed and even encouraged makes a fertile ground for spontaneity and creativity.

**Sociometry* is both a specific method and a general approach to measurement of group dynamics (Blatner, 2000).

3.3.2. EXPLAINING THE BASIC PSYCHODRAMATIC ELEMENTS AND RULES

Before start it is wise to explain the basic psychodramatic elements, particularly the stage and the audience zone: the division of the stage where psychodramatic enactments take place and the audience zone, where we are out of the scene, have to be clearly made (and that anybody who feels overwhelmed or otherwise uncomfortable in the scene can always choose to shelter to the audience zone). The rule of time-out or freeze, so that psychodramatic enactment can be stopped at any time (we don't need to wait in silence and by all means endure it), and the rule of saying no if chosen for a role that we don't want to play, are important to explain before starting with first psychodrama work. We also need to point out the basic group rules like: confidentiality (stories of others that are shared in the group stay in the group), benevolent intention (we share our stories for personal growth and not for hurting the others) and the rule of not to physically harm anybody.

Building a personal safety place on the stage and getting to know better what that is can be of big help. In this exercise - that can be used as a first scene in a personal protagonist psychodrama work before going into more stressful scenes, or can be a group work where all members participate at the task of getting in touch with personal powers - we build the scene where we feel very safe. We bring physical elements (other members of the group, chairs, or other objects in the room) and give them meaning, names, sounds, etc. These elements so become roles that

compound personal safety place. Examples of the safety places can vary from simple everyday moments with best friends, to places in nature, to more exact moments experienced in life, as a concrete road trip taken last summer, etc.

3.3.3. MAKING THE SCENE AND THE EXTERNALIZATION

Taking the story or the theme out of the person's mind not only by the act of talking, but by putting it in front of us into the real physical space by using real physical objects and other people in the group that symbolically represents the elements in our story, is a unique characteristic and advantage of psychodramatic psychotherapy. The story in the head is much more chaotic, confused, out of control and above all fused within us than it is when put in front of us. By doing so we externalize our internal personal material in order to process it and integrate it back in a healthy way. When the inner story is out in the scene, we can literally go around it, see it from different perspectives, move the elements of the scene, change them, talk to them from the distance we desire, etc. It is true that psychosomatics are typically too much in the head and that being out of the role and the scene is a more cognitive principle than body-emotional principle which still needs to be properly developed; however, at the same time psychosomatics are too much, to say, "improperly" into the body (as we have explained above, what they feel are general sensations rather that differentiated meaningful emotions), so taking the right distance is crucial in the beginning of the treatment. Another thing is also that looking at the scene is more of intuitively sensing the scene when seeing it and not necessarily thinking about what is seen (as directors we can further contribute to make this difference by, for example, avoiding the questions like: "What do you think about this?" and using more questions like: "What do you see/sense/feel when looking at this?").

3.3.4. ENTERING THE ROLE AND DE-ROLLING

When you enter the role in the psychodramatic stage, this often means that you have maybe for the first time re-entered in a particular emotionally and otherwise important life situation with your whole body-mind, but this time in a safe context. Being in the role, even if on the artificial "as if" psychodramatic stage, can be very intense and must be accompanied with the awareness of the choice and possibility of de-role when needed. The latter means that you have stepped out of the role (usually this is accompanied by an auxiliary ego entering that role, or an empty chair

in an individual psychodrama) and so established a distance from the role and a challenging or traumatic situation, and have thus re-entered in a more cognitive state deliberately without the usage of different unconscious mechanisms of defence: Adult Ego-sate in terms of Transactional analysis (Berne, 2011). The right dosage of being in the role and going out of the role is so interchanged.

3.3.5. SCULPTURING AND SYMBOLIC SCENE

At this stage sufficient safety and easiness is already established: trust into the therapist, group and the psychodramatic method (the client has learned what it means to be in the role in the scene, and the options of safe place, de-rolling, mirroring and time-out), so the therapist has wider options and methods he/she can use.

As already mentioned in the section of symptom formation, the symptom contains the essence of the original wish that is sustained and fuelled by repressed anger. However, as all the material is deeply hidden into the unconscious, the only visible thing is the symptom: in case of psychosomatics, the malfunctioning and sick body. As the latter is mainly the only problem perceived by the psychosomatic protagonist, we normally start with this. “The body in pain” becomes a psychodramatic role for itself (separated from the person) that we put on stage in relation to the person. The protagonist makes a sort of sculpture composed by “The role of pain” and the role of him/herself and the relationship between the two of them. If we find out that there are more “pain roles” and not just one the sculpture is amended accordingly. Many options are now open from this symbolic scene: we can interview the pain(s) asking if it is a he or a she, how old it is, what he/she is doing here with the protagonist, how he/she is getting along, what is his/her purpose in relation to the protagonist or maybe also to somebody else, etc. Sometimes the protagonist doesn’t feel enough unease in the body, so we can use additional physical pressure while the protagonist is together with the pain in the sculpture: the auxiliary ego that is playing the role of body in pain presses physically the part of the body of the protagonist. As the pressure and the unease to the protagonist grow, the protagonist often spontaneously reacts to it. These reactions often have masked emotion residues within them. An example of a somatic reaction is “you are getting on my nerves” that can be a masked expression of anger. Reactions can be also of a more behavioural nature, like “I would like to kill you”, which can again be a

masked expression of anger or hatred. Following the emotion-like reactions, we get to the real context in life where differentiation and emotional literacy are further specified.

3.3.6. EMOTIONAL SMOKE AND FINDING THE CONTEXT

When we go little by little from the symbolic scene and somatised sensations to the real context and differentiated emotions connected to them, we usually follow the so called emotional smoke: the vivid, felt energy on the scene. Our focus is on this emotional smoke, so the real context gets more and more clear naturally. The most important and turning point is the awareness and the identification of the emotions and the corresponding context. The illness doesn't stand on its own anymore, but it has gained the meaning and the source, the context where the shift from emotions to illness has happened.

Slowly getting to know the mechanisms that we use in order to avoid real emotions and identifying and confronting the original *who,* where anger plays the main role, is the next step to change for the better.

3.3.7. MEETING UNMET NEEDS, REPARATION AND TRYING THE NEW

As already mentioned above in the section of symptom formation, the symbol contains the essence of the original wish that is sustained and fuelled by the repressed anger. As the emotions and real context are getting clearer also the corresponding unsatisfied needs are more distinct.
Here the therapist mustn't get into the trap of helping the psychosomatic client fulfil the unsatisfied needs - as he feels disabled, incapable and powerless by doing it on his/her own - by doing it for or instead of him. Rather he/she has to tackle any smallest, hidden initiatives and potentialities in the client and encourage him to take steps towards change, as tiny as they would be.

3.3.7.1. HEALING THE INNER CHILD

"The fundamental problem is not the external stress, such as life events quoted in studies, but an environmentally conditioned helplessness that permits neither of the normal responses of fight and flight. The resulting internal stress becomes repressed and therefore invisible. Eventually,

having unmet needs or having to meet the needs of others is no longer experienced as stressful. It feels normal. One is disarmed" (Mate, 2004).

Our most profound early developmental needs that were not met during our growing-up have an inner call, an urge, to be satisfied. Being in touch with this call and listen to what it is that it wants is like being in touch with the inner child. The child of course doesn't have only one need, but what is certain is that he/she wants to be seen, accepted, valued and nurtured.

3.3.7.2. HEALTHY BOUNDARIES

Realisation of full separateness from the others, our uniqueness and free will without losing connection and a sense of co-creation with others come along with awareness of our boundaries. Having a sense of differentiation from the others makes it possible for us to have closeness and at the same time a clear sense of personal identity. With boundaries comes interdependence rather than dependency. As psychodrama is a very active and plastic method, we can clearly distinguish when someone is being in a reactive state (the idea that someone is causing our emotions and behaviour) or in a state of taking action (actively choosing and taking responsibility for oneself).

"The blurring of psychological boundaries during childhood becomes a significant source of future psychological stress in the adult. There are ongoing negative effects on the body's hormonal and immune systems, since people with indistinct personal boundaries live with stress; it is a permanent part of their daily experience to be encroached upon by others. However, that is a reality they have learned to exclude from direct awareness" (Mate, 2004:15).

3.3.7.3. ANGER MANAGEMENT

As the repression of anger is one of the main causes of many psychosomatic illnesses, one should think that the other extreme of over-expression of anger (rage) is the answer to health. However, it is not so: both repression of anger on one side and the unregulated acting-out and exaggerated venting on the other are examples of abnormal release of emotions that doesn't contribute to re-adaptation and actually represents a fear of genuine (deeply felt emotion without defence) experience of anger. As both extremes are filled with anxiety, both also trigger various physiological stress responses, either consciously felt or not. Another dysfunctional twist that is common for psychosomatics is an emotion of guilt experienced soon after the expression of

anger. We often experience the anger with the ones we also love and want to keep in contact with, but since the anger has the attacking energy, it can be a threat to the contact. So, the anger can be an incredibly anxiety-and-guilt-provoking emotion as we don't want to lose and/or hurt the other.

"Naturally, the more parents discourage or forbid the experience of anger, the more anxiety-producing that experience will be for the child. In all cases where anger is completely repressed or where chronic repression alternates with explosive eruptions of rage, the early childhood history was one in which the parents were unable to accept the child's natural anger." (Mate, 2004:201).

Expression of healthy anger on the other hand is a strong request/demand for change of others' behaviour and defining of our boundaries whenever our wish for which we think that is fair and justified is threated. Healthy anger is empowering and mobilizes us to contemplate what may have triggered the anger and to search for a solution. The more we are aware of the emotion, the more present and energized we are and the more we are in charge of the emotion. On the other hand with repression and suppression the one that it is in charge is the symptom.

In the next chapter we will see that learning to express genuine feelings is the only way for health and actually also a part of conflict resolution rather than complication.

3.3.7.4. ASSERTIVENESS AND CONFLICT RESOLUTION

Assertiveness is a set of non-violent and non-competitive principles of authentic self-presentation where the outcome is secondary (you stop trying to control circumstances or other's behaviour – for example: accept the fear of being rejected for expressing your disagreement, anger, etc.) and being clear about yourself is primary. "The art in assertiveness is to ask strongly for what you want and then to let go if the answer is No." (Richo, 1991:23).

Assertiveness is a skill and a personal power of being clear about your feelings, choices and agenda; being able to express your needs and ask for what you want; taking the responsibility for your thoughts, feelings and behaviour; being free to choose how to explain or not explain yourself.

Assertive attitude and behaviour is crucial for psychosomatic amelioration and overall positive validation of oneself. Assertiveness openly acknowledges the conflicts between people, it doesn't keep them underground and so distance people from one another. Also it doesn't invade anyone else's boundaries. It changes relating out of compliance and compromise to relating by

actions of open negotiation and agreements (to remind: psychosomatic families are especially prone to avoiding conflicts).

When we actively decide to leave old dysfunctional roles, we may find periods of difficulties of the whole system adjusting - as people around us must adjust their counter roles. Here one of primal psychodramatic methods for finding a solution out of a conflict is *role reversal.* This is a technique when the protagonist switches roles with the group member playing the role of someone in protagonist's life that he is being in conflict with to better understand both positions. This shift from our own role into the shoes of others and back usually results in a higher level of knowledge, empathy and not rarely leads to a creative conflict resolution, a new win-win situation.

A full expression of one and the other by each of his or her own position, followed by a role reversal and then a return to his or her own role is the essence of *encounter*, which will be described in the next chapter (L. White, 2002).

3.3.7.5. "I-THOUGH" RELATIONSHIP AND ENCOUNTER

When a person is differentiated from the others, he is aware of his own individuality and recognizes individuality in others without feeling enmeshed or abandoned, without impression that he is controlled by the others, and without imposing his own responsibility on others. Only then he is ready for mature relationships where boundaries are clear and empathy, responsibility and learning about each other's uniqueness has replaced guilt, fear and acting out from a sense of obligation.

Martin Buber, a philosopher that inspired Moreno, wrote about the difference between "I – It" relationships (this is a relationship of one taking the other as if he/she would be an object or thing that can be controlled and manipulated) and "I – Thou" relationship (where the individuals are free and spontaneous. We mutually allow and respect the spontaneity of each other so our full potentials can be developed). Moreno defined the latter as encounter. "There is a greater value in promoting spontaneity in both the I and the Thou. The downside is that you're out of control, you get no guarantees, you don't always get what the little ego-you wants in the moment. The upside is a truly growing, discovering, interacting relationship. Also, in a mutually spontaneous relationship, you are able to discover and enjoy the world through the other person's eyes and senses and thoughts. Your world is greater because the other not only plays with you but also shares his or her own experience." (Blatner, 2000:70).

4. SUMMARY OF IMPORTANT POINTS OF PSYCHODRAMATIC THERAPY WHEN TREATING PSYCHOSOMATIC CLIENTS

4.1. EMBODIMENT OF THE ROLE

Being in the role with full awareness of the body, slowly connect with the body and gradually re-own the whole body we start to see and experience our body differently. We find out that the more we focus on sensations and the more we allow our emotions rising, resting and dissolving in our body, the less we fear them and more liveness we feel within ourselves. In this process, the method of *double* can be of help. When doubling the director or anyone from the group (if/when the protagonist is ready for and wants to be doubled and when the director decides that is appropriate), step near/beside the protagonist and take the same body posture, face expression and express verbally and non-verbally what is felt that is happening inside the protagonist, but he either cannot recognize it and so fully own it, or cannot express it or both. Sometimes when situations on stage are particularly difficult for the protagonists to express themselves (and seen above, one of the most powerful mechanisms of defence psychosomatics use is suppression), we can invite more people in the role of double, but this time more as support for full expression of the emotions and also for a better sense of the body support (grounding, breathing together, for example).

4.2. SELF-ACCEPTANCE

Acceptance is the willingness to recognize and accept how thing are at the moment. Self-acceptance analogically means to recognize our thoughts, feelings, intentions, wishes, concerns, body sensations, body shape; in short: all what we are at the moment, and being compassionate to ourselves rather than judgemental. “It is the courage to permit negative thinking to inform our understanding, without allowing it to define our approach to the future. Acceptance does not demand becoming resigned to the continuation of whatever circumstances may trouble us, but it does require a refusal to deny exactly how things happen to be now.” (Mate, 2004: 195). It also means that you are accepting yourself as somebody that has troubles with accepting him/herself. It doesn’t mean that we like everything we find out about ourselves; however the relationship stays of one of friendly, non-judgemental acceptance and care. Self-acceptance has to do with the notion of *meta-role* in psychodramatic terms, a kind of reflection role that takes care of us.

“These meta-roles are names for what in psychoanalysis or cognitive psychology is called “observing ego” or “meta-cognitive functions.” (Blatner, 2000:152).

4.3. AWARENESS OF EMOTIONS AS A SHOCK ABSORBER FOR THE BODY

Dissociating emotions from awareness and relegating them into the unconscious results in disorganization of the body that turns into destroyer of its own rather than protector (Mate, 2004). The source of poor emotion recognizing and mentioned disorganization can again be connected with the king of messages we have received in primal family and other important early systems. Mainly there were two mechanisms: one direct where we weren’t allowed to feel certain feelings (“Don’t be angry.”) and other more indirect, that are called *double-bind messages* in systemic terminology (Bateson, 2000). An example of the latter is when in verbal level the child has been allowed to feel certain emotion (“It is normal that your feel angry.”), but on non-verbal level the message is contrary: the parent verbal allowance is accompanied with physical gestures that are clearly showing disapprovals: face expression, tone of the voice, eyes openness, not listening and really paying attention, etc.

Developing emotional competence starts with embodiment and self-acceptance and continues with growing capacity of recognizing what we feel, where in the body do we feel it and what we need and the capacity of standing in a responsible, non-victimized and non-violent, but assertive mode of being and relating. This means to be true to oneself and to others, to express the emotions, most importantly the anger, and not to mask them with different unconscious and semi-conscious manoeuvres.

4.4. NO ROLE WILL BE DENIED

As a result of dysfunctional family context we have lived in, social constrains imposed on us and personal constraints we are putting on ourselves, most of our “inner material” is repressed, denied, split or in many other unhealthy ways transformed. In psychodrama we have a unique chance to enter in the roles that are for our mates normal but we don’t have enough knowledge or courage to own and live them. We can first try it on the safe psychodramatic stage, rehearse it, and then - when we gain enough confidence - try it in real life. Here we talk about the roles that

are underdeveloped, but otherwise quite a must if we want to step out of rigid dysfunctional relations and enter into more flexible and balanced ways of living and relating. The participant that is not used to be in a particular role in his/her every-day life (for example: an active helper is not used to being in the role of a passive receiver of help, or the role of "saying NO or refusing to offer or accept something" is perceived as too socially undesirable), can learn from other members in the group that it is possible to re-own this roles. In psychodrama this underdeveloped, however healthy roles, can be developed while trying a new role as the protagonist as well as when acting as the auxiliary ego with this characteristic in psychodramas of others.

Making the idea of Freud that no wish will be denied, would in Morenian style perhaps be: "No role will be denied". The truth is that in real life many wishes cannot come true, many thoughts and ideas cannot become materialized, and many raw emotions cannot be expressed. Still all this inner material is living within us and yearning to be expressed, to be lived. Moreno called the inner urge for fuller mode of expression where words are just not enough "the act hunger". "In addition to people hearing themselves say their thoughts and feelings and to experience others as really hearing them too, they further benefit from experiencing those feeling in their bodies. Short of this, in psychodynamic terms, genuine emotional expression many be inhibited by the defence mechanism of isolation of affect. The concept of act hunger simply extends this idea by offering a more holistic process of self-expression." (Blatner, 2000:103).

It is true that not only we have a need to materialize our wishes and express our emotions, but we also have a need to own every part of us, to put off the mask and accept all that is in us (thoughts, feelings, and body sensations) and wants to come out. One of the psychodramatic goals is to be able to enter, act and go out of any role that appears in the psychodramatic stage (for instance, when directing the psychodrama with co-therapist he must be able to enter in any role on the stage, physical limitations being the only thing that limits). The not permitted, obscure, sociopathic, incestuous, etc. roles are elements of our darkest parts of the soul that repressed into the unconscious live their life in form of all kinds of neurotic symptoms or can be lived in real life only as perversions and other antisocial expressions. However, in psychodrama we can enact and play any role we can imagine and so make it conscious and experience it with our whole body-mind and still no-body get hurts like in real life. Doing so, the unconscious forces and our automatic responses lose force and we can live our real life together with others more freely and harmoniously. There are also roles that are not deviant or otherwise subversive, but are just impossible to be experienced directly in the real life (like being again a 1-year-old

child held in a warm hug of a caring mother). However, we might get in touch with this internal body needs and heal them in the psychodramatic stage.

5. EXAMPLES

5.1. PERSON "A"

Patient "A" presents herself in relation to her father as helpful, empathic, always at disposal to help, always saying yes to her father's wishes and wants, etc. In psychodramatic terms we can say that her role of "good girl" is overdeveloped and the counter-role is being avoided. Her symptom – psoriasis – was on one hand "helping" her to avoid the original situation (the direct and "non-neurotical" confrontation with the father) by over-preoccupation with nurturing her skin and not being totally conscious (or at all conscious) of her anger at her father. On the other hand, the symptom – her skin – managed to get attention she was needing in the first place (having time for herself), unfortunately in the neurotic way (she was forced to nurture her skin and not nurture her wish for spending time in the nature with horses that she wanted). Here we can see that the patient's body "said no" to her father instead of her deliberated way of direct confrontation and setting the boundaries to him. Having the symptom is setting the change, but only temporary, not profound: when she "took" her time for nurturing her skin, she conserved the role of being a good girl, because her body forced her to take time for her - she didn't actually deliberately and directly say no to her father (that on the other hand would have meant being "a bad girl"). Having a symptom is also a displacement away from her role of bad girl and gratification of her wish to obtain the role of a good girl – to look adequate in her father's eyes (or more accurately to look adequate in what is she imagining of her father is seeing/thinking of her).*

"Even roles not pleasing to others have become embedded in our perceptions of ourselves and the world. In certain families of origin, roles are developed by the child that are vital to her survival…By mid-life they have outlived their usefulness and cause us grief." (L. White, 2002: 6). Profound change of the symptom would mean deliberately risk of taking the new role (which we have practised on several occasions during psychodrama sessions). The profound change further means the change that would permanently change also the family system as a hole: the complementary roles of others in the system. In her example the role of the bossy father that used to have his needs met by his obedient daughter would change into more independent role of the father and what is more important - it would change the spouse subsystem of mother-father.

Here I did understand that the change of A's role of "good girl" has major "risks" – it is not affecting only the relationship with her father, but also with her mother. Further is it also altering the way she perceives the "role of the woman" – she would need to reinvent her womanhood by differentiating herself from her mother as an old role model for womanhood. Here we can understand why the role rehearsal is so important: it slowly opens the space for creativity and freedom.

*When confronting her father she also altered the imagination she was having of her father – at the end he was also proud of her being herself.

The turning point from symptom meliorating was every time she has acknowledged the anger towards her father. When she got into the scene with him, she was struggling to express her anger, but each time the skin problems got better. Once she detected and made conscious her anger towards her father, her psychodramas changed from direct symptom focusing via sculpturing towards more concrete scenes: we went one level deeper towards where the problem actually began.

5.2. PERSON "B"

Patient "B" has epilepsy and s small paralysis-like defect at one part of his lips/mouth – they are lined down in one angle. He is a very quiet and shy person, but when he does speak he makes jokes – situational and also very good ones (many times the whole group burst into sincere laughter) – however, still feeling shy. On one session it was his first time that he spoke openly about having epilepsy. It was a group process session when many members of the group have already revealed their physical deficiencies and got over their shyness before him. Then it was his turn and he really "got into the role"; he spoke very freely, spontaneously and un-habitually long. It was only at that time that his condition in the lips completely disappeared for the whole time during his speaking. When he ended, I gave him feedback that I noticed his lips condition completely gone while he was speaking and asked him how he was feeling during his speech. He answered that he was totally relaxed, connected and accepted by the group and very genuine. I gave him another feedback that he was also for the first time speaking without making jokes and that maybe he often plays the role of the group entertainer. It was obvious that he played a new role during the speech: he indeed was not playing a role of "being a good entertainer for the group sake".

5.3. PERSON “C”

Patient “C” had many inexplicable spasms all along her body (mostly legs, but also stomach, and back). She was struggling at her early forties with getting away from her primal family home to her new home. Her emotions were mostly anger and guilt towards her mother who was giving her double-bind messages during many occasions: on one level her mother was saying openly and directly that she had enough of her, that she needed to behave as an adult and start her own life separately, but on the other level every time she went on her own, mother called her complaining that she needed help with the father. Once she had a psychodrama where she saw parent double-bind messages regarding independence at work, and she was shocked by the paradox revealed on the stage: “They are telling me to get independent with advice, this is a paradox – you cannot get independent by advice, but with your own ideas”. Her condition started to get better when she set proper boundaries and continued with a sense of freedom from guilt that she has a right of her own life.

CONCLUSION

In this paper we went through different chapters in order to reveal the background of the definition, the cause and the treatment of psychosomatic patients through three different psychotherapeutic theories and practices: the psychoanalysis, family systemic/structural psychotherapy and psychodrama. Although there are several authors and sub-shades in all three mentioned fields, we have talked as if these three groups were alike within them as doing otherwise we would fall out of the scope and meaning of the paper.

The initial thesis made in preface was that psychodrama is the most inclusive as theory and practice when it comes to the definition, the cause and the treatment of the psychosomatic patients compared to psychoanalysis and systemic/structural psychotherapy. By inclusive we mean that the theory and practice of the psychotherapeutic field discussed comprises several dimensions of the person in the context as the main subject(s) of the treatment. This is why we believe that the greatest extent of inclusiveness goes in favour of psychodrama.

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