**Post-traumatic Growth and Wellbeing in Mental Health Care:**

**Psychodrama Group Therapy with Mental Healthcare Providers**

**Introduction**

Difficult life events can trigger post-traumatic stress disorder (PTSD). However, research has found that they can also be a turning point that leads to positive changes in people’s lives and mental/emotional state. Post-traumatic growth (PTG) is defined as positive psychological change resulting from a struggle with life crises (Calhoun & Tedeschi, 1999). Following a crisis, hope and resilience play distinct and significant roles in coping, growth, and recovery.

The development or diagnosis of a mental illness is often a traumatic event. Mental illness may cause changes in an individual’s personality, behavior, thoughts, and feelings, both during the disease’s “active” phases and in the aftermath. This can cause multiple types of damage to one’s identity and system, and even “loss” of parts of one’s self (Cohen et al., 2009). Both the body and mind may be affected. A person living with mental illness may experience diminished enjoyment of life, lower self-esteem, and lose hope for realizing their plans for the future. Mental illness can damage a person’s social status, interpersonal relationships, and place in the family and/or social environment (Kaufman, 2011).

Being diagnosed with any serious illness is a traumatic experience with multidimensional impacts on the biological, psychological, and social spheres and on conditioning processes (Shilo, 1994). The person’s reaction may be a manifestation of PTSD. People who undergo a mental crisis and/or are diagnosed with a serious, chronic mental illness often experience a sharp disconnection from their previous life and self-image. There are difficult personal and social meanings associated with such a diagnosis and the person may adopt the identity of a “sick” person (Roe et al., 2005).

In recent years, researchers have begun to address the positive impacts of traumatic events; an area that had previously received relatively little attention (Laufer & Solomon, 2006).

**Post-traumatic Growth**

The term post-traumatic growth (PTG), coined by Tedeschi and Calhoun (year), describes the experience of people who not only survived a trauma and returned to their baseline level of functioning and wellbeing, but experienced an improvement, a fundamental change that made them even stronger. PTG is defined as a tendency to report significant positive changes in self-perception, worldview and relationships with others as a result of the struggle with a traumatic event or significant life crisis (Tedeschi, 1999). These positive changes are achieved by the person reframing the meaning and impact of the trauma. Such a shift can take place due to insights the person reaches independently, or with the encouragement and guidance of a therapist who is aware of PTG and who helps the patient develop an alternative narrative (Meichenbaum, 2006).

PTG occurs in three main stages: 1) collapse of the person’s previous system of perceptions of reality due to the trauma, 2) reorganization of the person’s perceptions, interpretations and meanings attributed to reality, and 3) acknowledgement of the traumatic experience and the restoration of a new system of perceptions of reality (Calhoun et al., 2000).

PTG does not mean that the person simply returns to their pre-traumatic state or develops resilience to the trauma. Growth brings about a change that gives the person new abilities and insights that did not exist before the trauma. PTG is reported following a wide range of difficult and traumatic life events such as bereavement, chronic or life-threatening illnesses, natural or man-made disasters, sexual assault and abuse, and more (Tedeschi & Calhoun, 2004).

PTG should be a goal of post-trauma therapy (Cohen, 2010). This therapeutic approach is characterized by encouraging the victim to be open to the possibility of positive changes in their life, creating of a new order of priorities, a deeper sense of meaning for their actions and life, and more. For positive change and growth to take place following a trauma requires someone to be attentive to the patient’s conscious and unconscious struggles, search for meaning, ambitions and goals. The therapist should guide the patient beyond the level of processing the trauma and becoming less distressed about it, to a level of developing a renewed self-image, schema for evaluating life, and a revitalized belief system (Janoff-Bulman, 2006). Jackson (2007) described PTG not as an outcome of trauma, but as a coping style with various manifestations such as: finding a personal meaning or universal meaning for the traumatic experience, reinterpreting the event, and/or a self-enhancing appraisal and positive self-image.

Tedeschi and Calhoun (1999, 2004) noted five dimensions in which PTG can occur.

1. Interpersonal relationships: attributing greater meaning to interpersonal relationships, improving intimate relationships with others, and developing greater compassion and empathy towards others and their pain and grief;
2. New opportunities in life: recognizing the fragility of life, which inspires the pursuit of new and different opportunities;
3. Personal strength: alongside acknowledging one’s vulnerability following the trauma, it is also possible to recognize one’s strengths and ability to deal with traumatic situations and crises;
4. Spiritual growth: dealing with trauma is often accompanied by religious and spiritual reflections on existential questions, which may be experienced as part of the process of growth and development;
5. Appreciation for life: a new view of life and its value leads to, among other things, attributing greater value to things that were previously taken for granted (Fromm et al., 1996).

A number of early theories and approaches preceded the concept of PTG, or developed in parallel with it including: logotherapy (Frankl, 1970), positive psychology (Seligman et al., 2005), the “strengths perspective in social work practice” (Saleebey, 1992), and models for processing grief and loss processing model (Herman, 1994; Kubler-Ross, 1969).

According to one noteworthy approach in the field of mental health, recovery is viewed as a profound process through which people fundamentally change their perspective, values, feelings, goals, and perception of their role (Anthony, 1993). This offers a path to a life in which the person can feel fulfilled, hopeful, and able to make a contribution, despite the limitations of the mental illness. People in the process of recovery recognize the hereditary and biological aspects of their illness, and also develop a perspective on the personal causes of their mental and emotional crises. They transition from dependence on professional authority figures towards making independent decisions based on diverse sources of information. People in recovery choose what is appropriate for them personally in all areas of life and take responsibility for those decisions and their consequences. Despite the symptoms of the illness, they strive to fulfill their dreams and life ambitions.

The primary tasks for a person in recovery are: developing a “positive” identity that is not limited to being a person with a psychiatric disorder; becoming able to self-manage the psychiatric disorder; developing an explanation/meaning for the psychiatric disorder, and developing valued social roles (Slade, 2009).

Anderson et al. (2006) identified four themes of the recovery processes: hope, self-identity, meaning in life, and responsibility. They further described five steps along the path to recovery:

1. Stagnation: denial, confusion, despair, identity confusion, and defensive withdrawal;
2. Awareness: the first glimmer of hope for recovery;
3. Preparation: taking the first steps towards recovery, such as learning about the illness/disorder and existing treatments, becoming involved in support groups, and making contact with others in recovery,
4. Rebuilding: developing a more positive personal identity, setting achievable and meaningful goals towards recovery, re-evaluating previous values, taking responsibility for managing the illness;
5. Growth: managing the disease, feeling motivated and self-confident, being aware of the benefits of going through this process.

Overall, each of the various approaches described above suggests giving individuals living with mental illness adequate space and opportunities to attribute subjective meanings to their experiences, to find their own ways to define the difficulties they face in life, and to encourage them to believe they have the ability to recover, overcome their challenges, and even grow from them.

**Research on PTG**

The post-traumatic growth inventory (PTGI) was developed in the 1990s (Tedeschi & Calhoun, 1996). This measurement tool is based on a 21-item questionnaire, divided according to the five dimensions of growth described above: interpersonal relationships, new opportunities in life, personal strength, spiritual growth, and appreciation for life. This questionnaire and other tools have been used to investigate various aspects of PTG and the factors that enable it.

One study examined the relationship between PTSD, world assumptions, and PTG among rescued prisoners of war (POWs) as compared with soldiers who had combat experience but had not been captured (Ronen-Norman, 2009). The study found a positive relationship between post-trauma and growth. PTG was higher among the POWs, and was expressed in the dimensions of interpersonal relationships, new opportunities, personal strength and appreciation for life, among other areas.

Several studies have found a positive correlation between cognitive processing and PTG. A study among parents whose children died of AIDS found a relationship between the degree of cognitive processing of their loss and PTG (Kemeny et al., 1998). Another study among bereaved parents who participated in self-help groups found that parents who performed cognitive processing shortly after the event tended to report higher levels of PTG (Calhoun et al., 2000).

Many studies have found that PTG is related to, mediated by, and enabled by a range of variables related to the person’s life before the trauma, during the traumatic event, and during recovery, such as gender, age, severity of the trauma, religious belief, belonging to a religious community, sense of responsibility regarding the trauma; for example, women and young people tend to report greater growth (Jackson, 2007; Overcash et al., 1996; Powell et al., 2003; Tedeschi & Calhoun, 1996).

Tedeschi and Calhoun (2004) found that the people who deal most effectively with traumatic experiences are those who engage in emotional expression and emotional processing. Emotional expression refers to talking about feelings with others or expressing feelings through writing. Emotional processing refers to active introspection using interpersonal, emotional, and cognitive processing strategies. There is evidence that expressing emotions through writing or talking about experiences reduces mental distress, and a significant positive correlation has been found between emotional processing and PTG (Pennebaker & Beall, 1986).

**Case Study: Psychodrama in the Recovery Approach**

**The CHIME Model as a Response Trauma and as an Engine for PTG**

This case study examines how a psychodrama group promotes PTG. The study was conducted among a group of workers with experiential knowledge in the field of rehabilitation. They participated in the Consumer-Providers program, which helps people living with mental illnesses who wish to work in the field of mental health and, across the full spectrum of this profession and its various certifications: rehabilitation instructors, mentors, social workers, psychologists, and more.

In the field of rehabilitation, work based on experiential knowledge emerged alongside concepts of recovery and providing therapeutic responses within the community. The guiding principles are enhancing people’s sense of belonging, offering them hope, helping them strive for a meaningful life, and empowering them by giving them the right and the ability to make choices regarding their own lives (about which they are the experts). Experiential knowledge complements formal or “professional” knowledge. For example, most professionals lack experiential knowledge about being hospitalized in a closed psychiatric ward, going through a major psychotic episode or deep depression, attempting suicide, receiving rehabilitative services from various agencies, etc.

The Consumer-Providers program was founded on the idea that the entire healthcare system – its therapists and other personnel as well as its patients/consumers – will benefit from truly listening to the people have undergone or are currently undergoing rehabilitative processes, and providing them with tools that will enable them to become professionals actively working in the field. This program helps people process traumatic events, deal with social and personal stigma, and to transform them and their experiential knowledge into beneficial resources in the healthcare system. Its starting point is the hope that every crisis event can be of real value for the person and for others, given the proper infrastructure. This type of treatment is most commonly given in community settings, not in an isolated setting such as a closed ward in a hospital.

The case study demonstrates how group therapy using psychodrama may create such an infrastructure. During the encounters, participants moved between three elements: action, sharing, and processing. Action refers to bringing the experience in the “here and now.” Sharing evokes a sense of being seen by others (visibility), validity, shared fate, and belonging. Processing entails assistance in transforming the traumatic experience into valuable knowledge for the individual and for others.

The group work used the CHIME model (Connectedness, Hope, Identity, Meaning and Empowerment). This model emerged from a study of the consumer movement in mental health, in which hundreds of people who underwent beneficial rehabilitation were asked what helped them grow.

The CHIME model is comprised of five potential responses to trauma that promote PTG. People coping with trauma noted that rehabilitation was beneficial when service providers supported them in these aspects:

**Connectedness**: Strengthening their sense of connection and belonging, identifying with their problems, and providers who shared their own difficulties.

**Hope**: Offering hope in a proactive way, rather than reinforcing a sense of desperation; encouraging them to set goals and objectives during the process.

**Identity**: Helping them process, accept their illness, and find value in the personal crisis, for themselves and others.

**Meaning**: Helping them connect with factors that offered them meaning, such as faith, friends, and work.

**Empowerment**: Helping them understand how to advocate for themselves and express their desires to authority figures such as parents, psychiatrists, and therapists, insisting that they make choices in the process, based on the idea that people are experts on their own lives.

The psychodrama group presented in this case study was found to be a suitable therapeutic space for work according to the CHIME model. Psychodrama is a proactive approach, according to which patients are actively involved in their own treatment. Instead of passively “lying on the couch” patients actively investigate, express themselves and communicate with others in the group.

This case study investigated how a psychodrama approach can promote PTG among people coping with trauma, and the various factors needed to promote recovery. Participants in the group used improvisation, games, drama, role reversal, and group discussion to encourage PTG.

The psychodrama group was part of the Consumer-Providers program, and the participants were mainly people with experiential knowledge. The group was led by two moderators. Master’s degree students in psychodrama also participated in the group, as part of their education and clinical training. The students’ role involved helping with modeling, reaching out, establishing contact, and more. The group activity lasted about eight months.

People coping with mental illnesses were accepted into the group if they indicated that they were ready to commit to it and viewed it as part of their personal rehabilitation process. Before being accepted, they were interviewed by the facilitators to determine whether they were suitable for the group.

**Quotes and Excerpts from the Psychodrama Group Therapy**

**First Steps: Contact with the Trauma Through the “Here and Now“ Technique**

The purpose of the first meeting was for participants to get to know each other and create a suitable setting for the process. The facilitators led group games and dramatic activities towards this goal.

At the beginning of the first meeting, participants became aware that there were also students in the group. In an attempt to determine who was a student and who was in treatment, participant M initiated this interaction with S:

M: You’re a student.

S: I’m a ‘struggler‘ [with mental illness]

M: You don’t look like it.

This dialogue took place during a short break after a group getting-acquainted activity, and before they sat back in the circle. The incident was repeated during a group conversation, and S ran out of the room. One of the facilitators went after her and tried to bring her back, but without success.

When S left the room, a storm of emotions erupted among the group. Participants expressed strong feelings about the incident, including confusion and embarrassment alongside feelings of security and the desire to participate in the group, to get to know each other, and to get out of one’s comfort zone. Questions were raised regarding how much it was appropriate for participants to disclose about themselves.

In order to process participants’ excitement and strong emotions regarding the first meeting, including the “acting out” that occurred, and to translate them into an initial outcome that would help them understand the needs of the group, the facilitators initiated a psychodrama activity. They placed two empty chairs in the circle and invited participants to sit on one chair and respond to the question: “What do I need from the group?” and then to sit in the second chair and respond to the question: “What do we need as a group?” They expressed the need as individuals for acceptance, non-judgment, and inclusion, and the needs of the group as recognition, time, boundaries, and security.

The trauma of being diagnosed as “mentally ill” may cause a person to feel that they have lost their previous self-identity and embarked on a new life path in which their whole identity is encompassed by this label. Therefore, in the first meeting, it was possible to sense the great anxiety in the room regarding the distinction between the students and the people struggling with mental illness (from here: “strugglers”). Moving through this challenge allowed the participants to progress towards a clearer understanding of the group’s function, and their expectations that it would help them rectify their experiences as people struggling with mental illness in society. Having faced this personal labelling and social stigmatization gave rise to the expectation that the group should serve an accepting, inclusive, and non-judgmental space.

In subsequent meetings, participants continued to process this topic with greater freedom, to ask questions, wonder, and make choices.

S: What happened last week, the tension between “struggler” and “non-struggler,” followed me all week. I encountered it a lot in my life.

M: Me too. As a service provider-consumer I dealt with this question at work: whether, and to what extent, should I share that I’m also a struggler?

**M’s Psychodrama: Diagnosis as a Threat to Identity**

The facilitator asked M if she wanted to participate in the group activity that day. M hesitated for a moment, then answered in the affirmative. M chose to enact a scene located in a hospital day ward.

M: “I want to bring in the hospitalized people, the personal therapist, and the psychiatrist.”

M picked group members to serve as auxiliary egos, representing the characters she chose to bring to the psychodrama stage. The facilitator invited M to say a sentence or two as she brought each participant onto the stage.

As M called them up, they said things such as: “M, we want to get to know you, look inside. You are special and interesting. You intrigue us.”

The personal therapist said: “I came to lift all you people up! I know what needs to be done, and I came to do it fast.”

The psychiatrist: “I don’t have much time. We should raise the level of the requirements for functioning. I passed the information on to your personal therapist.”

As M responded to each, she responded to the other hospitalized patients cordially, to the individual therapist with contempt, and to the psychiatrist with disdain and anger.

M: “You all don’t look inside me, only from the outside, like that saying about the jug. Your diagnosis of me is wrong and I really want you to change it, so that I can receive treatment that suits me.”

The facilitator suggested that M invite an auxiliary ego to embody her diagnosis.

An auxiliary ego embodying the diagnosis entered as a character in the psychodrama activity. The diagnosis approached M and told her about the verdicts that the psychiatrist and therapist has passed about her. The facilitator put the document on the chair and invited M to do with it as she wished.

Facilitator: “You can even write whatever you want in it.”

M to the facilitator: “Can you crap on the diagnosis?”

The facilitator agreed to this suggestion and in a theatrical manner pretended to relieve himself.

M acted out, with evident pleasure, spreading the feces all over the diagnosis document. The participants smiled and laughed.

Following the psychodrama, the group sat in a circle and had a sharing session:

S: “I really identified with everything you did. I have some suggestions for you about how to change what is written in the document.”

H: “I also identified with it, and felt the injustice.”

Y: “I found myself in a place where sometimes I don’t see others, like the psychiatrist, and they don’t see me either.”

M expressed appreciation for everyone’s participation and for the opportunity to carry out the exercise. The reins were in her hands, and she seemed to know what she thought and what she wanted to say.

In the following meeting, a week later, M added: “This work stayed with me all week. It was meaningful for me. I brought up these things when they were fresh, so maybe they can still change.”

K added: “I was also overwhelmed by my diagnosis years ago, and by my anger about it and with the system. But today, I also work within the system. I understand it is complex. The overload is ridiculous. Everyone is collapsing.”

**Belonging and Hope: Processing, Pulse Check, and a Common Denominator for Coping**

The meeting began with time to process the protagonist’s work from the previous meeting. Then it continued, as usual, with a psychodrama group activity and a group “pulse check,” in which participants shared how they felt when they arrived, and their feelings, emotions, and thoughts at the moment.

Facilitator: K, did you have any thoughts after the activity?

K: No. I left it here and didn’t bother with it. Nobody wants to be with someone who is always sad. The group gave me the time and space to be with it, but you don’t have to be sad all the time. Come on, let’s move on, you can’t sink into this pain all day.

The facilitator began to talk, then noticed that M was crying.

M: I am 35 years old, and I have suffered my whole life. I hardly know what it’s like to be without it. What kind of life is there without pain?

The facilitator turned back to K: I have known you for some time, as a rehabilitation assistant. More than once it has happened that you helped me somehow, with your wisdom, and you encouraged me during difficult times. Maybe you have something to say to M?

K: You can go on. You must not get stuck in this place of pain.

N: I also have thoughts about life. All in all, it was a good week. I said goodbye to a struggler who I help as a rehabilitation guide. I also got an answer about getting treatment through the health fund. It seems that there will be a place available soon.

C: I’m still waiting for an answer about treatment from the health fund, for several years now... (the group laughs). I went on to private therapy.

H, a female student in the group asked: Are you currently in therapy?

C: Yes, of course.

Y: I was sick with Corona. Now, I feel that it will take me some time to return to the world. Staying at home was good, but now I have to go out again. Everyone took care of me when I was sick. They took care of me. It was nice.

Facilitator S: I was sick too. The most powerful thing for me was that my son, who I always take care of, really took the reins and showed responsibility.

Facilitator A: Really, during illness, there’s this thing that people take care of you and call you. For me, what comes up is that it feels like I’m always the one who maintains the connection with my friends. I’m always the one who calls, takes the initiative. They never do.

N: Maybe they see you as strong. You impress them.

**How the Group Pulse Check Strengthens Connectedness and Hope**

K, the oldest participant (over 60), was given the opportunity to process her experience during the meeting the previous week. As the “tribe elder” she had a special way of using the therapeutic space to strengthen a sense of connectedness, and the wisdom to address her difficulties at the right time, and to move on at the right time.

Facilitator A’s statement about how K supported him, although he is the therapist, brought their shared humanity to the forefront. K gave M hope, stemming from her life experience. In contrast to the norm in therapeutic groups, these facilitators were partners in the group dynamic. They presented themselves as emotionally vulnerable, in order to strengthening the sense of connectedness, and to transform their struggles into a unifying factor, on a human level. While despair could color the experience as monochromatic, the group dynamic can be seen as varied, including not only pain and difficulty, but also gratitude, concern, and more.

**“Pulse Check” Contributes to the Sense of Meaning**

Meaning is derived in various life realms, when someone is able to feel, “I am valued.” People struggling with mental health issues may feel a sense of meaning when they are valued by their service providers (mentors, instructors, therapists, treatment coordinators, psychodrama group leader). K received recognition when the facilitator asked her to help him by offering support to M. This showed her significance as a member of the group. As noted, participant N, told the facilitator: “Maybe they see you as strong. You impress them.” This type of role reversal, in which a person defined as a patient offers insights to the facilitator, can promote a sense of meaning.

**Connectedness and Empowerment: Who is Like Me?**

In a warm-up exercise at the beginning of one meeting, facilitator S invited the participants to play a game called: “Who, like me…?” One participant would say something true about him/herself. Then other participants for whom the statement is also true would exchange places in the circle with their friends. The warm-up exercise validates various experiences. The facilitator began with light-hearted questions, then moved to more substantial ones:

* Who, like me, prefers winter to summer?
* Who, like me, has not yet contracted Corona?
* Who, like me, smoked before the meeting?
* Who, like me, feels nervous today?
* Who, like me, does not know how to live life?
* Who, like me, has lost a loved one?

After several rounds, facilitator S placed a chair in the center of the room and invited participants to propose a question that may be relevant to others in the group.

M offered this question: How easy is it for me to receive love?

The group stood in relation to the chair in such way that standing closer indicated greater ability to receive love. K stood closest, while M. and C. stood farther away.

The facilitator’s invitation for a group member to propose a question offered a measure of empowerment. The facilitator was in effect saying: you know best which topics are important for you to explore together.

**How did M’s psychodrama strengthen the sense of identity and contribute to the sense of empowerment?**

The diagnosis of mental illness poses a significant threat to identity. People often feel that their diagnosis was an injustice and that it ignores knowledge they have gained about their own ways of coping. In the activity described above, M took the initiative, saying in effect: “you don’t make decisions about me, you don’t decide who I am or what I am.” The system had caused M to feel invisible, and this made her angry. Anger can be an engine for change among people struggling with mental illness. In this group’s work, empowerment and identity formation come together hand-in-hand. Legitimizing anger allowed M to say no, and set clear boundaries. Within these boundaries, she could redefine herself, and to say what she did want: “I deserve to be seen!”

This gave her clearer awareness of her self-identity: who I am, what is right for me, etc. This was combined with a sense of empowerment: I am allowed to correct others, I am allowed to say no. In this way, M. could comfortably, and without fear, correct the instructor about a doubling exercise he suggested at the end of the activity.

During the sharing session, it became apparent the group members felt that they collectively “owned” issues related to their diagnosis, such as the sense that an injustice had done to them and that they had become invisible. Their partnership became a source of strength and connectedness. Recalling this sense of connectedness will hopefully be a source of strength for them in any future meetings with official figures in therapeutic, rehabilitative, or social work roles who treat them in a shallow or patronizing way. Remembering that the group members validated their feelings and stand behind them may enable them to express themselves.

The facilitators again used the technique of two chairs. In the first meeting, this was done to transform the group’s “acting out” and strong emotions into a model for organizing their personal and collective needs and aspirations. The subsequent time, the activity was used to enable the participants stop for a moment to recognize what goals they have achieved and prepare themselves for the rest of their journey. A key motif in the recovery process is that the person in treatment takes action, an outgrowth of the idea that the individual is an expert on his/her own life.

Empowerment: the participants expressed the goals they want to achieve.

Hope: participants looked towards the future while setting goals and objectives.

Meaning: Participants were validated through their significance to others in the group. Meaning can be derived by taking on roles in various life realms. Participants noted, for themselves and others, the meaningful aspects of their lives that were already being expressed within the group setting and beyond it.

**N.’s Psychodrama: Islands of Connectedness and Hope when Facing the Trauma of Depression**

Facilitator: N, do you want to do the work today?

N: I’m afraid it will be at the expense of others.

Participants: It’s fine. We want you to work today.

Facilitator: You talked about the voices inside you. Maybe we will bring them?

N: S will represent Depression and Sadness.

The facilitator suggested that N should do a role reversal activity with Depression and Sadness. N said to herself, on their behalf: You are worthless.

After she went back to the role of being herself, N said: This is my first time acting, but I know this voice so well that it comes really naturally to me.

Facilitator: Is there perhaps a good friend in your life who would know how to respond to such voices?

N: Yes.

N chose a female participant to represent her friend.

Friend: You are good. You do good in the world. You are important to the world.

The participants playing N’s friend and Depression had a sort of verbal battle.

N: I need Depression to speak louder for it to be accurate.

Facilitator: Would you like more group members to express Depression, so it will speak at a really high volume?

N: Yes.

Three group members embodied Depression and shouted: You are worth nothing! You are nothing!

N shed a tear.

Facilitator: Maybe we need the friend? Should we hear her alone?

N: Yes.

Friend: You are good for the world. You are great! You have a lot of positive things inside you, even though these voices are overwhelming you now. Remember the goodness and beauty inside you. You are important.

Facilitator: I see that this experience is still difficult. It’s hard for you to trust your friend at all.

N: Yes.

Facilitator: How would you like to end the psychodrama?

N: If possible, everyone here, including my friend, Depression, and everyone else will stand with me in the circle.

In the circle, N turned to the voice of Depression and said: Life is shitty.

Then N turned to the rest of the circle and said: We are good people. Everything will be fine.

**Sharing**

C: I really connected with how your friend sees you. I also see you like that: someone who is stable and cooperative, who has a lot of courage and is an inspiration for the group.

H: These voices are very familiar to me. For the past two months, these were the voices in my head. They did not stop eating my brain with a spoon.

At the end, the facilitator invited each participant to say one word. They offered words such as: courage, boldness, liberation and optimism.

**Interim Summary of the Group Process: Experiences of Empowerment, Hope and Meaning**

The facilitator invited the participants to make an interim summary of the group process. He added two chairs to the circle. Each person sat in one chair and responded to the question: What have I received from this group? Then they moved to the second chair and responded to the question: What would I still like to receive?

S: I received security in my life, at work, and with my family. There are special people here who are inclusive and accepting. I want to gain more confidence later.

K: I received inclusion and support during my most difficult times. I want it to continue like this, the same.

S: I received assurance. In the future, I want to overcome my embarrassment, to participate more in the psychodrama activities that I avoided here.

C: I got more confidence to be who I am. Little by little, I feel more comfortable talking. The work I did was meaningful to me. (C turned to the group): Continue to be as you are, you are perfect.

M: I got a spark of light during a very difficult time, a place to come to. I’m happy to see these people. Regarding the continuation: I want to learn how to make a separation. What does the process of separating look like? If there is such a thing as a good separation, what is the difference between a separation and a loss?

Y: I got more confidence in various areas of my life.

**M’s Psychodrama: Empowerment and Returning the Power of Choice in the Face of Trauma**

M chose to act as the protagonist and said: I’m debating whether to go to a private hospital and if so, which one. I understand that just because I can suffer so much, it doesn’t mean I have to suffer. Because these days are really hard. I have constant thoughts, and they are difficult.

M chose H to be an auxiliary ego representing the difficult thoughts.

The person acting as M’s difficult thoughts said: We won’t stop bothering M from the moment she wakes up. We make M feel as small as the circle we make with our hands, as if there is nothing but us, the difficult thoughts.

M: It goes on like this until the time when the medication wears off, and then I feel better. After that time, something comes that brings it out and reminds me that good things exist.

The facilitator asked what happens at this time, what that time brings with it.

M: It widens the circle and reminds M that she is more than just hard thoughts... It brings spirit, strength, faith.

Some group members embodied the difficult thoughts and others embodied the hour and the spirit, strength and faith it brings.

M: I have no control over when the hour will come!

Facilitator: I suggest allowing you to be in control. We will act out your whole day in fast motion, from beginning to end, and you will have the remote control in your hand.

The participants representing the Hour, Spirit, Strength, and Faith were sent to wait on the other side of the room until she called them.

The facilitated gave M an actual remote control device.

Participants representing the difficult thoughts kept repeating in a loop: We won’t stop bothering M from the moment she wakes up. We make M feel as small as the circle we make with our hands, as if there is nothing but us, the difficult thoughts.

M did not choose to press the remote control until, at the facilitator’s request, the participants representing the Hour, Spirit, Strength, and Faith moved towards M. When M saw them, she pressed the remote control to silence the difficult thoughts. The Hour physically widened the circle that the difficult thoughts had created around M, while Spirit, Strength and Faith offered words of support and strength.

After the activity, the facilitator asked M how she felt.

M said: Even when I had the remote control and could stop the thoughts, I still didn’t. This goes back to what I said at the beginning, about the ability to experience suffering, and that I don’t really have to suffer.

**K: Encounter with Traumas Throughout Life**

During a guided imagination activity, participants were invited to go through various places in their life and then share.

K: Me, for example, I have been through a lot of pain in my life. My illness, my daughter’s illness, my son’s illness, the divorce, separation from parents, separation from my siblings. Usually, I would fight and move on.

Facilitator: When you closed your eyes, where did you end up?

K: In my parents’ house in Turkey. We had a door with a huge key. I saw and experienced terrible things there.

Facilitator: Come, stand up. During this activity, all these painful events will join at random.

K stood. Group members embodied the painful events in her life: her illness, her daughter’s illness, her son’s illness, the divorce, separation from parents, separation from siblings. One by one, a participant joined the line, faced her, and send something.

At the end, K said: The hardest thing is not that I was sick, it’s that my children got sick. This is the hardest.

**Sharing: Trauma as an Enabler of Growth**

Facilitator: I treat my injury as something life-changing. If it wasn’t for that injury, I wouldn’t be here today, doing this profession, so it’s really kind of a gift.

N: I have some trouble with defining it as a gift. It’s true that good things came of it. I learned to listen to myself and deal with many things. But I do sometimes wonder, why was this necessary? The depression and difficult things? It would have been better if those things hadn’t happened.

**Expressing Suicidal Thoughts in a Group**

N: This space is pretty much the only one where I can mention the voice that says, ‘I want to die.’ In most places, this is not accepted. They immediately think all kinds of things about me.

Facilitator: The truth is, I also have such a voice inside me. But this week, I actually thought about the fact that I am allowed to live. Sometimes we are afraid of living.

Co-facilitator: In addition to legitimizing the voice, I admit that I worried about you this week. I was wondering how you are. Your statement, ‘I want to die’ did make me afraid.

N. laughed: I hope you are not reporting me.

R: This week, I thought about how it is good to say out loud what you feel inside. It’s good, N, that you have this simple ability.

M: It’s really okay to want to die. We want many things.

K: This morning I felt like I wanted to die, so I just put it off. I moved it aside.

**Returning to the Group after Involuntary Hospitalization**

M returned from hospitalization and the facilitators invited her to share her experience.

M: It was difficult. The hardest thing I’ve gone through until now. All the worst thoughts about what this place was, and all the movies about a madhouse. So that’s it. My father had me involuntarily hospitalized. It was really hard for me. He told me he was doing it from a place of wanting to guide and teach me. There was no room for compassion towards me. Before the hospitalization, there were a few days without a phone. I wasn’t in good condition at all. The more I resisted, the more physical pressure was put on me. It was a forced hospitalization. The conditions in the ward were really difficult. I was treated like I wasn’t human. There was a moment when a crazy woman grabbed my legs in the hallway. Even in the bathroom, I didn’t have a moment of privacy. My belongings were stolen. Someone turned my sock inside out while I was sleeping. Basically, all private space was gone, all basic freedom to exist was ruined. I saw a lot of other people’s pain there. I was frustrated that I couldn’t help them. In all this, there were some small moments of humanity, for example a nurse who brought me a lock. Little moments of light.

The facilitator invited participants to respond and share their thoughts, but emphasized not to ask technical questions.

N: Wow, you did it fast. Lickety-split.

M: It felt like forever. Every day was like three days.

N: I wanted to visit you, but I didn’t know if it was appropriate or not.

M: It’s not too late to visit.

S: I also wanted to visit you, bring you a lot of chocolates. I want to have a party to celebrate that you got out of there and are back with us.

C: The truth is, while M was in there, I saw her, as a service consumer-provider. I came with an employee card and badge and visited her. I wondered, what the hell is she doing here?! She participated in a group I organized. Played music. For a few minutes, it even seemed to me that it was good for her.

M: How fun that you remind me that there was a moment like that too.

Participants asked C why he didn’t tell the group about the meeting

C: I wanted to protect M’s privacy.

**Theoretical Discussion: The Relationship between Mental Illness and Post-trauma**

Mental illness is a traumatic experience, and colors the person’s self-image, routine, and life. This type of trauma has several aspects:

**Isolation/loneliness**: People diagnosed with mental illness often feel like strangers in society. They feel like no one understands them, that they don’t even understand themselves. Their ability to understand society and social codes has been undermined. The emotional crisis takes the person away from a functioning role in society and into physical isolation, whether in a psychiatric hospital or at home. Added to this is the social and personal stigma that makes a person feel that they are fundamentally “damaged,” rather than suffering from an illness.

**Despair**: Mental illness can lead to severe feelings of despair, an inability to see how life can continue. They lack the motivation to take initiative and move forward, and may be apathetic about life. In extreme cases, these feelings lead the sufferer to harm themselves or even suicidal behaviors.

**Identity crisis**: Mental illness causes trauma at the level of self-identity. People may feel their sense of self has disappeared, leaving a vacuum, which is often filled with other people’s stigmatized perceptions. They feel like they are moving through life with a large question mark on their back. Sometimes they try to hold on to what used to be, but this does not allow for a compassionate and benevolent integration of the new reality into their identity.

**Loss of meaning**. People living with mental illness may lose contact with elements that used to give their lives meaning: friends, family, work, hobbies, dreams and ambitions.

**Inability to cope**. People living with mental illness may have trouble getting motivated and making decisions about life. In practice, they are hardly allowed to make any choices. Family members may choose what type of treatment they receive. A psychiatrist makes the diagnosis. They may be transferred from place to place, from a hospital to a group and back home, while being medicated and restrained multiple times.

Trauma is generally a physical or mental/emotional injury caused by an external event such as an attack, disaster, serious accident, war, etc. A possible response is the development of PTSD, with symptoms such as obsessive thoughts, hyperarousal, and avoidance of stimuli that remind the person of the traumatic event (Ehlers & Clarke, 2000). Some researchers have asserted that exposure to a traumatic event alone is not enough for PTSD to develop (Brewin et al., 2000). A number of factors that significantly affect the development of PTSD among adults have been identified: flashbacks of previous traumas, difficulties in adjusting, family history of genetic predisposition to psychiatric illnesses, perceived sense of threat at the time of the traumatic event, and emotional response at the time of the event (Ozer et al., 2003). Other significant variables in the development of PTSD include the severity of the trauma, degree of social support, and stress in the person’s life (Brewin et al., 2000).

Many people with serious mental illness (SMI) as defined in the Diagnostic and Statistical Manual*of Mental Disorders* (DSM) have experienced traumatic life events. Studies indicate a higher rate of PTSD among people with SMI as compared to the general population (Lomenn & Restifo, 2009; Morrison et al, 2003; Mueser et al., 2002). Traumatic events may be a catalyst for both the onset of PTSD and the onset of psychosis or SMI (Morrison et al., 2003; Read & Argyle, 1999).

Diagnosis of a mental illness or the experience of a psychotic episode may contribute to the emergence of PTSD (Frame & Morrison, 2001; Shaw et al., 2002). A study among adults who had been hospitalized in a psychiatric hospital for a mental illness found that 67% of them reported symptoms of PTSD during the hospitalization and 50% reported significant symptoms even 4-6 months after the hospitalization (Frame & Morrison, 2001). A study conducted among people aged 16-65 who had been hospitalized following a psychotic episode found symptoms of post-psychotic PTSD (PP/PTSD) among over half (52.3%) of the study population, regardless of demographic characteristics, previous trauma, or type of treatment (Shaw et al., 2002).

Another study of trauma and mental illness, conducted among people aged 14-30 who were in treatment following one or two psychotic episodes, found symptoms of PTSD in 66% of the participants, and 39% were diagnosed as suffering from full PTSD; these figures were not related to the nature of the traumatic event (Mueser et al., 2010).

In addition to studies indicating the traumatic aspect of living with SMI, psychotic episodes, diagnosis, treatment, and hospitalization, it is possible that psychosis or an outbreak of SMI can also be a response to trauma. Studies have found a higher rate of childhood sexual and physical abuse and other traumatic life events among people with SMI as compared to the general population (Morrison et al., 2003). A study among 200 patients being treated in community settings found a high correlation between experiences of sexual abuse (in childhood or adulthood) and symptoms of schizophrenia (Read & Argyle, 1999). Another study found that patients who had been sexually abused in childhood were more likely to report having psychotic symptoms (Ross, Anderson & Clark, 1994). According to the research, schizophrenia may develop either through endogenous activation, characterized by negative symptoms, or as a result of trauma in early life, characterized by positive symptoms.

Lommen et al. (2009) found that prior traumatic experiences among psychiatric patients tended to be under-reported. In a questionnaire, 97% of the study participants (aged 21-63) reported at least one traumatic event during their lifetime, but only about 70% of these events were recorded in the medical records, and none of them was given a diagnosis of PTSD during the treatment. The authors concluded that it is important to routinely assess traumatic history and PTSD among patients with schizophrenia and schizoaffective disorder because identification of these factors can suggest more effective treatment methods.

Further confirmation that trauma can lead to the onset of SMI or psychosis can be found in studies of Holocaust survivors. A relatively high percentage exhibit psychotic symptoms consistent with schizophrenia, which is attributed to the trauma they experienced in the concentration camps. Thus, according to these diagnoses, they are simultaneously dealing with schizophrenia and PTSD (Morrison et al., 2003).

In conclusion, the etiology of psychosis is a topic of ongoing debate, but many studies indicate that traumatic life experiences play a significant role in the development of mental illnesses and psychotic incidents. However, most studies in this field have limitations. Most were conducted on small samples, even individual case studies, which creates difficulty in achieving statistical significance. Some were not empirical, or the sample was not random. Most studies were based on self-reports of the traumatic event and the relevant symptoms. Additionally, there are significant technical and ethical concerns regarding doing research among people with serious mental illnesses or people living in difficult life situations.