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The Use of Drama Therapy to Create Safety in Psychoeducational Groups for Complex Trauma: The Development of a Method Using Ritual, Embodied Metaphor and Play

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The use of drama therapy to create safety in psychoeducational groups for complex trauma:

The development of a method using ritual, embodied metaphor and play.

Capstone Thesis

Lesley University

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Drama Therapy

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Abstract

In this research, I developed a method to bring drama therapy into psychoeducational groups that serve clients who have survived complex trauma. Through the use of play, metaphor, group ritual, embodiment and laughter, I explored the use of drama therapy to increase the experience of a group member's feeling of safety which I perceived in their capacity to take individual risks and to connect with other group members. I facilitated two separate psychoeducational groups that occurred over the course of 12 weeks, incorporating these elements of drama therapy, and reflected upon my experience of these interventions. Throughout the process, I asked "How can drama therapy help in the successful formation of a group to allow members to feel safe enough to do the trauma work and to take risks?" The data was coded around themes of containment and structure, the group member's perceived experience of fear, varied options for individual participation, and the use of the facilitator as a play object.

The results suggest that the use of drama therapy techniques allowed group members to choose their level of participation, have control of their own degree of sharing, and even opt out without having to completely disengage with the group. The method seemed to allow group members to work at their own pace, engage with others to their own level of comfort, and build a sense of group cohesion through play.

This method may potentially offer other psychoeducational or skills groups a way to support clients' experience of safety through the experience of group cohesion, the ability to access a higher level of embodiment, and opportunity have fun, which potentially may increase their participation and engagement.

 Key words: Drama therapy, trauma, complex trauma, ritual, play, psychoeducation, group therapy, safety.

The use of drama therapy in psychoeducational groups for complex trauma: the development of a method using ritual, embodied metaphor and play

We used our hands – we put them out to see how big the imaginary tree was. All the hands were facing each other and we saw a huge trunk. We felt the texture of its bark. We decided on its species, the time of year, the healthiness of the tree. We made jokes about how big the trunk was. Some noted that their hands were tingling.

Introduction

In this thesis, I will examine the use of drama therapy and its application to psychoeducational groups for individuals who have Complex Post Traumatic Stress Disorder (CPTSD). I will specifically explore the use of drama therapy within these groups as a tool to increase the experience of a group member's feeling of safety, both in themselves as well as within the group. This research question is drawn from the legacy of trauma scholars and clinicians who name the creation of safety as a crucial goal when working with individuals who have survived complex trauma histories. (Herman, 1992; van der Kolk, 2005; Courtois; 2004). This inquiry also comes from my own experience as a facilitator for trauma groups consisting of CPTSD clients, which has occurred at both of my internship sites in the past two years. At these sites, the creation of safety has been named by my supervisors as a priority in group work with this population in particular.

Within the field of complex trauma treatment, scholars who discuss safety are looking for ways for CPTSD clients to successfully do the trauma work. Most seem to agree that safety is a crucial factor in a client's ability to do the work of healing. However, they have differing beliefs around how this safety is created. For some, the work relies on the following strategies: 1- Restoring control to the group members primarily by giving them each the option to not participate in group activities if they don't feel comfortable and 2- The stated avoidance of the

clients' traumatic material during group– or perhaps, differently stated: the establishment of

safety and stability *before* trauma processing can occur (Herman, 1992; Courtois, 2004). Others

do the work of creating safety by actually *including* the individual group member's trauma

disclosure as a necessary part of the group. These clinicians state that, in fact, this disclosure is a

key component of the establishment safety (Lubin & Johnson, 2008).

In this thesis, I seek to contribute to the conversation of how safety gets created in

groups, but to do so without focusing on the discussion surrounding client disclosure. I explore

what tools drama therapy may have to add to the process of safety creation specifically within a

group so that there can be more possibilities to answering this question. I am interested in how

drama therapy may be uniquely positioned to create safety by inviting members *in* to experience

connection with other group members, to feel connected to their bodies and to be able to take

risks. I look at how drama therapy could be a useful tool regardless of whether the group is

working with, or avoiding the disclosure of members' traumatic histories.

In order to do this, I co-facilitated 12 sessions of psychoeducational groups at my

internship site, a community mental health clinic in Central Vermont. The groups were

comprised of individuals who have complex trauma histories. I brought drama therapy into these

group processes, week after week, and consistently reflected upon each group after the fact in the

form of journal entries. I made observations about how I perceived the drama therapy to be

effective or ineffective in creating elements of safety within the group dynamic. I tracked safety

in the group member's ability to connect with others, to share themselves, and to take individual

risks. I observed what the group members shared, and how they shared it. I observed elements of

group dynamic and the relationships of the group members to the facilitators. These journal

entries were coded for themes and my research draws from the results of this coding. Throughout

the process, I asked "How can drama therapy help in the successful formation of a group of individuals who have CPTSD so they feel safe enough to allow them to do trauma work. I posit that the drama therapy method allows this to happen in a unique way.

Author's Position

My personal opinion surrounding the clinical conversation around disclosure is that there is much more at play in the culture of trauma disclosure than simply the clinical truths around what is best for the client. I am of the opinion that the clinician's fear of a client's trauma often reflects a cultural fear and silencing of trauma, and that this is often insidiously at play in clinical spaces. Whether or not it may be clinically advisable to ask clients to wait on the processing of traumatic material, there may be a dangerous side effect to this protocol when used as policy, which is that the client may experience shame due to the clinician's avoidance or it may reinforce the client's own avoidance, which is part of the symptom profile of PTSD and CT.

Additionally, the clinician's fear of re-traumatization, in one way or another, does not offer therapeutic spaces of engagement. I am concerned that, instead, contributes to the already present avoidance of interpersonal connection, embodiment, and risk taking that often are already a difficulty for complex trauma clients. This bias is not necessarily in reaction to my experience of the clinical choices made around when to ask clients to disclose, nor do I oppose the methods that advocate for CPTSD clients to learn to self-regulate before going into the processing of their histories which may be masterfully tucked away and managed. However, I *am* concerned about how the culture around this clinical perspective affects a clinician's capacity to sit with a client's material and therefore, how it affects client's experience of safety and shame. This thesis comes from a desire to find ways to invite clients in, to celebrate their sharing of themselves, and ask them to take risks in vulnerability, even within the context of my site where disclosure is advised against during psychoeducational groups.

Literature Reveiw

What is Complex Trauma?

The term complex trauma (CT) references a specific movement within the clinical field of the treatment of traumatic stress. A thorough and complete dive into the nature of CT or Complex Post Traumatic Stress Disorder (CPTSD) as it is described by some members in the field, is not the subject of this thesis, however a simple definition must be provided as it relates to the symptoms that the methods introduced are designed to address and respond to. CPTSD is defined by Bessel van der Kolk (2005) as "The experience of multiple and/or chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and early-life onset" (p. 2).

CPTSD is distinct from Post - Traumatic Stress Disorder (PTSD), which is typically the result of an individual's response to a one-time traumatic event. As summarized by van der Kolk and Christine Courtois (2005), the diagnosis for PTSD "Focused on three categories of symptoms: re-experiencing, numbing and hyperarousal as the core criteria for making the diagnosis (p. 385). Though the diagnosis of PTSD was created in 1970 in response to the psychiatric problems that were experienced by veterans returning from Vietnam; the disorder was, and has, not been limited to wartime trauma. Symptomology of PTSD as a diagnosis has been used to diagnose a wide range of victim populations including "Rape victims, refugees, and victims of accidents, disasters, child abuse, and other forms of domestic violence" (p. 385). However, the PTSD diagnosis does not encapsulate a large portion of trauma survivors; this awareness led to the introduction of CT and CPTSD as a concept in the field.

CPTSD entered the discussion in 1992 when Judith Herman released a book entitled *Trauma and Recovery*, detailing the need for a new trauma diagnosis that took into account the

experience of people who, as van der Kolk (2005) stated, had experienced chronic, repeated

trauma, oftentimes beginning at an early age. The symptoms that these clients present are not

covered in the PTSD diagnosis because, as Herman (1992) highlights, these clients may often

come in for treatment with complaints of physical symptoms, chronic insomnia, anxiety,

depression, or relationship problems (p.157). Herman argues that the symptom picture of these

clients is more complex than that of client suffering from PTSD (p. 116). She proposes a

diagnosis Complex Post Traumatic Stress Disorder (CPTSD) which would include a "Spectrum

of conditions rather than as a single disorder" (p. 119). The symptoms as she identifies them

include: 1- A history of subjection to totalitarian control over a prolonged period (month to

years), 2 - Alterations in affect regulation, 3 - Alterations in consciousness, 4 - Alterations in

self-perception, 5 - Alterations in perception of perpetrator, 6 - Alterations in relations with

others, and 7 - Alterations in systems of meaning.

  Christine Courtois (2004) further describes the difference between CPTSD and PTSD in

her article "Complex trauma, complex reactions: Assessment and treatment." She states that:

   Individuals exposed to trauma over a variety of time, spaces, and developmental periods

   suffered from a variety of psychological problems not included in the diagnosis of PTSD,

   including depression, anxiety, self-hatred, dissociation, substance abuse, self-destructive

   and risk-taking behaviors, re-victimization, problems with interpersonal and intimate

   relationships (including parenting) medical and somatic concerns and despair. (p. 413)

Bessel van der Kolk (2005) collaborated both with Courtois *and* Herman to support new

diagnostic criteria for the same populations. He was instrumental in the creation of an alternate

diagnosis called Disorders of extreme stress; Not otherwise identified (DESNOS). Though this

diagnosis did not get accepted into the DSM when it was proposed, van der Kolk continued to do

further research into the populations that were most likely to fulfill a DESNOS

symptomology. It was found that chronic interpersonal trauma at an early age was more likely to

produce the DESNOS symptomology than trauma occurring later in life (van der Kolk, et al.,

2005). Van der Kolk (2009) has since focused on how the experience of (specifically) early

childhood trauma creates the CPTSD symptomology and eventually, he proposed that a

diagnosis of Developmental Trauma Disorder (DTD) should be added to the DSM V. Though

again, this addition was not made, the field of traumatic stress continues to consider

Developmental Trauma as a significant category of traumatic stress.

   Marylene Cloitre et al. (2009) in collaboration with van der Kolk among others, explore

further the results of early developmental trauma as it correlates to symptom complexity in

adults. Their studies suggest that exposure to multiple or repeated forms of maltreatment and

trauma in childhood can lead to outcomes that are not simply *more severe* than the results of

single incident trauma, but are qualitatively different in their tendency to affect multiple affective

and interpersonal domains. In childhood, traumas are comprised not only of acts of commission

(such as sexual assault), but of acts of omission as well (such as neglect or abandonment) where

the absence or withdrawal of certain resources may create a threat to the child's survival and

physical well-being. Such events can be argued, in many cases, to in fact create actual harm just

as a prototypical trauma would, or to create the threat of harm to the person. Their findings

support van der Kolk's proposal for an additional diagnostic category for those who have

suffered from repeated trauma as children, Developmental Trauma Disorder (DTD). Cloitre et

al. (2009) state:

   These data suggest that lifetime cumulative trauma is related to symptom complexity due

      to the presence of childhood cumulative trauma. Moreover, the relationship between

cumulative trauma and symptom complexity was found in a sample of children and

adolescents. Thus, the results of the two studies together suggest that childhood

cumulative trauma is associated in a rule-governed way to a complex symptom set and

that childhood cumulative trauma significantly influences the presence of these

symptoms in adulthood. (p. 405)

This is significant and important research because it dictates the need to treat DT and CT as their

own pathologies. Authors (2009) suggest that, currently, patients are diagnosed with co-morbid

conditions when they present with the sort of symptom complexity present in those who have

suffered from chronic, early trauma. This may result in the treatment of those multiple

conditions, rather than the treatment of the trauma which is the initial source of the distress.

Similarly, Herman (1992) also describes the importance of this client population

receiving specific treatment according to their trauma history. She highlights the political and

cultural context in which survivors of CT are stigmatized and inappropriately treated. She

described how individuals, (oftentimes women), are the victims of chronic abuse and then, when

seeking help, are misdiagnosed as having personality disorders. Herman highlights a sexist

tendency to blame the victim for their own abuse, and that this tendency was interfering with the

diagnosing and treatment of these women because treatment was not addressing their trauma.

She states, "Instead of conceptualizing the psychopathology of the victim as a response to an

abusive situation, mental health professionals have frequently attributed the abusive situation to

the victim's presumed underlying psychopathology" (p. 116). This political critique serves to

highlight how important it is for the trauma field to have an understanding of CPTSD, its

presentation, and appropriate treatment.

In conclusion, recent findings in the field of CT and DT suggest that those who have

experienced trauma at an early age, those who have had recurrent trauma starting in childhood, and those who have experience multiple and varied traumas as adults all have symptom complexity that results in very distinct pathology to the traditional PTSD diagnosis. This distinct pathology calls for distinct treatment.

As detailed above, there are many terms that have been used to define the symptomology that Herman began to outline in 1992; the most common include CPTSD, DESNOS, DTD. Throughout the course of this thesis, for the sake of clarity, I will be using the term CPTSD.

Treatment of Complex Trauma

As the subject of this thesis is group work in the treatment of CPTSD, I mostly focused my study on the literature that describes group trauma treatment methods, and how group treatment has been adapted to work with this particular population. There are a variety of approaches that have been developed to treat CPTSD in groups. As mentioned above, two of the primary symptoms for individuals who have suffered from CPTSD, are 1- Difficulty with safety within relationships (Courtois, 2004) and 2- Difficulty with self-regulation (Herman, 1992; van der Kolk; 2005; Courtois, 2004; Cloitre, 2005). A group environment increases the demand for both of these skills. Though groups can be uniquely therapeutic for those with CPTSD, particularly because they provide a safer place to engage the relational difficulties (Herman, 1992; Frydman and McLellan, 2014; Crenshaw, 2006), Herman (1992) also notes that groups can be places of increased stress and trigger. In this context, Herman emphasizes the importance of safety being the main focus of any group process for survivors of CPTSD. She states that if a group loses this focus on safety, group members can "Easily frighten each other with both the horrors of past experiences and the dangers of their present lives" (p. 219). Though Herman does

not specifically describe what she means by *safety*, she does describe what it is like when safety

is *safety* is not present. She states:

> Survivors often feel unsafe in their bodies. Their emotions and their thinking feel out of
>
> control. They also feel unsafe in relationship to other people…Establishing safety begins
>
> by focusing on control of the body and gradually moves outward toward control of the
>
> environment… (p.161)

Though the importance of establishing safety is consistently noted as crucial in both individual

and group work with CPTSD, the *ways* that safety is *achieved* are not consistent across different

therapeutic approaches. As mentioned in the introduction, some professionals believe in the

creation of safety through an avoidance of discussing traumatic material altogether (Rathus et al.,

2014), or a delay in the discussion of traumatic material *until* safety, control and individual

resources and stability have been achieved (Herman, 1992; Cloitre, 2009; Courtois, 2004).

Others believe that the discussion of the traumatic material is a critical step *towards* the creation

of safety and stability (Johnson, 2014; Lubin and Johnson, 2008, Mayor and Dotto, 2014). Other

treatment methods fall somewhere in the middle of these two perspectives (Frydman and

McLellan, 2014; Sajnani et al., 2014).

As this thesis seeks to explore how to use drama therapy as a way to create safety that

invites group members into participation and risk taking, the next section of the literature review

will focus on how different group treatment modalities describe the process of creating safety for

group members. My hope is to situate the drama therapy interventions within the larger

conversation around how to create safety in a group of CPTSD client.

Stage models of trauma treatment. The stage-based model of trauma treatment is a

popular approach to the treatment of CPTSD. Herman (1992), who originated this approach,

dictates a 3-stage model that, she claims, mirrors the complexity and stage-oriented nature of

recovery. Briefly stated, Stage One's task includes: the establishment of safety; Stage Two

centers around mourning and includes the processing of the traumatic experience; Stage Three

focuses on reconnection to life and moving forward. She does, however, qualify that these stages

are not rigid, nor are they identical for each client. She states that "A form of therapy that may be

useful for a patient at one stage may be of little use or even harmful to the same patient at

another stage" (p. 156). Stage One will be the focus of this section of the literature review as it

relates to the establishment of safety.

In service of the Stage One goal of establishing safety, Herman names the importance of,

firstly, restoring control to the individual, as trauma "Robs the victim of a sense of power and

control" (p. 159). Herman is referring here to therapeutic work with any CPTSD client, not

necessarily in groups and Herman states that no other therapeutic work can be accomplished

without this initial piece having been established. She identifies that survivors feel unsafe in their

bodies in relationship to others, in their thinking, and in their emotions and so "Therapy must

address the patients' safety concerns in all of these domains" (p. 160). In Stage One groups,

therefore, Herman (1992) says that facilitators should focus on "Exchanging information on

traumatic syndromes," and "Identifying common symptom patterns, and sharing strategies for

self-care and self-protection" (p. 210) and that the group must be focused more on education,

cognition, and members' strengths, rather than past experience.

Herman (1992) states that the strength and structure of the group container is critical. It is

important to note that Herman distinguishes between group connection and the group container.

She states that safety is not necessarily about group cohesion. Instead, "Safety inheres in the

rules of anonymity and confidentiality and in the educational approach of the group" (p. 220).

For Herman, the discussion of the traumatic material does not come until Stage Two, and does not come at all, until group members have successfully completed Stage One.

Christine Courtois (2004) builds off of Herman's approach to treatment and also supports a three - staged model. She speaks specifically about the challenges of treating those with CPTSD due to the complexity of their symptoms. She states that, "Exposing these patients too directly to their trauma history in the absence of their ability to maintain safety in their lives can lead to re-traumatization" (p. 415). Specifically, in regards to safety, she states that safety is "Defined broadly and involves real and perceived injury and threats to self and to and from others" (p. 419). She cites that the most recommended treatment approach is "A meta-model that encourages careful sequencing of therapeutic activities and tasks, with specific initial attention to the individual's safety and ability to regulate his or her emotional state" (p. 417). Courtois' Stage One focuses on "Pretreatment issues, treatment frame, alliance-building, safety, affect regulation, stabilization, skill-building, education, self-care, and support" (p. 418). Treatment from the beginning should be working to help the client believe that safety is possible and attainable and to move away from the trauma-informed "cognition" (p. 419) that one can never ever be safe.

Trauma Focused Cognitive Behavioral Therapy is another form of therapy that is used with CPTSD clients. Specifically, in regards to working with youth with CPTSD, Cohen et al., (2012) also describe a phase model of treatment. The stages are slightly different in this behavioral model but do follow a similar trajectory as Herman (1992) and Courtois (2004). Phase One, entitled Coping Skills, focuses on enhancing safety, creating a safety plan, working to create safety in the youth's environment at home, psychoeducation (both with parents and youth), relaxation, emotional regulation skills, and cognitive coping skills. Phase Two includes the Trauma Narrative and processing of traumatic material and history. Phase Three includes

Consolidation and Closure. The establishment of safety in this model does not preclude the mentioning of trauma, however it is referenced in a more psychoeducational context, or in relationship to the development of skills. Depending on how dis-regulated the youth becomes in relationship to the mention of trauma information, the therapist will adjust the treatment. As Cohen et al. state (2012),

> Some youth become highly dysregulated if the initial coping skills sessions contain even minimal trauma information. For these youth, the therapist often starts TF-CBT using relaxation skills without gradual exposure...That is, these strategies are initially not paired with the youth's trauma reminders. (p. 534)

In all three of these models, safety is established in the first phase of treatment while the direct interaction of the client's traumatic material occurs later on in the process. Individuals are encouraged to build on their safety using education, self-regulation, and their own cognition, rather than in their connection to each other and processing of the traumatic material.Herman (1992) specifically notes that group connection is not a primary goal in the early stages of a group. Though she states that connection around daily experiences and symptom problem solving can be a way for the group to connect in a healing way, the nature of that connection is not outlined. Both Herman and Courtois (2004) discuss the importance of including the client's body in treatment because an embodied safety must be re-learned, but there are not clear directives of how this can happen. In considering the stage approaches to treatment, what seems lacking is a clear explanation of exactly *how* individuals are encouraged to enter treatment; in particular the way that individuals can cultivate an experience of safety in relationship to others in the group. In fact, the concern with overwhelming the individual is much more emphasized in all of this literature.

Safety as a result of trauma disclosure. There are group methods of trauma treatment that have different opinions around the establishment of safety and structure in trauma centered groups. David Read Johnson and Hadar Lubin (2008), in their book *Trauma-Centered Group Psychotherapy for Women*, also support the importance of structured psychoeducation in group work, but they do believe in early disclosure as a critical piece of creating safety. They do not believe in the avoidance of the trauma early on, or in structuring the group to stabilize members only through self-care, problem-solving and self -regulating skills.

Johnson and Lubin (2008) begin with a foundational belief that states that individuals who have suffered trauma are dealing with their experience of that trauma every day, in every part of their lives, and that a critical piece of therapy is their ability to share what they have actually experienced in a safe way. In the group therapy model, the ability to disclose within a group is that much more healing. As they write,

> The experience of safe disclosure so early in the group development sets the norm for trauma-centered work. Because every group member is fully preoccupied with her trauma prior to the commencement of the group, immediately addressing this preoccupation reduces the anticipatory anxiety associated with such treatment. Our experience in the past ten years shows a very small dropout and attrition rate which we believe is due in part to the use of early disclosure. (p.8)

Johnson and Lubin (2008) are also careful to include their intention to work particularly with individuals who have symptom complexity, those that would fit into the DESNOS diagnosis. They state that with more symptom complexity all that is needed is a more highly structured group, but the disclosure piece does not vary depending on symptom complexity.

Though Johnson and Lubin emphasize the need for disclosure early on in a trauma group, they do not state how exactly safety gets *established* within the group, or how the individuals develop a safe connection with one another to facilitate the success of group bonding which they do name as central to the group process.

Body-centered methods of trauma treatment. There have also been alternative approaches to treating trauma which have less empirical research, however are relevant to this discussion. This includes more body-based treatment. One of these alternative approaches, Somatic Experiencing (SE), is a "Body focused therapy that integrates body awareness into the psychotherapeutic process" (Brom et al, 2017, p.1). It is similar to exposure therapy in that it works with the nervous system's fear response to traumatic experience, but different in that the content of the survivor's trauma is not necessarily the central material to the therapy. Instead SE focuses on "Bottom-up processing by directing the client's attention to internal sensations, both visceral (interoception) and musculoskeletal (proprioception and kinesthesis), rather than primarily cognitive or emotional experiences" (Payne, Levine, & Crane-Godreau, 2015, p. 1). This offers an approach to trauma treatment that supports individuals in finding internal stability and self-regulation before going into any of the content or story-based traumatic material. However, the internal stability is found not in a psychoeducational context alone, as much as it is found within direct work with the client's experience of their own body. As van der Kolk (2000) states about body-oriented therapy,

> Being able to manage the sensations as distinct chunks that change as a person attends to them creates a sense of mastery and ownership. This is the beginning of establishing new islands of safety and purpose, in which people come to trust the process of the body,

instead of trying to fight and dominate it – using the mind to support body processing. (p.

21)

While a newer application, Taylor and Saint Laurant (2017) explore the use of SE in group

therapy and offer another window into the creation of safety within a group through a focus on

the individual's felt sense of their own bodies in the work. Similar to Courtois (2004) and

Herman (1992), Taylor and Saint Laurant (2017) name choice as one fundamental piece of safety

being established. The primary method through which safety is created is through each

individual learning for themselves what safety feels like through an attention to their own body's

threat response, not necessarily through education, cognitive methods, or self-care. Choice is

established through internal awareness of the present tense experience in group. They state:

Moreover, not only is there a choice, but subtle signals felt in the body might usefully

inform that choice ("what tells me, in this moment, that it would be ok to engage with

that other group member?") rather than just forging ahead and toughing it out. Simply

encouraging group members to "take the risk" of engaging—without paying conscious

attention to body-based cues—leads group members to reenact old patterns that override

choice, that don't allow accurate assessment of interpersonal or internal cues...Working

in this way, group members begin to recover their deeply felt sense of what is safe and

what is not. (p. 3-4)

In this way, the traumatic material is not necessarily delayed or avoided in order to create safety,

but instead attention is placed each group member's present tense experience of what is arising

for them within the group, what their threat responses are, and how they can experience safety

and take risks while in connection to other people. This model does support the ability to heal

without replaying or repeating the traumatic incident or incidences because SE offers ways to work with the threat response as it arises in the more day to day interactions.

SE does similar work to the stage model approach in that it works towards self-regulation as the primary therapeutic intervention and Taylor and Saint – Laurant (2017) do state that an SE group would be less focused on the telling of trauma stories: "In the SE informed group, fewer issues are brought up, with slower and deeper exploration of those that are; the group focuses on resolution and healing rather than telling stories" (p. 8). However, it is distinct from stage work in that it asks the participants to go deeply into their own bodily experience from the beginning of group work. It also is distinct from the stage models in that it appears to be more willing to name the results of trauma as they are arising moment to moment with other group members, not only in a psychoeducational context.

It is important to note that this article does not address the treatment of CPTSD specifically, but speaks more generally to the group treatment of trauma with SE. Additionally, the authors state that a group member would only be appropriate if they came into the treatment with a curiosity and willingness to "Befriend their bodies" (p.7). This may attract a different client population than a psychoeducational trauma group.

Use of Drama Therapy to Treat Trauma

There are many different ways that drama therapy has been used to support individuals who have experienced trauma, and they follow similar trends as the rest of the field of trauma group treatment in their considerations of safety being a primary goal. However, the methods of the creation of safety and internal stability in the drama therapy community are different, tending to utilize ritual, role play, fictional storytelling, dramatic play, among other tools. As there is less literature on the specifics of drama therapy and CT, I will include drama therapists who

speak about general trauma treatment in groups in this section of the literature review. Many of

these sources are taken from an edited book entitled *Trauma-Informed Drama Therapy* edited by

Nisha Sajnani and David Read Johnson (2014).

In *Trauma Informed Drama Therapy*, editors Sajnani and Johnson (2014), echo the

different approaches to trauma treatment that have been described in earlier sections. They

summarize three general approaches to trauma treatment; suppressive, expressive, and

educational. They state that in the first one, *suppressive*, patients are not encouraged to speak out

about what has happened. Sajnani and Johnson suggest that the trauma is suppressed "Through

direct social pressure[], medications, or structured social settings such as hospitals (where the

patient is 'stabilized'). The *expressive* approach has been one in which the individual is

encouraged to share their story, express themselves and 'vent their emotions'" (p. 11). The

methods most closely aligned with this approach include exposure therapy, flooding therapies,

art, and "Public testimony or demonstrations" (p. 11). Finally, the third approach, *educational*, is

considered to be in the middle of the other two, where individuals are given information about

the nature of trauma and how it may have affected their lives, in addition to being provided with

mostly cognitive behavioral methods to create healthier patterns in their lives. The three

approaches identified by Sajnani and Johnson reflect the distinction that was made earlier in this

thesis between those approaches to trauma treatment that avoid the trauma in order to create

safety and those that require disclosure as a core element to the establishment of safety. Elements

of the educational response is present in all three; The stage models, the body - based model of

Somatic Experiencing, as well as Johnson's more disclosure - based model of group work. The

authors set up these three tendencies in trauma treatment to set the stage for the ways that drama

therapists interact with these options.

As such, Sajnani and Johnson (2014), also identify the agreed upon values inherent in effective use of drama therapy in the treatment of trauma. Their list of agreements begins with: "Trauma informed drama therapy is conducted in an organized environment that provides safety and trust for the clients" (p. 33). So again, safety is identified a critical piece of treatment. However, the way in which this safety is established, similar to the rest of the field of trauma treatment, varies amongst drama therapists. Authors highlight the fact that the drama therapists included in their collection do not necessarily agree on "The degree to which traumatic experience should be directly address and processed within the session" (p. 34). They do, however, identify the ways in which drama therapy has unique tools to offer trauma treatment including, "Dramatic re-enactment, flexible titration of cognitive distance, role reversal, and pleasure, among others" (p. 18). Finally, Sajnani and Johnson distinguish between the work of "Trauma - informed drama therapy," and "Trauma-centered drama therapy" (p. 34). Many of the therapists highlighted in their collection of essays are working to bring their already established drama therapy methods to individuals who have experienced trauma. This the authors identify as trauma-informed as they are bringing what they understand about the effects of trauma into the work they are doing with their already existing methods. The second, trauma - centered, speaks to the work that has been created specifically to work with trauma survivors in a way which centers on the traumatic experience itself. The examples below are trauma – centered.

Healing the wounds of history. Armand Volkas (2010) is a drama therapist who expands the definition of trauma to include historical and generational trauma. His method is called Healing the Wounds of History (p.127-146). His method works with groups of individuals that often come from polarized communities to find paths towards reconciliation that is not simply a result of diplomacy or politics, but instead made up of the sharing of grief and

collective healing. The question that he asks is: "How do the descendants of perpetrators and victims feel about their collective trauma? How do they carry it in their psyches and what do they need emotionally from themselves and from each other to transform this trauma? (Leveton, 2014, p. 46). This guiding question led him into a series of 6 steps of a workshop (2014) including: 1 – Breaking the taboo and having the two groups speak to each other, 2- Telling stories to find humanity in the other, 3- Exploring the "potential predator" (p. 47) in each of us, 4 – Grieving together, 5- Integration through performance or ritual, etc.

Volkas (2014) states that this process works because "First we need to face history and uncover our unconscious emotional reactions and beliefs. We can then give ourselves the opportunity to transform the trauma through acts of creation or acts of service" (p. 47). He believes that the details and images of the traumatic memories and messages that have been passed down need to be directly dealt with and attended to. Engaging with the traumatic material is essential for Volkas' process however it is done with the tools inherent in art and drama therapy. He states "The principle behind encouraging Healing the Wounds of History participants to use the traumatic images, memories, and messages they have inherited to create art or take social action is that this is the most powerful way to ultimately master the trauma" (p. 47). Volkas does not directly discuss the creation of safety in this article; however, he does talk about the establishment of trust in the group coming from the sharing of stories, and taking risks around connecting with other group members. He also uses the arts as a way to communicate which has the potential to allow individuals to choose how they would like to engage, which echoes the importance of individuals reestablishing choice in their treatment.

De-Railing history. Christine Mayor and Stephanie Dotto (2014), in their essay "DeRailing History," also discuss the way historical and collective trauma affect individuals'

lives in the present. These authors describe their work with a youth theater project entitled De-Railed that works with youth in Toronto, ON who experience severe and consistent trauma in their daily lives. Mayor and Dotto contextualize these kids' trauma as being a result of "Living in a community with high rates of violence and poverty, reporting little sense of security" (p. 308) and attend to the fact that these kids' daily experiences are a result of a historical legacy of racism, poverty, displacement, among other systems of marginalization and oppression that this community has been subject to, historically as well as in the present day. DeRailed works with youth to create a performance based on the youth's own, autobiographical stories being told to the public. Mayor and Dotto suggest that this work is both therapeutic and political and they cite their decision to *not* shy away from the violent and traumatic material that emerges from the youth during improvisation. Though met with resistance from other educators who suggested that they not bring the violence that these kids experience in the rest of their lives into the classroom, Mayor and Dotto believe that the act of working with the youth's reality is therapeutic. They state:

> This became a conscious decision made to counteract the avoidance that is typically enacted by youth and facilitators alike when faced with traumatic material...Rather than collude with this culture of silence, we asked questions and offered drama and discussion as was of addressing these experiences. (p. 313)

In this way, Mayor and Dotto link their work to the work of exposure therapy. In the use of play and embodiment of the traumatic material, as well as in the rehearsal and performance of individual stories, authors offer the possibility of imaginal exposure and desensitization. Additionally, Mayor and Dotto (2014) counter the culture of silence by bringing the participant's own material into all aspects of the play. For example, they used warm up activities to play with

the participants' real-life experiences by asking them to "Walk around the room like your

walking through your neighborhood at night" (p. 314). Safety in this method is created by

engaging with and playing with the participants' real stories, not by waiting until resilience and

stability are created before talking about the traumatic experience. They use theater exercises and

warm up games as tools to invite the participants into the play, into the disclosure, in a safe way.

It is an example of how the structure inherent in the use of play and facilitated improvisational

exercise can provide a container for the group to explore the intensity of these subjects safely and

therapeutically.

   Trauma – centered developmental transformations. David Read Johnson (2014), in

his chapter, "Trauma – centered Developmental Transformations" agrees with the importance of

direct engagement with a client's trauma and states that it is *crucial* to inquire directly about the

trauma early on in the work. Johnson (2014) claims that a delaying the processing of traumatic

materials is actually detrimental because it increases "Anticipatory anxiety" (p. 69) which then,

Johnson states, may cause the client to leave treatment. And so, in trauma-centered

Developmental Transformations (DvT) the client is encouraged and invited to engage in play

around the content of the trauma. What occurs is a process of play that allows the client to

explore their own repetitive patterns that have become rigid and ingrained as a result of their

traumatic experience, until the client has exhausted the pattern and can potentially let go of it, of

the role, and of the repetition. Additionally, the client is asked to disclose their trauma history

with the therapist prior to the play even beginning, so that disclosure is out of the way early on.

Then the therapist and client are left to play with the client's material at the pace that is

appropriate as determined by both the client and the clinician. According to Johnson (2014), the

way that the trauma is played with is specific to each client. The play itself brings the client's

content into a different imaginal reality and the therapist finds ways to create discrepancy in the

play, so that play does not become too real, or direct. The therapist in this method does not shy

away from the intensity of the client's traumatic material, but they do, use the play itself to create

an appropriate level of distance to the material so that the client can remain engaged in the play.

The clinician can make offerings in the improvisation; however, at the center of this modality, is

a client – centered play, where the client is closely followed and attuned to.

Safety is addressed in Trauma-Centered DvT by establishing the trauma frame with the

clients by naming that this therapy will work directly with their traumatic memory. It is in this

trauma frame, that Johnson addresses the anticipatory anxiety, and this allows for the work to

begin. DvT is widely used in group work, but it is important to note that in this article about

trauma – centered DvT, Johnson is speaking about the use of DvT for trauma treatment with

individuals. It is unclear from the existing literature what the process of safety creation or

individual trauma disclosure would look like in a trauma-centered DvT group.

Fiction, metaphor and role. Frydman and McLellan (2014), in their article "Complex

Trauma and Executive Functioning" use drama therapy to work specifically with individuals

who have suffered from childhood trauma during crucial developmental periods. The authors

claim the use of drama therapy can be effective in addressing early developmental gaps created

as a result of the trauma. They note that the establishment of safety in childhood is crucial in

order for other developmental milestones to occur and that those who have not experienced this

safety may also experience delays in the development of their cognitive executive functioning.

One of these disadvantages, according to Frydman and McLellan, is that individuals who suffer

from both PTSD and Complex PTSD have experienced an "Interruption of the imagination,

echoed in the symptomology of PTSD as a foreshortened sense of future limiting the individual's

ability to envision and therefore embody future roles and relationships" (p. 154). They argue that

drama therapy has the capacity to expand an individual's access to their own imagination, by

giving them opportunities to "Envision roles and relationships that exist outside of the frame of

the traumatic memory" (p. 154).

  Frydman and McLellan (2014) describe the stages of their treatment model and though

they do not directly endorse the disclosure of traumatic material, they also do not seem to shy

away from the trauma stories when they arise. They state that when traumatic story arises in

group, the facilitators usually encourage the material to be processed in the play because, as

authors state, "...In the therapeutic playspace the client has the potential to become an active and

creative force once more" (p. 154). They also explain how the use of metaphor and fiction can be

used as a "protective factor," allowing the stories, roles, images to be engaged with more

indirectly within a, as they name it, a "Parallel realm, thereby reducing the risk of re-

traumatization" (p. 154). The use of fictional story can be helpful to clients as a way to engage

their trauma at a distance where they can play with it, engage with it, and even re-story it without

becoming overwhelmed, which Frydman and McLellan are concerned may occur if the trauma

was explored directly without the aesthetic measures being used.

  Finally, Frydman and McLellan talk about creating safety during the early stages of the

group through the formation of group cohesion. They state that early stages in the group process

are centered around creating safety and connection within the group, while respecting the fact

that this population, in particular struggles, with trusting others. They state that "The larger goal

is establishing a group culture in which participants feel able to share feelings and experiences in

words and action, placing emotional communication and subsequent empathic connections

formed at the heart of the group experience (p. 163).

Aesthetic distance. Finally, Judith Glass (2006) in her article "Working Towards Aesthetic Distance: Drama Therapy for Adults Victims of Trauma" explores the use of drama therapy as a way to, (similarly to both Johnson and Fryman and Mcllellan), adjust the distance that a client may have to their traumatic material. She references Robert Landy's definition of that "Aesthetic distance is defined as the point at which the client can have access to his feeling and also maintain and observer stance" (p. 58). She describes the use of creative arts therapies to "Contain and distance, particularly with the use of imagery that can be seen as separate from the self, and therefore approach" (p. 58). Glass describes using both an "Over-distanced" approach and an "Under-distanced" approach to working with clients who are in different stages of their work. These over-distancing techniques are for the purpose of symptom management, or for the building of internal strength and resilience that are needed to cope with the effects of the trauma. As an over-distanced approach, she describes her work with role play to offer clients a chance to experience themselves outside of the role as victim, which allows the client to build internal strength and flexibility, accessing parts of themselves that can then give them the nourishment they may need to deal directly with the traumatic material. An under-distanced approach on the other hand, is used when the client is ready to explore the actual relationships by taking on the different roles of the real people in their life. She discusses that exposure therapy can be used within the context of drama therapy in the form of enacting pieces of the traumatic scene, or having the client "Describe sensory details about the scene: sights, sounds, smells, tastes" (p. 66). The work in these enactments is to desensitize the client to anxiety relation to trauma triggers or memories.

The concept of aesthetic distance speaks to the way that drama therapy can offer threads of complexity to the conversation within the larger trauma field as to whether or not it is

necessary to work directly with the traumatic material. With creativity, metaphor, fiction, storytelling, or however else the aesthetic distance is created, there are perhaps more options available. The drama therapists highlighted above offer unique perspectives in their consideration of how to engage with clients who have experienced trauma while both attending to their histories and also being sensitive to the importance of establishing safety in the work. Some do it through improvised play; others through metaphor and ritual; others through scene work; others through role play. The presence of such a variety of tools within the field of drama therapy creates the opportunity to develop a truly client centered approach, where each person can work through the artistic medium to find their way into the trauma work at a pace and distance that is sustainable and accessible for them. One of the elements that was highlighted in several of the examples of trauma-centered drama therapy was the importance of group cohesion. In all of the examples of group – based drama therapy mentioned above, the authors named how group members' connection to each other was part of the success of their interventions.

Where Does This Thesis Fit In?

This thesis looks at what constitutes safety and how it may be achieved within a group and it asks whether drama therapy may have some new ideas about how safety can be created and sustained individually for each group member and for the group as a whole. The examples of trauma-centered drama therapy detailed above use the tools inherent in drama therapy- role, dramatic play, metaphor, fiction, and ritual - to support clients in being able to safely engage with the traumatic material in some way, but not in such a way where a direct disclosure is always necessary. Safety is not created in these methods by avoiding the trauma all together, but instead is created in the use of the drama therapy itself to engage with the trauma in appropriate and client-led interventions.

However, these models do not explore how drama therapy can be used in the context of more stage - based psychoeducational groups that are detailed in the first section. My thesis addresses this gap, to explore the use of drama therapy within a Herman – informed (1992) Stage One, psychoeducational group. This inquiry looks at how the use of particular drama therapy interventions may add to the creation the of safety getting established within this kind of group? And what, in particular, does the drama therapy add that would not normally be available in a Stage One inspired, psycho-ed group? I look at whether drama therapy may offer a way in so that the clients can enter the treatment with ease, feel safe enough to share themselves in an appropriate way, and take risks with vulnerability and group connection. I look at whether drama therapy can add to this group while still working within the structure and focus of a Stage One psycho-ed group.

Method

In this study, I examined the use of specific drama therapy interventions in two consecutive psychoeducational groups in the trauma program at a community mental health agency in Vermont. Drama therapy was specifically used at the beginning and end of each group to encourage group members to participate, while still providing them with the experience of control and safety that the site recognizes as critical for groups of clients with CPTSD.

The two groups were called Emotional Regulation and Self - Esteem and all of the members were survivors of CT. Though they were not screened to have the symptoms of CPTSD, the population of clients within this agency's trauma program largely falls into that category, and the philosophy of the groups follows Herman's (1992) stage-based model for trauma treatment. Each group ran for six sessions so this evaluation includes 12 weeks of experimentation and reflections on this process. These groups were voluntary psychoeducational

groups with a range of 4-6 participants in attendance each week. Within both groups, there was

one returning client and the rest of the participants were new to the group process. These groups

had existed without the use of drama therapy in the past and I was invited to join as a facilitator

specifically to bring drama therapy to these groups.

       For the data collection, I wrote journal entries after every group. These entries were a

stream of consciousness - style writing project. I journaled on my experience in the group, my

observations of whether or not the interventions were successful, and my experience of group

members' participation in both the drama therapy interventions and also in the rest of the group.

Halfway through the second group, I decided to add a layer of data collection into my process

which included a body scan that I did directly after the group ended. This was a simple

attunement to my own body, noticing the sensations, feelings and experiences that I had right

after the group got out. This is something that, because of its later inclusion, was analyzed

separately as its own group of data. It is a possible source of data collection for future similar

projects and potentially a source of data collection if, in a post-graduate study, I were able to

include group members' experiences of the group in my research. As my interventions

incorporate the body and attend to the experience of safety in the body, it would be useful to be

able to collect data from every group member after the group on how they feel in their body.

       To analyze my journal entry data, I used thematic analysis.   After the last group of the 12

sessions, I read through all of my journals and identified themes through continuous comparison

of recurrent topics, keywords, and identified experiences. Coding categories and relationships

among the data sources were mapped out. The most prominent themes were 1- Ritual as a tool

for building safety and structure, 2 - Individuals can participate at their own risk, 3- Play

decreases the perception of fear, and 4- Facilitator as play object and group member. I then

coded all of the journal entries according to these themes and the results reflect this process.

Interventions Used

       The following is a very brief synopsis of the drama therapy interventions that were

woven into the weekly group.

       For both the Emotional Regulation and Self Esteem groups, the main drama therapy

intervention used was an opening and closing group ritual that involved play, the imagination,

and metaphor. The particular metaphors are detailed below. I drew from Johnson's use of play

and embodiment, Glass's use of aesthetic distance, Fryman and McIlellan's focus on group

cohesion, and Volkas' emphasis on sharing as a tool for group connection.

       Emotional regulation group. During this group, I opened and closed with the metaphor

of a giant imaginary soup pot. The soup pot served as a representation of the group process

where all the feelings, thoughts, experiences from the past, present and future of the group

members could exist together. This was an attempt to acknowledge and attend to the clients'

histories and realities without having to name all of them outloud. Each week we opened the

group by standing in a circle, retrieving the soup pot from the corner of the room where it was

"stored" in between sessions, throwing something into the soup pot (something we need to let go

of, something we are bringing into the group to share with everyone else, something we are

hoping to get out of today's group, etc). We ended by all, on the count of three, physically

sending the imaginary soup pot back into the corner of the room where it would rest until it was

revisited in the closing ritual. The closing ritual was similar in that we would retrieve the soup

pot and then, in a standing circle, go around and each take something from the pot with an

imaginary ladle (i.e. something you want to take home with you that you learned in group,

something that you appreciated about group today, etc.). The prompt was different for each

group.

Also, in this group, I incorporated a couple of other drama therapy interventions when it

was appropriate. During Session Four, I provided the group with four movement exercises

geared at helping them regulate their physical experience of emotions when they felt

overwhelmed. This was my way of offering drama therapy in the form of a *skill to take home*

that is characteristic of the Stage One psychoeducational skills group format. The exercises were

chosen because they are very physical and fun and they included making funny faces, shaking

and jumping around, and a little ritual of relaxing breaths.

Finally, I used a group sculpture technique inspired by Renee Emunah (1994, p. 157) to

bring the group members into direct conscious experience with how their bodies are affected by

their experiences. During Session Four, we facilitators asked the group to sculpt each of us into

the bodily experience of different emotions. For example, the group members got to call out, and

direct us into the physical shape of how the feeling of "anticipation" was expressed in their body.

We modeled it in the front of the group.

Self esteem group. This group's weekly opening ritual was centered around a big old

tree as a representation of the capacity to grow one's self esteem. Each week we opened the

group by reaching up and pulling down on the roots of the tree that the group had determined (on

the first day) lived on top of the roof of the agency's building. We would pull down on the roots

until the tree was in the middle of our circle of standing group members, at which point we

would put our hands out in front of us to feel the tree. This ritual showed the group members

each week how big the tree was, which was determined by how many people were in attendance.

At that point, we would go around and answer a prompt that were a variation on the themes

described above (What are you bringing that you want the tree to hold on to so you can be present in group? What are you looking for from today's group?). Then, we would, as a group, send the tree over into the same corner of the room, where it would stay until the end of group. During the closing ritual, we would recollect the tree from the corner of the room, and re-form a circle around it. This time we went around, with a closing prompt (What would you like to take home with you today from group? What do you want to ask the tree for the week?). It is important to note that I did not decide *how* the tree (or the soup pot) would appear each day, where it lived in between sessions, or how we could connect with it (aka putting our hands out to feel it). This was all decided by the group as the series continued or was something I discovered in the moment. This is significant because it demonstrates the level of active participation the group members had in the activity. These interventions were collaborative experiences.

Also, in the Self Esteem group, I used a drama therapy intervention to explore one of the psychoeducational concepts of self - affirmation. The group was guided into an exercise during Session Five, where I asked group members to take on the roles of both the voices inside their heads that critique them, and those that support them. One of us facilitators would act ask the actor in a scenario, and the group participants would, in small groups, enroll as that protagonist's inner voices. This exercise gave the group members a chance to vocalize their inner critics and potentially to explore the presence of an inner cheerleader or support system**.**

Data Collection

The data of journal entries that were done after each session of each group were coded into the following four themes: Ritual as a tool for building safety and structure; Individuals can participate at their own risk; Play decreases the perception of fear; Facilitator as play object and group member. These themes will be detailed and explained within the Results section. The data is a reflection of my own observations of the group members as well as my own personal

experience of the groups. As I observed the group members, I was looking for expressions of safety which took the form of an individual's capacity to take risks, to become more embodied and engaged in the activities, and in the individual's capacity to connect to other group members.

Because the data for the body scan was only limited to the last three sessions, I have analyzed it separately, similarly looking for themes and whether there was any significant correlation of the content of the body scan to the session's activities or how the session ended.

<div align="center">**Results**</div>

Ritual as a Tool for Building Safety and Structure

As detailed in the methods section, each group began and ended with an opening and closing ritual. This ritual was the same each day, in that each day we worked with the same metaphor (the soup pot in Emotional Regulation and the tree in Self Esteem) though the prompt was changed from week to week. It was highly ritualized, structured and repetitive, yet always playful, imaginal and spontaneous. The data reflects the fact that the repetitive structure of this ritual in combination with its playful spontaneity increased group cohesion, supported a safe and regulated transition into and out of group, and supported the participants in sharing themselves in a contained and Stage One group-appropriate way.

Firstly, I noted in my entries that the ritual's repetition was important because group members could anticipate what was going to be expected of them. By the second session of Emotional Regulation, the data reflected the fact that the group was already getting more familiar with the ritual and that the members were having an easier time participating. As noted in session Two of Self Esteem, *"People are building a capacity for metaphor and the repetition of ritual helps people feel safe and be able to anticipate what is going to happen."* By Session Six of that series I noted the ease with which group members were able to join in a popcorn style sharing of what they have appreciated about this group instead of the go around that we had used the entire

series thus far. *"This would never have been possible in the first half of the series, but people really just joined in - again safety here has already been established and we took it to the next level of provide the space for everyone to opt in, out of order."* This demonstrates the possibility that repetition and structure may support the creation of safety, and that once relative group safety and trust have been established, the structures can be more easily adjusted without disrupting the experience of safety. This points to the possibility of the group members becoming more resilient to change and more flexible in the taking of risks.

Secondly, the data demonstrated that the opening ritual served as an important tool to act as a transition into the group dynamic, and that the ending ritual at the end of group served to bring the group back together in the present moment, before sending them off into their daily lives. During the Session Three of Emotional Regulation, I noted that the closing ritual ended the group on a fun, playful note and that it allowed the group members to refocus on the present moment in their bodies;

> *As we all join together to move the tree back up on top of the building at the end of the group, the group jokes about how the tree will fare while we are gone, and we stuff the roots up over the ceiling. The group loves it, they are playful with each other and … eventually everyone joins in.*

The journal entry after Session Three of Self Esteem echoed this sentiment:

> *Ending ritual seems to help the group find closing in a way that is fun and more connected - after all the sort of heady psycho-ed that occupies most of the group. It helps also [] transition them back into their bodies and back into the world.*

In this way, the ending ritual serves as a tool for self-regulation. The group members are focused on one thing, together, this imaginal metaphor. Through the connection with other group

members and through a return to a more actively embodied state, this tool appeared to help the group members self-regulate. Though I am not able to claim this without the group members' experience to reference, I imagine this would have been especially true if any of the psycho-ed elements of the group brought up any pieces of an individual's trauma story that may have been distressing during group. The ending ritual could serve as a way to come back into the present moment, to help them self-regulate before they left group.

The opening ritual was also noted to be helpful with self-regulation in that it engaged us all in group play. After Session Four of Emotional regulation, I reflected on my own experience of how important the opening ritual had been for me to self-regulate after being in an car accident that occurred directly before I entered group.

> *It was helpful for me to experience [this] - thinking about the state of activation that group members may come in with every week and the fact that, upon entering, they are brought into a ritual in which they can focus on a playful object, an imaginary one. [This can] offer the experience of the present moment without pointing at each person and asking them all to 'Get present!'*

Thirdly, in the data I discovered that the use of the structured and metaphoric opening ritual was able to seemingly help clients share themselves in the context of a group. I reported that the modeling of the prompt each day, and the repetition of experiencing the ritual, dictated the relative amount that was expected for the client to share. I observed that this may have contributed to the clients' experience of safety. I observed that this solved the problem of telling people how much to share or shaming them for sharing too much. The ritual offers the chance to provide the client with what is expected, playfully and gently. After Session Six of Emotional Regulation, I wrote:

> *Ritual here serves as such a sturdy container for people to safely share feelings and know*
>
> *that they don't have to share forever - the repetition of knowing how much is usually*
>
> *shared I think creates a level of security in knowing what is going to happen that*
>
> *members may be able to relax into it.*

This was echoed in the data from Session One of Emotional Regulation, where I noted that group members had, even in the context of their first experience with the ritual, regulated their sharing to be appropriate in length and detail though also taking what appeared to be risks with vulnerability. One client, during this opening session, stated that her hopes for the group is that she be able to deal with and understand her trauma. We knew from that client's therapist that she was nervous about group and so we believed this to be a big thing to share. She began tearing up during this sharing, but then appeared to self-regulate by taking a deep breath and passing the ritual to the person next to her. Another client in this group had a similar experience during the first session where she stated that she is coming to the group to feel less alone. She also got emotional during this sharing, but, I noted in the data, did not go into extensive detail in her sharing. Instead she too, expressed her emotions, made contact with the group through eye contact, and passed the ritual on to the next person. In the journal, I observed that these clients had been able to both bring a vulnerability to the group, be witnessed in their vulnerability, and also not take over the group because of the nature of the ritual's container. The experience of these clients is impossible to know of course. But I, in the data, explored the assumption that the structure of the ritual created a safe enough container for the individual client to be heard and yet held within the larger group as the ritual continued on to the next person when it seemed appropriate. I also took note of how the client appeared able to self-regulate.

The data also consistently referenced the structure and repetition of the ritual to be useful in developing safety through the group cohesion. After Session One of the Self Esteem group, I recorded my experience of introducing the tree metaphor to the group:

> *We used our hands - we put them out to see how big the tree was. All hands were facing each other and we saw a huge trunk…this served as a connector. We created something very visibly real between our hands, and even some folks noted that they felt their hands tingling.*

The ritual in this case, provided a very tangible experience of the connection between people and this journal observation highlights the power of the metaphor to bring people together. It also demonstrates the possibility of cohesion coming from a shared somatic experience amongst group members.

The repetition and structure of the weekly metaphoric ritual seemed to serve as a tool to provide the clients with an idea of what to expect and what is being asked for, while still providing a chance for each group member to bring their feelings to the group in service of the overall connection and cohesion of the group as a whole.

Individuals Can Participate at Their Own Risk

One of the most powerful themes that arose from the research was that the drama therapy interventions created spaces where group members were able to have control around their level of risk during the group exercises. The data consistently reflected my observation that there was an alternative to simply *sharing or not sharing,* and that there were infinite ways that group members chose to join in the play, the sharing, and the group dynamic. According to the data, the opening and closing rituals created these options for several reasons.

First, group members were always able to pass when it was their turn in the circle to share. However, passing during this ritual did not mean the group member was not a part of the

play or a part of the conversation. They were still standing with the rest of the group, focused on

the imaginary object in the middle of all of us so when someone passed, they were still involved.

In the journal reflections I detailed when a group member passed, and most of the choices to pass

came in the first or second session when group anxiety was higher. However, when group

members did pass, they were still listening and witnessing with the rest of the group, and

continued to stay visibly engaged in the ritual.

Secondly, as the rituals were centered around metaphor and the imagination, there was an

infinite number of options for participation. In the journal reflections, I noted different group

members being able to make different choices around how much they would join into the

play. This was made note of in almost every journal entry, but a great example of this was

during the Self Esteem group's opening ritual of pulling the tree down from the roof of the

building. As the group had already decided that the tree lived atop the roof of the agency's

building in between sessions, each week we all had to grab a hold of the tree's roots and drag it

down through the roof, into our room. While I and the other facilitators threw our whole bodies

into this task of pulling down a very, very giant and heavy imaginary tree in through the ceiling,

the group members all varied as to how involved they became. Some went through the motions,

while others joined the facilitators in the huffing and puffing of such an arduous task. As I noted

in the journal reflections after Session Two of Self Esteem,

> As we all join together to move the tree back up to the top of the building at the end of
>
> group, the group jokes about how the tree will fare while we are gone, and we stuff the
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> roots up over the ceiling. The group loves it. They play with each other and are silly and
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> sometimes they are not sure if they want to join in, but then the whole group is doing it,
>
> so eventually, everyone joins.

Each week, during this part of the ritual, there was laughter; jokes were made between group

members and jokes were made in the miming of the task itself. I noted the same trend when the

group lugged the giant soup pot into the center of the circle during the Emotional Regulation

group. Some decided to join in the picking up of the soup pot and bringing it over. Others just

watched. Some ducked to allow it to go over their head without having to get up. *Who*

participated and *how* was spontaneously decided each week in the moment.

This was echoed in the data from Session One of Self Esteem when, during the closing

ritual, I asked group members to take something home from the tree. I invited them to share what

they wanted to take and why. Some members were able to do this, but others were not. As

recorded, "*I encouraged those who wanted to pass to take something from the tree, even if they*

did not know why and did not want to talk about it." I tried to provide another way to "play"

even if they wanted to pass so that they could feel a part of the group. This appeared to be an

effective use of the drama therapy to demonstrate that there are different levels of participation

possible. In this way, someone could name what support they needed from the tree or they could

just take a piece of bark and appreciate the image of keeping that bark in their back pocket.

This leads to a third reason that these opening and closing rituals created the space for

different levels of participation. Because the rituals had an infinite amount of ways to join, I was

able to invite different group members into the play differently. I observed this numerous times

throughout both series, but one of the most clear examples was during Session Five of the Self

Esteem group. J, who, being the most shy group member, was the only one who continued to

sporadically choose to pass when her turn came. During this session, she opted out of the

opening prompt which was "What are you bringing to the group today that you want to share

with everyone else?" Also on this day, I had increased the demand by asking each group member

to provide a movement that would demonstrate the thing they were sharing with the group and I asked the whole group to mirror it back to them. When I introduced the prompt, J said that if she had to be positive then she had nothing to share with the group and when her turn came, she passed. However instead of letting her simply pass, I paused on her and said, *"Wait a second, I see a little smirk there on your face. Can you share that smirk with the group?"* She laughed, and shyly nodded and I exaggerated her little smirk for the rest of the group to mirror it back to her. The rest of the group joined in with enthusiasm and the group member next to J said something supportive to her about how much she liked her smile. J was smiling and seemed to enjoy this nudge and the group's enthusiasm over her smile. As I reflected in my notes, *"She [J] did not have to enter in any kind of way that was stressful but she could be as she was, blocked, scared, and still play…"* Additionally, despite J's desire to pass when it came to her turn, she was still mirroring the other groups members' offerings and so she was embodied and participating in some way during the whole ritual. This example demonstrates the way I, as a facilitator, through the drama therapy, can encourage different levels of participation with different group members depending on what I assess about their levels of internal safety and self-regulation and I can offer different interventions accordingly. This also provided the space for individuals to increase their level of risk taking at their own pace.

        In addition to the use of the opening and closing rituals, other drama therapy interventions also created a space where individuals could opt into their level of involvement. During Session Four of Emotional Regulation, the group explored how different feelings were held in the body. However, to do this, the facilitators became the sculptures that the group members were asked to sculpt into the shape of different emotions. This structure allowed group

members to participate and reference their own body, without being on the spot, or having to really take on the postures themselves. As I reflected,

> *As they were trying to explain to us facilitators, they would put their own bodies into the poses to try and reference them, so this did offer yet another way for the participants to opt in, in playful ways, without having to be in a scary situation like being on the spot. They could choose the level of their own embodiment when exploring the different featured emotions, and of course it's a given that they did not HAVE to do this [to participate].*

Play Decreases the Perception of Fear

In addition to the clients' capacity to choose their level of involvement, the data reflected the importance of the use of play as a tool that increased group connection and decreased anxiety about the group process, which, in turn, potentially supported the group members to take risks and feel safe enough in doing so.

The data reflected the fact that as facilitator, I was able to introduce new interventions in a playful way, so that the group members were invited to participate in ways that did not ask the group members to consciously consider their own participation. I noted that because the group was engaged in play, I observed group members joining with what I perceived to be little visible stress. I reflected that the play may have created safety in that it provided an easy and organic way for group members to try potentially more stressful exercises.

A great example of this was when I introduced creative movement into the Self Esteem group as I mentioned in the above example about J. The journal entry after Session Four of that same group noted that I invited the group to add a movement to the prompt which was to *Give something to the tree that you need to get rid of in order to be present in group today*. However, I did not prep the group for this new added layer to the exercise beforehand. Being aware that the

group members might opt out or get scared off by being asked to *move* if I offered this new

request in the beginning, I did not mention it until I was modeling for the group during the ritual.

I shared what I would like to offer the group, and then I added a movement with my sharing and

asked the group to join in the movement with me. The whole group instantly joined in. And then

I asked the other individuals after they shared their offering, to add a movement. If I assessed

that one member might have a tougher time with this, or might freeze from being on the spot, I

would support that group member by picking a movement up off of something they were doing

unconsciously as they spoke about their offering and exaggerating it for the group. As I reflected

in my notes,

> *I did not have to name it or introduce it or prep anyone for it. People felt safe enough to*
>
> *do the movements, because it made sense to them on some level. Everyone joined in, and*
>
> *I felt absolutely no resistance to adding that element into the group - whereas I feel that if*
>
> *I were to have followed a more traditional safety model, I might have let people know*
>
> *what is about to happen so as to not spring anything on anyone in the group. This was*
>
> *absolutely sprung on everyone and they took to it organically and playfully.*

With the use of play, the data suggested that the increased demands were less scary and

potentially less consciously fixated on. The data from Session Two of Self Esteem echoed this as

I reflected on the ease with which I was able to challenge the group as a whole to take bigger

risks. During the point in the closing ritual where the whole group was asked to push the tree

back above our heads onto the roof at the end of group, I played with the group that they were

not pushing hard enough. I told them to "*Get your whole body into it!*" This was the way that I

could invite participation and play, while also, of course, allowing people to participate at their

own level, in their own way. The play was what allowed me to challenge them, and also what

allowed almost all of them to laugh and become more active, without fear of being more embodied, a fear that very well may have been present would I have directed them to be more in their bodies in the context of some other exercise. The play potentially got us around having to point at the scary thing. We could just play and the scary thing could be included in the play.

The ease with which the drama therapy allowed me to challenge the group members to take bigger risks, leads me to conclude that, if the facilitator is able to accurately assess the group's level of risk taking and engagement level, safety can be created with less caution. In this example, I increased the level of risk without the group members having to really choose it consciously, but this did not appear to result in a breach of trust or consent because the group members were able to opt in or choose in how they shared, how much they shared, and how embodied they were during their sharing. Additionally, I could read each group member for their level of safety and so could add additional supports if necessary. And mostly, this was possible because it was fun and because a culture of playfulness had been established as a foundation for these kinds of risks to seem potentially not so risky.

Facilitator as Play Object and Group Member

The final theme that was frequently reflected upon in the data was the fact that the drama therapy interventions in these groups provided a unique role for the facilitator of a more traditional psycho-education group. Firstly, I noted that as facilitator I was able to model the play, goofiness, and risk taking that I was asking of the rest of the group. The data observed that this served to encourage the group members to feel more permission to enter the play and take their own risks.

I noted in the entries that this role of playful facilitator potentially altered the power dynamic between the group members and the facilitators. All three facilitators of the group joined in each ritual and also participated in the other drama therapy interventions. I noted many

times that because the facilitators were willing to be silly and join in the drama therapy

themselves, the group seemed to perceive us in a less formal way. I was in my body, playing

with them, and therefore allowing for personal spontaneity and vulnerability. This, I observed,

may have decreased the perception of us as infallible and allowed us to be fuller humans in the

groups. I noted,

> *The group gets to see each of us be in our own bodies, thinking through what it is that we*
>
> *want to bring to the group, what has been sitting with us since the last group…In this*
>
> *way I believe it offers the experience of humanizing the facilitators.*

I noted that the drama therapy seemed to serve as an "equalizer" between group members and

leaders. Though, of course, this kind of reflection is impossible to really know being that the one

in the power position is the one creating the data, this equalizing effect was observed in the

frequency with which the group members were willing to be playful with, and challenge, the

facilitators. There were moments where group members playfully scolded a facilitator for

forgetting a part of the exercise, or for pronouncing a word wrong. For example, during Session

Six of Self Esteem, I almost forgot to ask everyone to "move" the imaginary tree into the corner

of the room and a group member reminded me with a playful scolding of a *How could you?* Sort

of attitude. These kinds of comments were made in jest, and with a smile and I observed that

they demonstrated a level of informality and that the joking was made possible with the level of

playfulness that the groups enjoyed. The challenging of the hierarchy in this case, I believe,

allowed the group to take ownership over the ritual and thereby potentially increasing their

perception of their own choice and control of participation in the group.

Finally, the journal entries reflected the importance of facilitator as a "play object"

(Johnson, 2009, p. 95) onto which the rest of the group could project their experience, and

through which they could decrease their own level of risk. I took note of how this happened in

small ways every time any of the facilitators would use our own lives as examples for instance,

or when we shared our own feelings during the rituals, or if we would model some of the

behaviors and movements we were describing in the psycho-ed. But the most striking example

that was noted in the data was when the facilitators asked the group to sculpt us into the shapes

of how different feelings lived in our bodies. The group was able project their own experience

onto *our* bodies, thereby decreasing their level of risk and visibility. They could see their own

suggestions reflected back to them in our bodies which offered the chance for them to see

themselves in a more distanced, safe way and then were asked to feel how they felt in their own

body, while looking at us in sculpture.

Body Scan

Due to the limited amount of data in this section, I am synthesizing the analysis without

formally coding for themes. The three body scans all mentioned the following themes in some

way: the amount of energy in my body; the location of tension; the distinction between upper the

body and lower body. In each scan, I identified where energy was located in my body. In two of

the three scans (Session Four & Five), energy existed in my face and upper body. This reflected

a similar pattern in those entries of tension being in my chest and heat in my head and face.

While the third scan (Session Six), did not mention energy in the upper body or face, and instead

noted a relaxed quality in the face and legs, with no mention of tension.

It is impossible to really assess causality in such a small sample size. However, the noting

of energy and tension in the fourth and fifth sessions may reflect a level of activation (either in

enthusiasm or anxiety) in the facilitation. It may reflect the group's overall activation level upon

ending the group, that I, as the facilitator, was picking up on. I was specific in the scan after

Session Five to note that there was "*A lot of energy moving! In the group and in me! Excitement in my feet!*" Again, as this is my own observation of my body after a group experience, there is no way for me to know if the others experienced the level of energy that I experienced in observing them. But it is significant nonetheless that I noted energy in the group and I experienced the energy in my own body.

It is interesting that Session Six, while also being the last of the sessions, was also the one in which we ended the session with each group member (facilitators included) planting a little plant for themselves to take home. The ending ritual followed this planting and focused on individuals finding a place on the imaginary tree that they would like to sit, or a way they could take the tree imagery home with them. Some group members imagined sitting on its branches with their legs swinging free. Others mentioned hugging the tree and leaning up against its bark. Session Six was also the body scan that reflected less tension, more settling in my body. Though there is no proof of a causal relationship here, it is interesting that this last session, where something very active and soothing (like manually digging in the dirt and planting) was followed by a group ritual of closure and completion, ended with a body scan that demonstrated ease and relaxation in my body. I even noted in the scan that I felt *"Clear. Breathing deep…there is a settling here."*

Discussion

In working with groups for CPTSD clients, trauma experts emphasize the need for individual control, safety and stability. As is noted by Herman (1992), van der Kolk (2005), and Courtois (2004), individuals with a complex or developmental trauma history experience difficulty with self-regulation, relationships, identity, safety and security, among many others symptoms.   According to Herman (1992), particularly because of the difficulty with self-regulation and experiencing trust within relationships, groups have the potential for being a

therapeutic experience as well as a challenging (and risky) experience as well because of the increased demand of being in dynamic with other strangers. A focus on the creation of safety, therefore, is an agreed upon priority within groups for this population. However, how exactly this safety is created is either contentious as it relates to trauma disclosure, or simply not laid out in specifics in the literature.

My exploration was geared at the use of drama therapy to support the creation of safety in a group of CPTSD clients. I was particularly interested in reflecting on the tension that exists in CPTSD literature around how much to ask clients to disclose, when the disclosure happens, whether it happens at all and how that affects the creation of safety for a group serving clients with CPTSD. I was interested in searching for an alternative way into this conversation through the use of drama therapy, hoping that I would find that there are ways to invite group members into safety and participation in group dynamic that did not center on this dichotomy.

The data suggests that the drama therapy interventions used in this method were successful in addressing my inquiry. This study provides an approach of using drama therapy interventions that centered on play, metaphor, ritual and the imagination to provide a safe enough experience for clients to, at their own pace, enter the work and remain engaged with the group and with each other. Though this group was a Stage One psychoeducation group and does not allow early trauma disclosure, I would argue that clients were able to share pieces of themselves, and their experience of trauma, in contained and group-appropriate ways and that this sharing contributed to the safety of the group. The rituals offered the chance for the clients to share their truths, and be seen in their vulnerabilities (should they so choose) while also adhering to the limitations of Stage One groups.

The results suggest that the use of drama therapy techniques allowed group members to choose their level of participation, have control of their own level of sharing, and even opt out without having to completely disengage with the group. In this way, the drama therapy can be said to offer a way for each individual to find their own aesthetic distance from the material. Judith Glass (2006) used different expressive therapy techniques to support clients in finding the perfect distance from their own material that would allow them to continue to engage without being overwhelmed. I propose that the techniques included in this study, offered a chance for each individual to find that for themselves, and that it could be different for each individual. The opening and closing rituals seemed to create the kind of container that allowed group members to work at their own pace, engage with other group members to their own level of comfort and build a sense of group cohesion through play and laughter that allowed the group dynamic to support individual group members to become more comfortable to share and partake in the play.

I noticed that the drama therapy provided a layer of containment that came in the form of an invitation to join, to connect, to try something new, to have fun. This research suggests that the group connection may be, contrary to Herman's (1992) theory, an excellent way to establish safety in a group of CPTSD clients. Instead, it offers, as Frydman and Mcllellan (2006) identified, that the group cohesion itself serves as a method of containment that facilitated the creation of safety within the group. The data suggests that drama therapy, in a group, can successfully engage a CPTSD client while providing the experience of safety and stability for the client to relax and be able to join. This echoes the work of Johnson (2014) and Mayor and Dotto (2014) in that the play serves as a regulator and container in and of itself. These drama therapists suggest that the use of play can help clients be able to enter into the trauma work through engaging with their own life experience. This study, though not focused on using play to

disclose, does seem to support the notion that play itself can support clients to take risks and engage in the work, again, at a pace that they choose and that the group can contain. As it relates to my own positioning coming into the research, I found that the method allowed me, as a facilitator, to set guidelines around how much personal information was shared while not adding to a culture of shame or avoidance around their trauma histories.

The results also suggest that the drama therapy allowed group members to practice, in real time, taking risk of engaging in relationship. This echoes the work of Taylor and Saint Laurant (2017) who focused on using Somatic Experiencing to support group members in noticing and engaging with their own internal patterns of survival while being in group. Because this method provided a container and a culture that facilitated play and connection, and because the group was offered the chance to reflect on their experience of the group by engaging with the metaphor, I believe the members were encouraged to engage, then notice, and then share with the group, in perhaps similar ways that Taylor and Saint Laurant laid out.

Limitations

It is important to note that this study is limited because it is only taking into account the drama therapist's experience and is not taking into account other group participants. It is also limited in that I was not able to include the reflections of the other facilitators with whom I co-led groups. Thirdly this study is limited in that it is site specific, group specific. It did not control for variety of trauma exposure, nor did it control for the experience each member had with group work. It was a mixed bag in terms of acuity of symptoms of group members as well as exposure to group experience. A further study could be done to apply the same interventions to a more controlled population.

Further, with the body scan only being added midway through the study, the data and potential implications from this source of information remains limited. This small data sample

leaves me with lots of curiosities around how a body scan, done both by research and group members, could be used to chart group process, individual group members' self-awareness, and even an individual's capacity to experience safety in their own bodies. Questions that could be explored further include: How does the group experience affects the individual's somatic experience?; Does the group member's individual experience reflects the facilitator' own somatic experience? As this somatic experience of safety is something that CT survivors often struggle to feel, it would be a useful diagnostic tool as well as a useful intervention to ask group members to notice their own physical experience in both the beginning and ends of each group session.

Conclusion

This study provides several simple methods with which to add drama therapy into beginning trauma groups in service of creating the successful formation of a group that allows them to feel safe enough to allow them to enter into treatment. I am most interested in how we can make it possible for individuals to join a group knowing that these individuals often have trouble trusting others. I posit that this drama therapy method allowed this to happen uniquely because it provided a way for group cohesion and connection to occur while allowing for a diversity of individual choices amongst members of the group. The ritual provided a structure that allowed each individual to go at their own pace, while still cultivating an overall group culture that was invitational, fun and consistent. The group was enjoyable, engaging, and safe enough to join because there were infinite ways that *joining* could happen.

The data suggests that using a similar beginning and ending ritual, even in isolation, may potentially offer other psychoeducational or skills groups, a way for group members to connect to each other, access a possibly higher level of embodiment, and have more fun, which potentially may increase participation and engagement. Though as stated in the limitations of this

thesis, the groups were not controlled for trauma exposure or group therapy exposure, it is likely that the opening and closing rituals could be tailored to be appropriate for any psycho-ed or skills group. This data suggests that the repetition of the ritual, the imaginal quality, and the playful group experience were the importance additions to the group structure and that they enhanced the quality of the group's ability to connect to each other and share in safe and appropriate ways, in the context of a group that was not geared towards processing of individual's experience.

The next phase of this work would be to increase the amount of drama therapy in each group, using embodiment, movement and more structured exercises to explore the material that is being imparted during the group. Another possibility altogether would be to take this work into a group that used drama therapy exclusively to work with CPTSD clients and worked towards the relational themes that arose during these groups.

The results of this study, in addition to my personal experience in these groups, leaves me more committed to finding ways to treat trauma that work to safely confront the culture of fear and silence that surrounds trauma survivors. As I mentioned my own bias in the introduction of this work, I am leaving this experience more convinced that drama therapy holds within it the possibilities of decreasing fear through the use of play. Drama therapy interventions offer clinicians the chance to gently and playfully encourage clients towards the clinical work both directly and indirectly. I offer this reflective study as a contribution to the conversation around trauma treatment to encourage the possibility that we may, as clinicians, work without the fear of over-disclosure by creating creative and playful ways for clients to feel supported to share and also feel safe by providing opportunities to join into the group.

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