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Corrine Mertz
The effectiveness of psychodrama
for adolescents who have
experienced trauma

ABSTRACT

This study focuses on the effectiveness of psychodrama as a treatment for adolescents who have experienced trauma. This study looked extensively at adolescent trauma and three treatment frameworks designed to treat it, The Neurosequential Model of Therapeutics, Attachment Self Regulation and Competency, and Trauma Focused Cognitive Behavioral Therapy. This study also looked at psychodrama and psychodrama frameworks that are intended for use with trauma survivors. Psychodrama is an action- based treatment framework, where clients engage in therapeutic enactments.

The effectiveness of psychodrama was researched through qualitative interviews with seven clinicians who practice psychodrama with adolescents. Participants were asked specific questions about the effectiveness of psychodrama as well as how they measure effectiveness. Within this study all participants spoke to the effectiveness of psychodrama as a treatment for adolescents who have experienced trauma. Participants identified many ways in which they measure the success of their work, however only one participant spoke about using scientific measurements when measuring success.

**THE EFFECTIVENESS OF PSYCHODRAMA FOR ADOLESCENTS WHO HAVE
EXPERIENCED TRAUMA**

A project based on an independent investigation,
and submitted in partial fulfillment of requirements
for the degree of Masters of Social Work.

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2013

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TABLE OF CONTENTS

| | |
|---|-----|
| ACKNOWLEDGEMENTS | ii |
| TABLE OF CONTENTS..... | iii |
| LIST OF TABLES | iv |
| CHAPTER | |
| I INTRODUCTION | 1 |
| II LITERATURE REVIEW | 3 |
| III METHODOLOGY | 38 |
| IV FINDINGS | 44 |
| V DISCUSSION..... | 54 |
| REFERENCES | 63 |
| APPENDICES | |
| Appendix A: E-mail to Colleagues and Classmates as well as Facebook Posting.. | 69 |
| Appendix B: E-mail for Clinicians Identified Through Psychodrama Website | 70 |
| Appendix C: E-mail for Expressive Therapies Professors Identified through Lesley Professor Directory | 72 |
| Appendix D: LinkedIn Message for Searched Members.. | 74 |
| Appendix E: Talking Points for Recruitment Conversations with Colleagues, Classmates, and Possible Study Participants..... | 76 |
| Appendix F: E-mail to Possible Study Participants.. | 77 |
| Appendix G: Informed Consent..... | 78 |
| Appendix H: Questions for Interviews with Participants.. | 81 |
| Appendix I: HSR Approval Letter..... | 82 |

LIST OF TABLES

Table

1. Attachment Self Regulation and Competency Building Blocks 13

CHAPTER I

Introduction

The purpose of this study is to research the potential benefits of psychodrama as a treatment modality for adolescents who have experienced trauma. At their conference in May 2013 in Arlington, Virginia, members of the American Society of Group Psychotherapy and Psychodrama spoke about the lack of research within the field of psychodrama, and the need for more research to exist. Psychodrama is a specific treatment model that uses dramatic action to explore truth (Ridge, 2010, p.1). I am studying this topic because I hope to bring to light the effectiveness of this expressive art therapy. Psychodrama is of interest to me because I believe in the power of all expressive therapies and I want to contribute to the knowledge of expressive therapies within the field of social work. I chose to focus on psychodrama for my study because it is an intervention that speaks to me. I have been involved in drama and music most of my life and have found both of the avenues to be very therapeutic.

Traumatic experiences are events that are overwhelming, terrifying, shocking, and potentially life threatening. These experiences are subjective and developmentally bound. (Black, Woodworth, Tremblay, & Carpenter, 2012; Blaustien & Kinninburgh, 2010; Cohen, Mannarino, & Deblinger, 2006; Perry, 2009). According to the American Psychological Association “more than two thirds of children report experiencing a traumatic event by age 16” (American Psychological Association, 2013).

There are many treatment frameworks designed to treat trauma in adolescents, and three of these frameworks will be explored within this study. All three have been extensively researched, and have been proven effective treatments for adolescents who have experienced trauma. According to Zerka Moreno, a founder of psychodrama, “Psychodrama has been known as one of the most powerful approaches to the treatment of traumatized people for more than half a century”. Currently there are no studies that evaluate the effectiveness of psychodrama as a treatment for adolescents who experience trauma.

This study is beneficial to the field of social work because it contributes to the existing research on models for treating adolescent trauma. Currently the Social Work profession is driven by managed care and is shifting towards efficacy based treatments (Drisko & Grady, 2012). It is important that we look to evaluate all possible methods of treatment and not just focus on therapies that are already proven effective through studies. It is my hope that this study will provide insight for the social work profession about the effectiveness of psychodrama, and pique interest in other social workers about the use of this tool.

This study interviewed seven clinicians about their beliefs related to the effectiveness of psychodrama as a treatment for adolescents who have experienced trauma. This study will look at those findings, as well as the literature presented and draw conclusions on the effectiveness of psychodrama for adolescents who have experienced trauma. The first step of this study was to explore the literature on both adolescent trauma and psychodrama. This literature is presented in the following chapter.

Chapter 2

Literature Review

This study seeks to research the possible effectiveness of psychodrama as a treatment for adolescents who have experienced trauma. In order to understand whether psychodrama is an effective treatment, we must first understand adolescent trauma, how it affects the body, brain, and overall wellness, as well as the current recommended treatment options and their goals. This literature review will discuss adolescent trauma theory, and three common interventions. These three interventions are the Neurosequential Model of Therapeutics (NMT) (Perry, 2009), Attachment Self Regulation and Competency (ARC) (Blausteine & Kinniburgh, 2010), and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen et al. 2006, 2012).

The next step in answering this question is to gain an understanding of psychodrama and the theory behind it. This literature review will discuss a brief history of psychodrama, the theory behind it, and the main interventions involved when using classical psychodrama, followed by a review of psychodrama with trauma survivors. Two adaptations of classical psychodrama intended for use with trauma survivors will be explored. These two frameworks are the Therapeutic Spiral Model (Hudgins, 2000), and Cycles of Healing (Mosther & Yuckman, 2000). Finally, a section of related studies and research projects will be included.

In order to understand whether psychodrama is an effective treatment for adolescents who have experienced trauma we must discover themes within the recommended treatment goals of adolescent trauma from all three adolescent trauma theories/frameworks, and seek to

understand whether or not psychodrama is capable of helping adolescents reach some or all of the recommended treatment goals. By understanding this we will understand whether psychodrama is an effective treatment for adolescents who have experienced trauma.

Adolescent Trauma

Traumatic experiences are those that are overwhelming, terrifying, shocking, and potentially life threatening. These experiences are subjective and developmentally bound. (Black, Woodworth, Tremblay, & Carpenter, 2012)(Blaustien and Kinniburgh, 2010) (Cohen, Mannarino, & Deblinger, 2006, p.) (Perry, 2001). The DSM-IV-TR classifies traumatic experiences as “those events that involve experiencing or observing actual or threatened death, physical injury, or threat to physical integrity (American Psychiatric Association, 2000) and that result in feelings of terror, horror, or helplessness” (Blaustein and Kinniburgh, 2010, pp. 3-4).

Blaustein and Kinniburgh explain that this definition is limited and many “experts examining a newer diagnosis of developmental trauma disorder expand this definition to include other overwhelming experiences of childhood, that often occur within the attachment relationship, such as neglect, psychological maltreatment, attachment separations, and impaired care giving systems” (Cook et. al, as cited in Blaustein and Kinniburgh, 2010, p. 4) (van der Kolk, as cited in Blaustein and Kinniburgh, 2010, p.4).

The DSM- IV-TR’s definition of trauma is imbedded within the diagnosis of Posttraumatic Stress Disorder (PTSD). PTSD was added to the DSM-III after a number of social movements sprung up drawing awareness to the effects of interpersonal violence, and combat. PTSD pools all reactions to traumatic events under one category, within the DSM. PTSD is the only diagnosis in the DSM that is directly related to symptoms of trauma exposure, and is a

widely used diagnosis for people affected by trauma (Friedman, Resick, Keane, 2007, p. 4).

However, according to Breslau “only 5-13% of individuals exposed to a traumatic event will develop PTSD” (as cited in Blaustein and Kinniburgh, 2010, p.4).

Cook et al. argue that PTSD does not capture the effects of developmental trauma well. They state that children exposed to rupture in attachment, maltreatment, or violence within the home often do not meet the criteria for PTSD, however these children often do meet the criteria for the following diagnoses: “depression, oppositional defiant disorder, and attention-deficit/hyperactivity disorder, conduct disorders, anxiety disorders, eating disorders, communication disorders, separation anxiety disorder, and reactive attachment disorder” (Cook et al., 2005, p. 392). These diagnoses only capture symptoms of the child’s behavior and do not capture a picture of the child’s impairment. (Cook et al., 2005)

Through a comprehensive literature review, Cook et al. identify seven areas of possible impairment observed in children exposed to trauma. These areas are: attachment, biology, affect regulation, dissociation, behavioral regulation, cognition, and self-concept (Cook et al., 2005). Cohen, Mannrino, Kliethermes, & Murray add to this list perception and academic performance (Cohen, Mannarino, Kliethermes, & Murray, 2012). Given this information, for the purpose of this thesis I have chosen to use the Blaustein and Kinniburgh’s definition of trauma which states the following: “Traumatic experiences are those that are *overwhelming*, invoke intense negative affect, and involve some degree of loss of control and/or vulnerability. The experience of trauma is *subjective* and *developmentally bound*” (2010). Remembering that trauma is subjective and developmentally bound are key elements in understanding adolescent trauma.

The subjectivity of trauma is a key element within this definition because each person experiences trauma differently , and “what one individual finds traumatic may not be traumatic to another” (Black et al., 2012, p.1). The subjectivity of trauma is also connected to the symptoms expressed by trauma victims. Cohen, et al. argue children often have diverse and distinct symptomatic expressions of trauma: “Thus the experience of trauma depends not only upon exposure to a traumatic event but also on the individual child’s response to that event” (2006, p. 4).

The developmental component to trauma is another key point within this definition. Cohen et al. (2006) say “A child’s response to a trauma will be mediated by his/her age and developmental level” (p. 3). The Neurosequential model created by Perry also supports the idea that trauma is developmentally bound. Using this model Perry (2009) explains that brain development happens in a “hieratical fashion” (p. 241) starting with the brain stem, in utero, and finishing with the pre-frontal cortex in adolescents and early adulthood. As the brain develops it builds upon itself like building blocks with the lower parts of the brain acting as the foundation for the higher parts to expand upon. “Simply put, the development of higher parts of the brain depends on input from the lower parts of the brain” (Perry, 2009, p. 242).

When trauma impacts the brain it can slow down or stunt healthy brain development. If trauma happens to a child in the womb, perhaps by early exposure to drugs or alcohol, the brain can be negatively affected ---detouring the development of lower brain systems, such as the brain stem and the diencephalon. This dysfunction is then projected throughout the rest of the brain’s development, creating dysfunction throughout the brain system. However, if trauma happens when a child is 10, when the brainstem and diencephalon are fully developed, it will only affect the parts of the brain that are currently developing and those pieces that follow in development.

This developmental model explains why trauma effects an 18-month old differently than a 10 year old. (Perry, 2009) Cohen et al. (2006) support this argument by saying “ongoing traumas that start early in life have the potential to dramatically alter the trajectory of the young children’s development more than chronic traumas that begin later in adolescence.” (p. 4).

Trauma however does not only effect the way that the brain develops, but can alter the brain’s organization all together. Our brain organizes itself in a use- dependent fashion-- throughout development the brain strengthens neurons that are commonly used and prunes away neurons that are not. When the child experiences a trauma the stress response system within the brain is activated. If a child experiences continued trauma and stressors, and the stress response system is often activated, than the brain learns that this system is often used and it develops a “use dependent’ adaptation” (Perry, 2009, p. 244) which will cause the brain to reset and act as “if the individual is under persistent threat” (Perry, 2009, p. 244).

At the same time this is happening other neurotransmitters are being pruned to make room for the prioritized stress response system. This explains why some children who have undergone perverse trauma have difficulty retaining information learned in school. When a child is worried about being kept safe, and their stress response system is on high alert. This system takes over the brain and there is little room for other information or development. This can result in brain development being stunted, and children falling behind in other developmental tasks. Trauma can also alter brain patterns and neurotransmitter connections for an extended period of a child’s life, and possibly forever if the child does not receive proper treatment (Perry as cited in Black et al., 2012) (Perry, 2006).

Blaustein and Kinniburgh also highlight the impacts of trauma on development. Blaustein and Kinniburgh (2010) begin by explaining that a child is busiest in the first year of

life, they say within this time children are learning “the essential building blocks for the remainder of development” (p.11). They go onto explain that the child does most of their learning through the relationship forged between themselves and their primary caregiver. The infant relies solely on the primary caregiver as a form of reference to relate to the outside world. If the primary caregiver is able to provide a safe environment, meet the child’s needs consistently and provide predictability, than the child will internalize that the world around them is safe, consistent and predictable. Similarly if the primary caregiver is unsafe, unpredictable, and the child’s needs are not always met, then the child will create an internalized image of a world that behaves similarly. The child may also internalize that they are the only ones who can keep themselves safe (Blaustein and Kinninburgh, 2010).

Through his research in brain development Perry created the Neurosequential Model of Therapeutics (NMT). NMT “is not a specific therapeutic technique or intervention, it is an approach to clinical work that is informed by neuroscience” (Perry, 2009, p. 248). NMT is used as an assessment tool, and through this use of this assessment tool Perry expands on the idea that trauma can stunt brain development. If a Child is exposed to repeated trauma, their stress response system will be given developmental priority within the brain. “A 10-year-old child, for example, may have the speech and language capability of an 8-year old, the social skills of a 5-year-old, and the self-regulation skills of a 2-year-old” (Perry, 2009, pp. 249–250). Perry goes on to say the developmental age of a child also has a large bearing on the type of intervention that will be successful (Perry, 2009)

Within this model Perry also talks about the important role that caregivers play in the lives of children. Perry says that that an inattentive caregiver can directly affect the levels of norepinephrine, serotonin, and dopamine levels, which are chemicals inside the brain that affect

development, especially in young children whose brain stem is still developing. Perry also talks about the importance of the relational history and attachment. Perry says relationships where a child has a secure attachment to the caregiver “have some capacity to buffer the impact of trauma” (Perry, 2009, p. 249). Where as if a child has an insecure attachment, perhaps due to the impact of having several primary care givers throughout life, not only brain development, but also the child’s ability to be resilient in the face of trauma can be compromised.

Cohen et al. highlight the importance of the child caregiver relationship as well. Cohen et al. state that younger children are especially dependent on their parents reaction to a trauma, “if parents cope well most younger children do not develop serious long lasting trauma symptoms” (Cohen et al. 2006, p. 4). We also know that if a child develops an insecure attachment that their ability to be resilient in the face of trauma is diminished, as well as in other facets in life (Perry, 2009).

As stated earlier, Cook et al. focus on attachment as one of their seven impaired domains observed in children exposed to trauma. Cook et al. say “Early care- giving relationships provide the relational context in which children develop the earliest psychological representations of self, other, and self relation to other” (2005, pp. 392). They go on to report that 80% of maltreated children develop insecure attachment styles. This means that they learn to relate to people in the world from an insecure base. Children who are maltreated are not taught unconditional love, and instead are taught that they have to relate to their caregiver in a particular way in order to get their needs met (Cook et al., 2005).

Blaustein and Kinniburgh agree with this assessment by saying children who grow up in environments where their needs are not consistently met adapt their own behavior in hopes of their needs being met more often. Examples of these adaptations could look like a child who is

frequently fussy and overtly attention seeking. On the contrary other children might adapt by retreating and minimizing communication all together. The important thing to remember is the child will learn to communicate in the way that is most likely to get their needs met. Like Perry Blaustein and Kinninburgh also explain these communication deficits travel with the child throughout life and effect development moving forward (Blaustein & Kinninburgh, 2010, p. 13).

In accordance with Cohen et al., Cook et al., and Perry, Blaustein and Kinninburgh also talk about the importance of the caregivers. Like Cohen et al. they say caregivers are important in teaching the child self- soothing, also known as self -regulation skills. They say that without proper soothing from a caregiver during the early phases of life children can internalize emotional experiences as scary and lack the self -soothing skills to deal with their emotions.

Blaustein and Kinninburgh, like Cook et al., and Perry, also talk about the impact of a child with insecure attachment who does not have a secure base to explore from. Without a secure base the child is not able to feel secure enough, within themselves or their primary relationship, to explore the world around them. This can affect a child's sense of the world. "The child in the constantly stressed environment has less control, less impact, and less predictable understanding of the world, and often begins to internalize a sense of helplessness" (Blaustein and Kinninburgh, 2010, p. 13).

Blaustein and Kinninburgh pay particular attention to attachment within their own treatment framework, Attachment, Self-Regulation, and Competency (ARC). Blaustein and Kinninburgh (2010) say that early attachment "provides a model for all other relationships" (p.49). They also highlight the importance of attachment in helping children learn to cope with their early emotions. They highlight that the "attachment system provides a safe environment for healthy development" (Blaustein and Kinninburgh, 2010, p. 49).

Blaustine and Kinniburgh say, like Perry, that children who have experienced trauma are chronically in self-defense mode, and that they react quickly when they believe danger is present (2010), due to the over reactive stress response system described by Perry (Perry, 2009). Also related to Perry, Blaustine and Kinniburgh say that children without a secure base must invest all of their energy into keeping themselves safe, and do not have the ability to invest their energy in other accomplishments, which can in turn leave them behind in other developmental aspects (Blaustine and Kinniburgh, 2010).

One large developmental aspect that can be affected by trauma is the ability to learn and retain information in school. Blaustine and Kinniburgh (2010) state that “Positive school achievement, for instance, may require cognitive ability but also hinges upon the capacity to concentrate, ability to modulate arousal levels, ability to regulate behavior and control impulses, frustration tolerance skills, and interpersonal relationship capacities. Children who have experienced trauma may have impairments in any or all of these domains” (p. 15). These impairments make it exceedingly difficult for children who have experienced trauma to succeed in school.

Blaustine and Kinniburgh differ from Perry some on the topic of resilience. As mentioned earlier Perry states that an insecure attachment makes it difficult for children to foster resilience, however, Blaustine and Kinniburgh look at resiliency a little differently. They define resilience as “The process of, the capacity for, or outcome of successful adaptation despite challenging or threatening circumstances.” (Masten, Best & Garnezy, as cited in Blaustine and Kinniburgh, 2010, p. 18). They explain using this definition because it offers a wide array of possible scenarios to be viewed as resilience; they state that by using this definition “every child

we have seen is resilient, in some way and on some level” (Blaustine and Kinniburgh, 2010, p. 18).

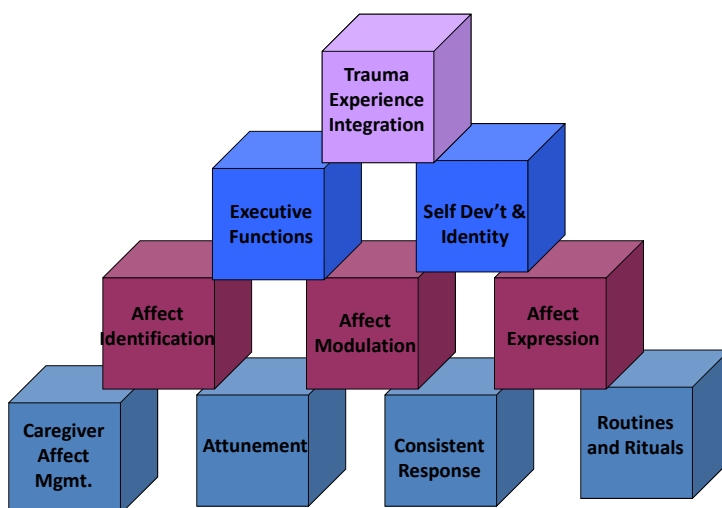
The effects of trauma on children and adolescents can be egregious. How severely an individual is effected by trauma depends on the severity of the trauma, the age at which the trauma occurred, and the direct relationship with the primary care giver. When trauma occurs at any age it effects current development and development moving forward. The younger a child is when a trauma occurs the more severe the impact will be. (Blaustein and Kinniburgh, 2010), (Cohen et. al, 2006), (Perry, 2009)

The effects the primary care relationship can have on a child are huge. The relationship between a child and their primary caregiver is a model for all relationships to the child. A rupture within this relationship can be a trauma for some children. When this relationship is not safe and secure, the effects can alter a child’s development and way of relating to the world. The effects of these alterations can be devastating (Blaustein and Kinniburty, 2010), (Cook et al., 2005), (Perry, 2009).

A deeper look at adolescent trauma models. Informed by this basic understanding of trauma and its impact on development, it is important to now look at what treatment models are currently being utilized in the treatment of trauma with children and adolescents. Echterling says trauma informed interventions are interventions which are “attachment grounded, resilience focused, and strength based” (p. ix). Three models that are widely used to inform and treat developmental trauma today are A.R.C. (Attachment, Self Regulation, and Competency), NMT (the Neurosequential Model of Therapeutics), and TF-CBT (Trauma Focused Cognitive Behavioral Therapy). All three of these models have a focus in Echterling’s three arenas.

Attachment, self regulation and competency (ARC). Blaustine and Kinniburgh (2010), who are the founders of the ARC model, say that in order to reverse these effects children first need a secure base that provides them with “some degree of felt safety” (p. 51). The ARC model is based on the idea of achieving mastery of three domains (Attachment, Self-Regulation, and Competency). In order to achieve this mastery of these domains they use a model of ten building blocks for the clinician and client to work towards. They arrange these ten building blocks in a pyramid, with each level of the pyramid making up a different domain.

10 Building Blocks



Blaustein & Kinniburgh, 2010; Kinniburgh & Blaustein, 2005

Four blocks that make up the base are all under the umbrella of Attachment. Blaustine and Kinniburgh (2010) say “Across cultures, the caregiving system, in whatever way it is defined, serves as the foundational context for healthy development. A safe, healthy attachment system can buffer the impact of highly traumatic stressors (Cohen and Mannarino, 2000); conversely, a stressed attachment system can, in itself, recreate a significant risk (cf. Crittenden, 1995; Wakschlag & Hans, 1999)” (p. 36). Blaustein and Kinninburg also talk about Attachment

being the most important domain within their framework. The four blocks that make up this domain are; Caregiver Affect Management, Attunement, Consistent Response, Routines and Rituals. Blaustein and Kinniburgh also notate this domain is the most important of the domains, as well as often the one with the most time spent on it.

The next level of the pyramid is formed from three blocks, and comprises the Self-Regulation Domain. Steele and Malchiodi also write about the importance of self-regulation (Steele and Malchiodi, 2012). Blaustein and Kinniburgh remind that trauma has a significant impact on a child's or adolescent's ability to regulate their "emotional, behavioral, and cognitive experience" (pg. 38). "The self-regulation building blocks target children's awareness and understanding of internal experience, ability to modulate that experience, and ability to safely share that experience with others. The three building blocks that encompass this domain are; Affect Identification, Modulation, Affect Expression.

The final domain of the pyramid is Competency. This domain is comprised of the following two blocks; Executive Functions, and Self Development and Identity. Blaustein and Kinniburgh note that children and adolescents who experience trauma, often do not develop a positive sense of themselves in the world, so it is important within the therapeutic alliance that we work towards helping them feel a sense of importance and place in their world. This domain is aimed at doing just that.

The last piece of the treatment model and the top of the pyramid is Trauma Experience Integration. Blaustein and Kinniburgh explain that this process is "ongoing and occurs over time within treatment, [as well as] embedded within the caregiving system" (p. 41). This piece surrounds helping children and adolescents integrate the memories of their negative experiences

into their lives, make sense of them, and “draw upon their learned skills to help them create an integrated understanding of self and the compactly to engage in present life” (p.41).

Throughout their text Blaustein and Kinniburgh offer suggestions and tools on how to reach mastery within each of these domains, as well as explain in depth the importance of each block. However, they intentionally do not offer a step by step instruction manual on how to achieve each of these, because they believe that each client and situation is individual and therefore needs an individualized approach to achieving these building blocks. What works for one client may not work for another.

The neurosequential model of therapeutics (NMT). The NMT is a model using Neuroscience to inform clinical interventions with children and adolescents. This model similar to ARC is not based on a step by step treatment plan. NMT begins with assessment and “identification of the primary problems and strengths” (Perry, 2009, p. 249) and then using that information to inform the “application of interventions (educational, enrichment, and therapeutic) in a way that reflects the child’s specific developmental needs in a variety of key domains and is sensitive to the core principles of neurodevelopment” (Perry, 2009, p. 249; Perry, 2006).

The NMT assessment is focused on the “developmental history of the child” (Perry, 2009, p. 249). It focuses mainly on the “timing, nature, and severity of developmental challenges” (Perry, 2009, p. 249), and then scores them “resulting in an estimate of developmental load” (Perry, 2009, p. 249). From the assessment one can put begin to put together what areas of brain development may have been affected by the trauma, remembering from earlier that trauma which happens earlier in life will have graver effects due to the cascading nature of brain development. The NMT also pays special attention to the relational

and attachment history of the child. Perry reminds that “Relational milieu can be protective and confer some capacity to buffer the impact of trauma, while relational instability and multiple transitions can exacerbate developmental insults “ (Perry, 2009, p. 249).

The next piece of this model is brain “mapping.” Brain “mapping” is a review of current functioning and allows us to make estimates of which neural systems and brain areas are involved in the various neuropsychiatric symptoms”(Perry, 2009, p. 249). Part of this process is done by analyzing a brain scan of the client’s head. The analysis must be completed by trained clinicians who know “child development, clinical development, clinical traumatology, and developmental neurosciences” (Perry, 2009, pp. 250 & 251). This process helps us to assess a child or adolescent’s developmental age, which in turn will help us understand how to work with the client. NMT says that the interventions which target the child or adolescents developmental level are more effective in helping to correct development. Brain “mapping” can also help to track the progress of treatment if it is reevaluated periodically.

From these two assessment frameworks NMT then offers specific treatment recommendations. The “mapping” process specifically helps to delineate a “unique sequence of developmentally appropriate interventions and enrichments that can help the child reapproximate a more normal developmental trajectory” (Perry, 2009, p. 251). Perry highlights, similar to ARC, that the sequence in which treatment is addressed is important, as well as the individualized structure of the treatment.

When sequencing interventions Perry says that you want to start with interventions that target the lowest level of brain development and then move upwards in development as progress is noted. Perry talks about the use of drumming to regulate the heartbeat, yoga and mindfulness is helpful for this as well, he also talks about using interventions that are appropriate for a

child's/adolescents developmental age. Similarly to how you teach a child to read at the level of reading he is able to complete. If you're working with an adolescent who presents as three, melts down and throws temper tantrums at hearing the word no, you have to work on this with them like you would a child who is actually three and then progress upwards as their development catches up (Perry 2006). Interventions are not only tailored to the individual but also to the different environments in which an individual receives treatment, and many of the interventions focus on using "repetitive activities [to] shape the brain in patterned ways" (Perry, 2009, p. 252).

Similar to ARC, NMT treatment recommendations also focus on the relational milieu of the child. Perry says "A primary finding of our clinical work (and many other researchers) is that the relational environment of the child is the major mediator of therapeutic experiences. Children with relational stability and multiple positive, healthy adults invested in their lives improve; children with multiple transitions, chaotic and unpredictable family relationships, and relational poverty do not improve even when provided with the best "evidence-based" therapies"(Perry, 2009, p. 252). NMT uses "relational health indexes to score the number of quality and relational supports capable of providing the safe, nurturing, and attuned environment in which the recommended therapeutic" (Perry, 2009, p. 252) interventions can be provided. Perry also recommends co-therapeutic activities that have the parent and child participating in activities together (Perry, 2009).

Trauma focused cognitive behavioral therapy (TF-CBT). TF-CBT is an evidence-based treatment with specific session structure. Cohen et al. notate several authors whom "recommend that youth with complex trauma respond best to phase-based treatment with an initial stabilization phase to provide coping skills, a trauma processing phase to understand

personal trauma experiences, and a final integration phase to consolidate and generalize safety and trust” (as cited in Cohen et al., 2010, p. 529, Ford and Cloitre, 2009; Ford, Cortois, Steele van der Hart, & Mijenhuis, 2005). The treatment focuses equally on the following three treatment phases; coping skills, trauma narrative and processing, and consolidation and closure. Usually clients attend 8-16 50 minute sessions with the sessions equally divided between the three phases. Cohen et al. notate that because adolescents who have experienced trauma have significant regulation problems within many areas as well as difficulty forming attachments within the therapeutic alliance that half the sessions should be re organized to have half the sessions focus on the coping skills phase, in addition they recommend that the total number of sessions increase to 25-30 sessions total (Cohen et al., 2012).

Cohen et al. also speak about the importance of creating and “sustaining the therapeutic relationship” (Cohen et al., 2012, p. 529). They however also highlight that this is especially important for adolescents who have experienced trauma and their caregivers. As stated earlier adolescents who have experienced trauma have difficulty trusting and attaching to people in their lives (Blaustein, M., Kinniburgh, K., Spinazzola, J., van der Kolk, 2005; Cook et al., 2005; Perry, 2009), and all three of the treatment modes examined have highlighted the importance of working on attachment with adolescents who have experienced trauma and their caregivers (Cohen et al., 2012).

The first phase of treatment is Coping Skills. The main goal of the coping skills phase is for the client to establish a trusting relationship with the therapist. This is gravely important for adolescents who have experienced trauma, as mentioned above. Within this phase it is also ideal for the therapist to gain some understanding and attunement to the adolescents’ trauma responses; however due to the unpredictable environment in working with youth this is not

always possible. Within this phase there are six headers which include enhancing safety, psycho-education, parenting skills, relaxation skills, affect modulation skills, and cognitive coping skills. Through teaching coping skills, relaxation skills, and affect management, as well as modeling a safe and predictable relationship with reasonable boundaries, the therapist helps the youth develop self-regulation skills as well as the ability to tolerate a reasonable level of frustration (Cohen et al., 2012).

In TF-CBT with adults enhancing safety is usually the final component, however Cohen et al. state that “for youth living with ongoing threats to safety or stability, addressing safety concerns becomes the first treatment priority and often is an ongoing process throughout TF-CBT” (Cohen et al., 2012, p. 530). Cohen et al. state that building a sense of safety is the most important goal of working with adolescents who have experienced trauma. They identify one of the most important ways to address safety is to include the primary caregiver in the TF-CBT treatment, and to help foster a safe relationship between them and the adolescent. The other important reason to include caregivers in treatment is to build or rebuild a health attachment between the caregiver and the adolescent. Building safe attachments can be expanded to other adults in the adolescent’s life such as teachers and direct care staff as well. The more safe and primary attachments that the adolescent experiences the more safety is enhanced (Cohen et al., 2012)

Once safety and attachment is achieved, and coping skills are taught TF-CBT moves into its second phase, Trauma Narration & Processing. In this phase youth are asked to talk about their traumatic experiences, with the goal of helping them understand how these experiences have affected who they have become. There are two headers within this phase and they are; traumatic narrative & processing, and in-vivo mastery of trauma reminders. This phase is similar

to the Trauma Experience Integration block from the ARC model. Cohen et al. warn however that it is increasingly difficult for youth who have experienced trauma to create a “fully integrated trauma narrative due to fragmented and non-linear nature of complex trauma memories” (Cohen et al., 2012, p. 536). With this knowledge however the therapist is encouraged to do what they can to promote integration of trauma within self, one idea of how to do this is by creating a “life story” (Cohen et al., 2012).

Trauma exposure is the second step of this phase and is done by creating a hierarchy of trauma events, places, and people etc. that trigger and or evoke anxiety. Through planned exposure to these events, places and people the client can practice using their self-regulation skills to regain control over their bodily reactions when triggered by these items (Cohen et al., 2012).

The third and final phase of TF-CBT is Consideration & Closure. The goal of this phase is to transfer the primary trust relationship and communication about trauma from the therapist to the primary caregiver. There are three headers within this phase and they are Conjoint Youth-Parent Sessions, Enhancing Safety and Future Developmental Trajectory, and Traumatic Grief Components as indicated (Cohen et al., 2012).

In Conjoint Youth-Parent Sessions the therapist meets conjointly with the youth and caregiver, and has the youth share their trauma narrative directly with the caregiver, with the hopes that the caregiver will respond supportively and the youth will learn that the caregiver is a safe person to communicate with about their trauma (Cohen et al., 2012).

In the Enhancing Safety component it is acknowledged that youth often need extra time to apply what they have learned in TF-CBT to their environment. They also need time to experience setbacks in those environments and be supported by the therapist in working through

those setbacks. In these sessions the therapist focuses on helping the youth tolerate setbacks and continues to help the youth frame the work overall as a positive experience.

The Traumatic Grief Components as indicated component focuses on the traumatic grief that may be experienced by the youth. Cohen et al. say that many but not all youth with trauma experience some traumatic grief. In this phase the therapist uses traumatic grief psycho education, and talks with the youth about their traumatic grief experiences, then also helps the youth understand how this grief might be affecting current relationships. Following this final phase youth are discharged from therapy.

Themes found within treatment theories/frameworks.

In looking in depth at these three treatment modalities, many similarities and themes emerge. Two of the most poignant are that of caregiver involvement, and caregiver attachment. Another theme that emerges is the importance of teaching self- regulation skills. Both ARC and TF-CBT also focus on trauma narratives, as a tool used to integrate trauma within the youth. However, The ARC model puts this step at the end of the work and emphasizes strongly that some youth are not yet at a place to do this work. Blaustein and Kinniburgh strongly emphasize the attachment, and self-regulation blocks as being a much more important piece of the work, whereas TF-CBT seems to use the trauma narrative as a way to bridge attachment and connection between the youth and the primary caregiver.

In assessing the effectiveness of psychodrama as an appropriate modality for youth who have experienced trauma it will be important to understand whether psychodrama can achieve any of these important researched outcomes to treatment, such as caregiver attachment, self - regulation, or trauma integration.

Psychodrama

Psychodrama was “conceived and developed by Jacob L. Moreno, MD” (ASGPP, 2013, np.). “Moreno first defined ‘psychodrama’ in *Psychodrama Volume 1* (1946, 1985): ‘Drama is the transliteration of the Greek word which means action, or thing done. Psychodrama can be defined therefore as the science which explores the truth by dramatic action’ (p.a.)” (Ridge, 2010, p. 1). Moreno was not interested in what was wrong with patients, rather he was interested in what would empower patients to have more meaningful relationships and drive spontaneity and creative fulfillment (Ridge, 2010).

According to the American Society of Group Psychotherapy and Psychodrama (ASGPP) “psychodrama employs guided dramatic action to examine problems or issues raised by an individual (psychodrama) or a group (sociodrama). Using experiential methods, sociometry, role theory and group dynamics, psychodrama facilitates insight, personal growth, and integration on cognitive, affective, and behavioral levels. It clarifies issues, increases physical and emotional well being, enhances learning and develops new skills” (ASGPP, np.).

Moreno used five instruments to describe the psychodramatic method. “Client”, “subject”, and “patient” are used interchangeably within this description.

1. The stage, which is an extension of life where fantasy and reality are not in conflict, provides an objective therapeutic setting that is designed to create a relief from tensions. Enactments within this therapeutic space encourage a mobility and flexibility for the protagonist, which stimulates an ultimate resolution of deep mental conflicts.

2. The subject or the patient (later called “the protagonist”), who is “warmed up” to give an account of his or her daily life, acts freely and spontaneously with a variety of

techniques employed to explore a patient's internal world of self or external world of others who are involved in their psychological conflicts.

3. The director has at least three primary functions: first as a producer who must develop the dramatic action, second, as therapist who engages in a therapeutic relationship with the patient, either confronting or laughing with them, and finally, as an analyst who interprets the responses of both the patient and the group members as they respond to the patient.

4. The auxiliary egos are group members who are involved in the action as therapeutic actors and are the extensions of both the director and of the patient as they portray roles within the client/patient's world. The auxiliary egos have a three-fold function: as the actor bringing to life the roles for the patient, as therapeutic agent of the director, guiding the patient, and as a social investigator exploring the internal world of the role they are chosen to enact for the patient.

5. The audience or group has a dual purpose, either in assisting the patient or by receiving help from the work the patient portrays. The audience assists most importantly with a client/patient who lives in an extremely isolated internal world shaped by delusions. In such a case, the audience provides a sense of reality and unconditional positive regard for the therapeutic work of the patient (Moreno, 1985, p. a-d as cited in Ridge, 2010, p. 1 & 2).

Going along with these five instruments, psychodrama also has three distinct phases.

1. The warm-up: The group theme is identified and the protagonist is selected.
2. The action: The problem is dramatized and the protagonist explores new methods of resolving it.

3. The sharing: Group members are invited to express their connection with the protagonist's work (ASGPP, 2013, n.p.).

Sociometry is a large component mentioned within the definition of psychodrama. Sociometry simply put is the "scientific measurement of social relationships" (ASGP, 2013, n.p.). Moreno developed this idea by studying and investigating "the structure of groups and society" (ASGPP, 2013, n.p.). Moreno believed that by studying the way in which a person engaged in relationships, one could learn a lot about a person. Moreno noted that people spend a lot of their time in groups, from infancy up and through adulthood. Using sociometric procedures/exercises within a psychodrama group, guides therapist/director into a patient's problem and are helpful in starting a psychodramatic session (Star, 1977).

"Psychodrama as a treatment tool (proposed by Jacob Moreno in the early 1920s) originated from the discovery that representing their own conflicts on stage enables people to release repressed and inhibited feelings." (Moreno, 1985 as cited in Gatta, Lara, Andrea, Paolo, Givoanni, & PierAntiono, 2010, p. 240). Zerka Moreno, Jacob Moreno's wife, also had a large role in the creation of psychodrama. Moreno began developing psychodrama in 1909, when he became "interested in treating Viennese school children by having them act out little plays written for them about various problems of behavior" (Starr, 1977, p. 2). This soon led to the children spontaneously creating their own plays. Moreno felt these spontaneous plays were a more direct representation of the children's individual experiences, and Moreno quickly began this spontaneous playing with adults through his Theater of Spontaneity (Starr, 1977).

Theater of Spontaneity was a theater group where members went out into the world and brought back information from news events. From there, actors were assigned roles in the story and were then asked to act out the scenario on stage in front of an audience. This way of acting

out stories shed light on the interpersonal workings and dynamics within the story, allowing the audience to see the story from a whole new perspective. Moreno called this technique Sociodrama. These were largely provocative shows as Moreno's troupe staged reenactments of "the Eichmann and the assassination of John F. Kennedy" (Starr, 1977, p. 3). Sociodrama is now used in classrooms, churches and community organizations all over (Starr, 1977).

Psychodrama itself has a close connection with catharsis, "meaning a cleansing and purifying" (Starr, 1977, p. 3). Historically, this word is connected with "Aristotelian ideas about tragic drama" (Starr, 1977, p. 3). Aristotle believed tragedy "deeply affects the spectator by arousing both pity and fear and eventually produces catharsis of emotions in the spectator as he watches the unfolding of human conflict" (Starr, 1977, p. 3). This is greatly relevant in psychodrama because all group members are encouraged to identify with the difficulties and roles of others, and to share about these experiences with group members. Psychodrama is almost always practiced in groups.

When practicing classical psychodrama, there are three main components; warm-up, enactment/action, and sharing. Warm-ups are "aimed at developing group cohesion, spontaneity, trust in the director, interest and concern for the protagonist, safety in the group, and the emergence of a protagonist whose problem is of concern for the group (Blatner, 1996; Taylor, 1998)" (Blatner, 2000, p.5). Sometimes the warm-up involves specific techniques such as sociograms or sociodramas. It is important when choosing a warm-up to begin with activities that are "relatively neutral", meaning "that the warm-up should be a task which affords the participant a good deal of choice regarding the amount of personal disclosure she is willing to make" (Leveton, 1992, p. 22). Following warm-up activities, the group begins the selection of a protagonist (Blatner, 2000; Leveton, 1992).

Protagonist “is the term for *the role* of the individual who is seeking to work out a problem, gain insight, or develop an alternative response pattern. It is generally the principal role played in an enactment, and the person’s experience that becomes the central focus of the group” (Blatner, 2000, p.3). Protagonists are usually selected by one of the following three ways: self- selection, meaning an individual volunteers; director selection, where the director chooses a group member; and by group selection, meaning the group either intentionally or unintentionally nominates a member (Blatner, 2000).

Once the protagonist is selected, the protagonist begins to set the scene for their enactment/action. This process may be facilitated by the director. Throughout the scene, the director may prompt the protagonist to call upon auxiliaries from the audience. All of the action within the enactment is derived directly from the protagonist themselves. This is made possible through several of the following psychodramatic techniques; these techniques may also be employed within the warm-up; “ role reversal, replay, mirror, soliloquy, doubling, asides, empty chair, role training, cutting the action, action sociometry (or ‘sculpting’), multiple parts of self, and surplus reality scenes” (Blatner, 2000, p.5). Some of the most commonly used techniques are explained further as follows.

Role reversal refers to an auxiliary trading places with the protagonist. Zerka Moreno explains doubling and mirroring as the following; Doubling refers to using the protagonist to call an auxiliary on stage to represent a part of the protagonist’s self. “The patient [the protagonist] represents the deeper, inner levels of experience which the ego [the auxiliary] acts as a double, copying physical bearing in every way and representing the outer levels” (2006, p.38). Mirroring is the act of a double, reflecting protagonist’s movements, sentiment, and sometimes words (Z. Moreno, 2006). The empty chair is literally an empty chair, which can be used within

the enactment to represent anything from an individual to an organization, or even a more abstract idea/concept.

The protagonist and the director decide together when the enactment is finished, usually by having the director check in with the protagonist about whether it is a good place to stop. The protagonist has the final say in this matter. Immediately following an enactment, the group members, as well as the director, participate in sharing. During sharing, each group member is encouraged to share with the protagonist how they were personally affected by the protagonist's work. Group members are asked to share only about their own experiences or feelings, and to avoid statements such as, "I never knew John was the kind of person who felt so deeply about his family" (Leveton, 1992, p.149). Instead, group members are encouraged to use statements such as, "I was touched by how much feeling you had for your family" (Leveton, 1992, p. 149). During the sharing, the protagonist is asked to listen without responding to other group member's statements (Leveton, 1992).

Adaptations for practicing psychodrama with trauma survivors. Given that PTSD is the DSM diagnosis for trauma, in the book *Psychodrama with Trauma Survivors*, Kellermann discusses trauma through the lens of PTSD. Kellermann states "[classical] psychodrama has been successfully employed with numerous traumatized clients for over 50 years" (Kellermann, 2000, p. 24). When using psychodrama with trauma survivors tweaks to the above classical model are suggested. The tweaks are designed to promote physical and emotional safety for all participants. The idea behind this all is that participants cannot confront their traumas or even begin to talk about them unless they feel safe in the environment (Hudgins, 2000). Two specific psychodrama models were developed to specifically for the use of treating trauma; The

Therapeutic Spiral Model (Hudgins, 2000), and Cycles of Healing (Mosher and Yuckman, 2000).

The therapeutic spiral model. Expanding upon classical psychodrama, Hudgins created the “therapeutic spiral model”, specifically for treating clients with a diagnosis of PTSD. “The therapeutic spiral model (TSM) was developed to provide clear clinical guidelines and action intervention structures for psychodrama with trauma survivors” (Hudgins, 2000, p. 229). TSM is a clinical structure of classical psychodrama intended to reduce the risk of retraumatization.

TSM “intends to provide;

1. Client-friendly constructs of experiential self-organization for trauma survivors.
2. Clear clinical structures for safe experiential psychodramatic psychotherapy; and
3. Advanced action intervention modules for containment, expression, repair, and integration of unprocessed trauma material” (Hudgins, 2000, p 230).

The TSM “was developed over 20 years of clinical and training practice using experiential methods with survivors of severe sexual and abuse” (Hudgins, 2002, p. 1).

TSM also has three main components which are represented by strands within its spiral graphic. The first strand is energy. “Energy is defined as the ever-renewable state of spontaneity and creativity from classical psychodrama” (Hudgins, 2000, p. 234). In TSM, this is representative of one’s spirituality, which can be “accessed through a rich source of historic familial, gender, racial, cultural, and spiritual roles” (Hudgins, 2000, p. 234). Tapping into this energy allows the protagonist to create empowering roles such as a guardian angel, physical strength, or a connection to a higher power within the enactment (Hudgins, 2000, Hudgins 2002).

The second strand is experiencing. “Active experiencing includes awareness of sensations, perceptions, non-verbal behaviors, intuition, and emotional nuances. Conscious

experiencing of the unprocessed images, body memories, distorted thoughts, and dissociated feelings is structured so as not to effectively overwhelm the protagonist and trigger uncontrolled regression” (Hudgins, 2000, p. 234). Experiencing allows the protagonist to become emotionally aware of when they may feel triggered during the enactment and when they need to return to the first strand of the spiral (Hudgins, 2000).

The final strand is meaning. People create narratives for their lives based on past experience and meaning. “When cognitive meanings are attached to accurate experiencing these symbolic representations create realistic goals and expectations about self and others. However, when trauma distorts belief systems, it is important to spend time sorting out new personal narrative based on personal experience, not introjected meaning” (Hudgins, 2000, p. 234). Understanding meaning from past experiences can help the protagonist rewrite their narrative for navigating similar situations in the future (Hudgins, 2002).

The TSM introduces positive roles within the psychodrama, specifically roles meant for containing safety. These roles are created through “the trauma survivor’s intra psychic role atom (TSIRA)” (Hudgins, 2000, p. 236). “TSIRA is a clinical map of the essential roles in the personality structure of a trauma survivor at any given moment (Hudgins 1998; Toscani & Hudgins 1996)” (Hudgins, 2000, p. 236). Enactments are completed through utilizing these roles as well as a continuous check-in from the director with the protagonist regarding feelings of safety. These three types of roles are prescriptive roles, restorative roles, and containing roles (Hudgins, 2000).

Another cornerstone piece of TSM is a warm-up, specifically designed to reinforce safety. This exercise involves various scarves being placed in the middle of the circle, and each member choosing “at least one scarf to represent a strength they bring to the group today”

(Hudgins, 2000, p. 235). This exercise can be called on again within the psychodramatic session if at any point the director feels the trauma material is breaking through to the present (Hudgins, 2000).

The inherent goal of TSM is “to produce a safe and effective system for treating trauma survivors” (Hudgins, 2000, p. 251). This is accomplished through melding classical psychodrama with the clinical structures learned through recent trauma theory.

Cossa writes about using the TSM with adolescents. Cossa says that when using this framework with adolescents particular attention should be paid to prescriptive roles. Cossa also states that. Within these roles are roles of interpersonal strength, interpersonal roles help adolescents connect to the world around them. Cossa states that when doing a group with adolescents one must spend a lot of time fostering interpersonal connections within the group. During adolescence it is common for interpersonal relationships to be a large part of how an adolescent defines themselves and their worth. Creating healthy interpersonal connections within the group is the key to creating a group atmosphere that feels safety (Cossa, 2006).

Cycles of healing. Mosher and Yukman created another psychodramatic model for the treatment of trauma. This model is specifically aimed at treating developmental trauma. This model is Cycles of Healing. “This model was initially derived from correspondences between the cycle of the seasons and the cycle of human development” (Mosher & Yukman, 2000, p. 255). This model identifies four types of developmental trauma; abandonment, betrayal, disempowerment, and chaos, as well as these four resulting personal mythologies. Mosher and Yukman explain personal mythologies as incomplete life cycles “driven by interrupted developmental cycles” (Mosher & Yukman, 2000, p. 255).

The healing circle is divided into four parts which are used in viewing the stages of human development. This cycle repeats itself and can be altered or interrupted by trauma. The quarters in this circle are tied to the cycle of seasons within the Native American Medicine Wheel. Mosher and Yukman say that when human beings experience trauma during one of the four stages of development, the experience of the trauma results in similar patterns of living whereby humans “continually seek out conditions in life that will enable them to replay trauma (Fromm and Smith, 1998)” (Mosher & Yukman, 2000, p. 257). “The quartered circle can be used to view our apparently linear lives as the repetition of a developmental cycle” (Mosher & Yukman, 2000, p. 257).

The quadrants of this circle focus directly on the relationship between the child and their social environment. Quadrant one is called nurturing. This quadrant coincides with Spring on the Native American Medicine Wheel. This stage encompasses the infant being held both physically and metaphorically by the parent. This stage “facilitates the development of *feelings* beginning with *trust*” (Mosher & Yukman, 2000, p. 259).

Quadrant two is called intruding. This quadrant coincides with Summer on the Native American Medicine Wheel. This stage encompasses the parent playing and making eye contact with the infant. This stage “facilitates the development of dealing successfully with *wanting* and developing *intuition*” (Mosher & Yukman, 2000, p. 259).

The third quadrant is called challenging, and corresponds with Fall on the Native American Medicine Wheel. The parent sets age appropriate developmental tasks for the child in order to lead the child towards a sense of mastery. This stage “facilitates confidence in *doing* and the experience of *sensation*” (Mosher & Yukman, 2000, p. 259).

The fourth and final quadrant is called structuring and coincides with Winter on the Native American Medicine Wheel. In this stage, the parent enforces limits to safely hold and restrain the child. This stage “facilitates the development of *thinking*” (Mosher & Yukman, 2000, p. 259).

A person can experience trauma in any of the stages. The effects of trauma on a person’s development are directly correlated to the developmental stage in which the trauma occurred. True as in the fashion of the Native American Medicine Wheel, the themes within these quadrants repeat themselves throughout human development (Mosher & Yukman, 2000).

In discussing trauma, Mosher and Yukman identify “four kinds of trauma relating to the stages of development within the early parent/child relationship” (Mosher & Yukman, 2000, p. 260). The first type of trauma correlates with the first stage of development, and is experienced when the nurturing environment fails to nurture the child, creating an attachment rupture. This rupture “can affect the child’s life long capacity for attachment” (Mosher & Yukman, 2000, p. 260).

The second type of trauma correlates with the second stage of development. It is referred to as betrayal trauma, in which a child may experience unfulfilled realistic or unrealistic expectations of others. This may lead to a child blaming themselves or others for difficult life experiences, rather than viewing the world from a balanced stance (Mosher & Yukman, 2000, p. 260).

The third type of trauma correlates with the third stage of development, and encompasses a child feeling a sense of disempowerment. This disempowerment stems from the child’s lack of being taught developmentally appropriate skills by either the parent(s) or other adults who act as

teachers. This form of trauma can stunt a child's growth and leave them partaking in manipulative attachment seeking behaviors (Mosher & Yukman, 2000, p. 260).

The fourth type of trauma corresponds with the fourth stage of development, and encompasses a child's feeling of being overwhelmed by their sense of inability to create and make sense of their world. This occurs when the child's social environment is inadequate for this growth and understanding to occur. This type of trauma can lead to the child experiencing what we refer to as post-traumatic stress disorder (PTSD) (Mosher & Yukman, 2000, p. 260).

This idea that trauma is developmentally bound is supported by the definitions and concepts within; the ARC model (Blaustein & Kinniburgh, 2010), NMT (Perry, 2009), CBT (Cohen et al., 2006).

Mosher and Yukman continue to explain if trauma is harsh enough, it can impact a person's ability to access the specific developmental stage in which the trauma occurred. This in turn, causes the person to create a personal cycle of development which excludes that specific quadrant. "Until we have integrated the traumatic experience into a fuller view of reality, access to this quadrant is under developed, because it is unknown to us" (Mosher & Yukman, 2000, p. 265). Without having access to the complete developmental cycle, a person is unable to experience the full integration of self. Mosher and Yukman refer to this as the half-life cycle.

Utilizing this developmental model, Mosher and Yukman provide a specific outline for psychodrama directors. This outline is called the healing circle model of intervention. This model provides specific psychodramatic interventions, each linked to specific human development quadrants within the cycle of human development. These interventions are designed to promote integration of a developmental stage that has been cut out of the cycle. Within this model, the director takes on different roles for each stage of development.

Designed to promote integration of the nurturing stage, the director takes on the role of caring leader. The caring leader role is a role that encompasses: “protecting, positive regard, friendship; love and affection; unconditional acceptance of being; inviting feedback, support, praise, encouragement, and genuineness” (Mosher & Yukman, 2000, p. 267).

Designed to promote the integration of the intruding stage, the director takes on the role of emotional stimulator. This role encompasses: “charisma; intimacy; creativity; playfulness; personal confronting; emphasizes release of emotions through demonstration; intrusive modeling: stimulates group by the use of self” (Mosher & Yukman, 2000, p. 267).

Designed to promote the integration of the challenging stage, the director takes on the role of director. This role encompasses: “challenges to new behaviors; asks for answers rather than providing them; stresses expression of emotion through suggestion; sets limits, goals, rules, norms; sets direction of action; directs” (Mosher & Yukman, 2000, p. 267).

Designed to promote the integration of the structuring stage, the director takes on the role of meaning attributor. This role encompasses: “interprets reality; concerned with group issues; gives names to experiences; teaches techniques of cognition; provides frameworks for how to change” (Mosher & Yukman, 2000, p. 267).

Integrating these methods, “increases the attunement between director, protagonist, and group” (Mosher & Yukman, 2000, p. 267). As noted in the ARC model, attunement is one of the four building blocks within the attachment domain (Blaustein & Kinniburgh, 2010). Although the healing circle model is based upon a developmental trauma framework, it only uses case studies with adult patients, and so, it is unclear as to whether this model is utilized with adolescents.

The Therapeutic Spiral Model and The Cycles of Healing Model were created with the intent of treating trauma. The existence of these psychodramatic models provides evidence that these psychodramatists believe in the ability of psychodrama as a treatment for people with trauma. It is, however, unclear from the description of these models whether or not they are effective models for treating trauma, as no research studies have been found proving or disproving these theories' effectiveness.

Zerka Moreno says that "Psychodrama has been known as one of the most powerful approaches to the treatment of traumatized people for more than half a century" (Kellerman & Hudgins, 2000). Keller and Hudgins go on to explain "The reason for this is very simple. Psychodrama reaches to the hearts of people who cope with everyday difficulties, misfortunes, crises and disasters of life" (Kellerman & Hudgins, 2000, p. 11). It is clear through this literature that there is belief for some in the psychodrama community that psychodrama can be used to treat trauma.

Similar Research Studies

Two studies focus on evaluating the effectiveness of psychodrama in treating PTSD, remembering from earlier that PTSD is the DSM IV-TR's diagnosis designed to encompass trauma, both were completed on adult patients. (Rademake, Vermetten, & Kleber, 2009, and Narr, Doreian-Michael, & Santhouse, 1998; Lantican & Mayorga, 1993). Rademake et al. and Lantican and Mayorga's studies do not focus on psychodrama exclusively but rather assess its effectiveness alongside other treatment modalities. Other adult studies pertaining to the efficacy of psychodrama include a study on the effectiveness of psychodrama on Alcoholics Anonymous groups (Avrahami, 2003), and a study assessing the effectiveness of integrating psychodrama

with Cognitive Behavioral Therapy when treating moderate depression in university students (Hamamci, 2006).

One study directly addresses the impacts of psychodrama treatment on adolescents who have experienced trauma, or who have been diagnosed with PTSD. This is a study on the effectiveness of psychodrama treatment on girls 11-13 who have experienced trauma (Carbonell & Partelano-Barehmi 1999). Similar studies found include symbol drama as treatment for adolescents with dissociative and PTSD symptoms (Nilsson & Wadsby, 2010); and a dissertation by Crook on the effectiveness of psychodrama as a treatment for school aged children who have experienced sexual trauma and who have dissociative characteristics (Crook, 2010).

Other studies focusing on the use of psychodrama with adolescents focus on other symptoms and treatment frameworks and include the following: neurotic aspects (Holmes, 1884) anxiety related to taking tests (Kipper & Giladi, 1978); psycho-behavioral disorders (Gatta et al., 2010); narcissistic issues (Guile, Ducasse, Aupetit, & Albert, 2005 as cited in Gatta et al., 2010); preventing behavioral disorders in adolescent immigrants; adolescents who have committed sexual offenses (Reveillud & Guyod, 2009 as cited in Gatta et al., 2010); adolescents struggling with eating disorders (Diamond-Rabb & Orell-Valente as cited in Gata, 2010); adolescents who have experienced violence (Verhofstad-Denev, 1999) substance abuse, risky sexual behavior, and academic failure (Caso & Finkelberg 1999 as cited in Gata et al, 2010; Kruczek & Zigelbaum, 2004). In addition, one study addresses the effectiveness of multimodal treatment, including psychodrama, on children and adolescents who expressed suicidality using the Global Assessment and Functioning scale as their measure of success (Högberg & Hällström, 2008).

Although the aforementioned studies do not specifically mention trauma, it is likely that participants in these studies have experienced trauma. Aside from Carbonell and Parteleno-Barehmi, and Crooks' dissertation, none of the other studies mention studying the efficacy of psychodrama specifically based on trauma. In their definition of trauma Blaustein and Kinninburgh note that trauma is subjective, meaning that trauma is based on a person's personal life experience, and what is traumatic to one person may not be traumatic to another (Blaustein and Kinninburgh, 2010). Knowing trauma is subjective, we cannot look at other studies and assume they assessed the efficacy of psychodrama as a treatment for trauma, because we do not know how or if trauma was a factor for participants.

The inclusive data provided from these studies directly points to the need for psychodrama to be studied further. It has not yet been determined whether or not psychodrama is an effective treatment for adolescents who have experienced trauma. In order to explore and begin to answer this question, this study sought to interview clinicians who practice psychodrama with adolescents. This method of study is one that has not yet been researched, and will hopefully provide some insightful data on the topic.

Chapter 3

Methodology

This study researched the possible benefits of psychodrama as a treatment modality for adolescents who have experienced trauma. This topic was researched through a qualitative study of 12 clinicians who employ psychodrama as a treatment modality in their clinical practice. This method was chosen for its ability to connect with data collected on an observational level. Rubin and Babbie say “In qualitative research we immerse ourselves in a more subjective fashion in open-ended, flexible observations of phenomena as they occur naturally, then try to discern patterns and themes from an immense and relatively unstructured set of observations” (2013, p. 96). They go on to say “A qualitative inquiry, in contrast [to quantitative], might probe into a deeper meaning and social context of the process and outcomes in each case.” (2013, p. 95). A qualitative study was chosen because the researcher wanted to dive into understanding the deeper meaning and constructs around the possible effectiveness of psychodrama in treating adolescents who have experienced trauma.

Researching this question through clinicians provided an expert lens that would have been missing in a study exploring the effects through adolescents directly, and this expert lens may prove to be helpful in analyzing the effectiveness of the treatment. Another reason the researcher chose to collect data from clinicians was the desire to understand the thoughts behind why a trained expert would or would not choose to use psychodrama with an adolescent who had experienced trauma.

A qualitative approach was chosen for its ability to glean more information and a deeper understanding from the specialist perspectives of each of the clinicians during a direct interview as opposed to a survey. Dogan studied the effects of psychodrama on attachment in young adults, and used a mixed method study model. In their findings they report that their quantitative data did not yield a “meaningful difference”, however they noted that their qualitative data showed “participants improved themselves in understanding the self; developing insight; having awareness of attachment styles being natural and forthcoming in their relationships; having self-confidence; developing listening, empathy and coping skills; and seeing life from a more hopeful perspective” (abstract). The findings from this study supported the researcher’s decision to use a qualitative method because it showed that the qualitative portion of their study produced more meaningful data.

Sample

For the purpose of this study, clinician was defined as any person with a master’s level degree or higher in Social Work, Psychology, Counseling, or a related field who has practiced counseling psychotherapy, or psychodrama with individuals or families. The sample was recruited using non-probability sampling, as well as snowball sampling. Participation in this study was voluntary.

E-mails (appendix A) were sent to classmates and colleges asking them to pass along the study to any of their own colleagues who might fit the study criteria. This message was also posted on Facebook, both on the researcher's own profile and on the Smith SSW Student Org. page.

Participants were also recruited from a data base of certified psychodramatists found on <http://www.psychodramacertification.org/>. This website has a public list of registered

psychodramatists which can be searched through a topic or area location. As this database was a public directory no permission was requested before contacting the listed psychodramatists. Psychodramatists were contacted, via e-mail (appendix B), if they identified working with adolescents on their profile.

Recruitment e-mails (appendix, C & D) were also sent to a public listing of professors within the Lesley University Expressive Arts program, and people who identified themselves as psychodramatists on LinkedIn.com¹. These e-mails were sent using the college directory, and prior approval from the colleague was not sought.

A small amount of recruitment was done through word of mouth using identified talking points (appendix E). Once potential study participants contacted the researcher they were sent the e-mail provided in appendix F.

Once study participants agreed to participate in the study they were sent the informed consent letter (appendix G) via e-mail. Participants were given the option to print the informed consent themselves, or to provide the researcher with an address where a printed form along with an addressed stamped envelope could be mailed. Participants were asked to read and sign the letter, and to return it to the researcher before interviews were scheduled. Participants were required to return a signed paper copy of the form to the researcher. In one instance this form was signed and returned in person.

Telephone and Skype interviews were scheduled only after the informed consent was received. The in person interview was scheduled first as participants participating in this person

¹ LinkedIn is a social networking website aimed at connecting people through professional experiences and interests.

was given the option to sign a paper copy of the informed consent at the beginning of the interview.

Data Collection

Before Data collection began, approval was obtained from the Smith College School for Social Work Human Subjects Review Board. Participants' confidentiality was protected by the researcher by removing any identifying information from data that was shared with the thesis advisor, and from information published in the findings chapter of the thesis. The researcher was the only person able to view participants' names and other identifying information. All electronic data collected including audio files were stored on a password protected computer, to be saved for three years, and then deleted if no longer needed. All paper copies of data and notes were stored in a locked file cabinet to be saved for three years, with only the researcher having access to the cabinet. Upon the completion of the three year time period if the data is no longer needed it will be shredded and recycled. If any data was needed past the three year window it will be kept in the same safe fashion and then disposed of when it is no longer needed.

Participants were interviewed either in person, over the phone, or on Skype. These methods were selected so as not to limit the geographic area of potential participants. All except for one interview were conducted via Skype or phone. In order to protect confidentiality the researcher placed herself in a room alone within her home with a closed door and quiet atmosphere. The one in person interview took place in the interviewees' home, when no one else aside from the researcher and the participant were home. Interviews were recorded using a digital voice recorder, and all audio files were stored on a password protected computer for three years.

Before beginning the interview questions participants were asked verbally to identify the following demographic information: race/ethnicity, gender, degree, geographic location, specific psychodrama training, and how many years they practiced in the field.

The interview was a structured interview and participants were asked open-ended questions in order (appendix H). Open-ended questions were used to give the participants freedom to answer any way they like. It also gave the interviewer the opportunity to use probes, and gather further information about an answer. Rubin and Babbie (2013) state that open ended questions can be useful when limitations leave “insufficient time to pursue less structured strategies in a comprehensive way” (p.126).

Following the first interview it became apparent that it would be helpful to have two specific pieces of information provided with the answer to the first question. In instances where the information was not already provided the researcher asked participants to identify whether they practiced individually or in groups, and they type of setting they practiced it (community mental health, private practice etc.). In one instance interview questions were provided to the participant in advance, per the participants’ request.

Questions were created by the researcher and the thesis advisor then approved the Smith College School for Social Work Human Subjects Review Board. Interviews were completed in a time frame of 20-30 minutes. Data collection began February 1st and was completed by May 15th.

Data Analysis

All audio files were transcribed into word documents, and then input into MAXQDA² software for coding. All codes were created by the researcher, and the software was used only to organize and highlight researcher created codes. Data was shared with the thesis advisor only after all identifying information had been removed. The codes generated reflected the themes that emerged in response to the interview questions and related to the participants' opinions of the possible effectiveness of psychodrama as a treatment modality for adolescents who have experienced trauma.

² MAXQDA is a unique Qualitative Data Analysis software program that allows users to systematically organize, evaluate and interpret textual and multimedia data. A powerful tool for classical QDA and knowledge management, MAXQDA has been the choice of academic and research institutions, individuals and businesses around the world since the release of the first version in 1989. MAXQDA is not limited to a certain type of research, but can be used with different approaches, such as content analysis, Grounded Theory, and mixed methods (MAXQDA Website, 2013).

Chapter 4

Findings

This chapter will present the findings of this qualitative study of clinicians who practice psychodrama with adolescents, and their answers to questions about the possible effectiveness of psychodrama as a treatment for adolescents who have experienced trauma. The first section of this chapter will identify the demographics of study participants. The second part of this chapter will outline the qualitative findings of this study. These findings will be organized in sub sections directly related to the five questions participants were asked. Following a breakdown of questions general themes will also be discussed.

Demographics

This study consisted of seven clinicians who identified as having a Masters in Social Work, Psychology, Counseling or related field, who have some psychodrama training, and who are currently practicing, or have practiced, psychodrama with adolescents (ages 13-22). Six participants self - identified as Caucasian. One participant identified as being raised Caucasian, however stated that she may not actually be white. Five participants identified as female, and two participants identified as male. When asked about their degrees, three female participants identified as holding a Masters in Social Work, two male participants identified as holding Masters in Counseling and Psychology, and two female participants identified as holding a Masters in Expressive Arts Therapy. Geographic locations ranged all over the country, with the bulk of participants identifying as being from the east coast.

When asked about specific psychodrama training, three participants identified as being certificated in psychodrama, two identified as working towards their certification, and two did not mention their certification status. Two participants also identified as being TEP (Trainer Education Practitioner) meaning that they train others in psychodrama. One participant identified as being a PAT (Practitioner Applicant Trainer) meaning she is working towards her certificate as a psychodrama trainer. Years of experience practicing psychodrama ranged from 5 years up to 36 years. The mean years of practice was 17 years (SD=16.85).

Qualitative Findings

Type of psychodrama practiced. The first question asked was “Tell me about the type of psychodrama you practice.” Participants responded in various ways. Five participants stated that they practice psychodrama in groups, and one participant shared that they practice psychodrama a deux (meaning one on one). One participant shared that they practice psychodrama both in groups and a deux. Both male participants identified as practicing classical psychodrama; one male member identified as practicing and being a trainer for the Therapeutic Spiral Model, as well as a certificated Drama Therapist; five of the six females did not specify a specific type of psychodrama; and one participant shared that she uses more psychodrama techniques than practicing full psychodrama. Participants identified various work settings including community mental health, inpatient psychiatric units, small non profits, and private practice.

Types of clients. If not mentioned without prompt, participants were prompted to talk about the types of clients that they work with. Participants mentioned a range of ages for their clients from six through adulthood. Participants also identified a range of client types, aside from the general categories of adolescents. Participants identified the following categories:

adults with major mental illness, trauma, eating disorders, gender variant people, children and families, male adolescents with anger issues, college students, and the “the worried well.”

How do participants decide to practice psychodrama. Within this question participants were also asked, “How do you decide to practice psychodrama with particular clients?” Participants’ answers varied here again. One participant stated “Well it’s just what I do.” This client also stated that she thinks psychodramatically and in action, so as she listens to clients talk she begins to see what kind of action method could be used for a particular topic. Another participant shared that she uses it if clients “buy into it.” Five participants spoke about clients voluntarily participating, either because the clients are specifically seeking out psychodrama, or because the clinician suggests using it and the client willingly follows their lead. One participant who worked in a psychiatric inpatient unit shared that psychodrama group was part of the treatment for all clients who were cleared to participate in groups.

Define adolescent trauma. Participants were asked “How do you define adolescent trauma?” Participants came up with a list of various types of possible traumas including drunk car accident, physical, sexual and emotional abuse, being raised in foster care, being an orphan from another country, parents who abuse substances, best friend being killed. When describing trauma more generally participants said things like “creates a tremendous amount of fear.”; “the bad enough experience.” and “life threatening threat to system.”

Both participants who identified as being TEPs stated that they believe trauma is subjective and “what causes trauma in one teenager might not cause it in another teenager.” Both male participants spoke about the effects that trauma can have on an adolescent’s developing brain. One male defined a traumatic event as “anything which causes a misfiling of memory in the brain.” Two participants spoke about the negative effects that childhood trauma

can have on adolescents, and specifically on the view that adolescents carry of themselves. They also commented on the effects trauma has on the healthy or unhealthy life choices that adolescents make.

One participant in particular made a point of stating that she does not define adolescent trauma differently from trauma in adults, however did speak about the possibility of an adolescent's brain being more resilient than an adult brain. Another participant stated that types of trauma are the same for adolescents as they are for adults. Both of these participants stated however that they believe trauma manifests itself differently in adolescents than it does in adults.

Effectiveness of treatment. Participants were next asked "How effective have you found psychodrama as a treatment for adolescents who have experienced trauma?" Six participants stated that they believe psychodrama is an effective treatment for adolescents who have experienced trauma. One participant stated "it's "profoundly effective, more effective I think than any other tool, any other therapeutic tool I've used." This same participant spoke about the surplus reality one experiences during a psychodrama, and the ability for this surplus reality to create a reparative experience for the brain. One participant stated that it was unclear how effective it is, and that more research is necessary to determine the effectiveness. Another participant also stated that he was not sure how effective psychodrama would be in mandated situations.

Three participants directly correlated safety with the effectiveness of psychodrama treatment. These participants stated when practicing psychodrama with trauma survivors establishing safety is the first step of the work. These participants stated that creating safety within the psychodrama group was a key component to client being able to open up within an enactment, and fully benefit from the treatment. One participant mentioned using scarves, such

as in the Therapeutic Spiral Model, to create this safety, and others did not specifically mention how this is done.

Most effective. As a sub category to this question participants were asked “Are there specific types of trauma that psychodrama is most effective with?” Answers varied. Four participants stated that it is not about type of trauma, but rather about how psychodrama is used, and certain psychodrama frameworks. Within this group one participant stated that she believes “Not every psychodramatist should do trauma work,” specifically because she believes it takes a certain type of person to understand how to work with trauma, and that many psychodramatists are too spontaneous for trauma work. Another participant spoke about the Therapeutic Spiral Model as an excellent tool for practicing psychodrama with trauma survivors. One participant explained two types of trauma: “simple trauma” and “complex trauma.” In explaining complex trauma this participant stated: “If you have a situation that creates horrific fear, fear of being psychically or physically annihilated you have to direct those dramas very differently.” This same participant stated that she believed psychodrama was most effective when the client feels safe, and that safety matters more than the type of trauma.

Three participants spoke differently about this topic. One participant stated that she did not feel able to answer the question. One participant stated “I have found it both effective with physical trauma, sexual trauma, and emotional trauma.” However, this participant added the caveat that all of the programs he has worked in have been voluntary programs. Another participant stated that she believes it is very effective for the treatment of childhood sexual trauma and in confronting abusers.

Least effective. As an antonym to this question participants were also asked “Are there specific types of trauma that psychodrama is least effective with?” None of the participants

spoke about specific traumas that are not suited for psychodrama work. However, three participants did speak about psychodrama being difficult with clients who are actively psychotic or dissociate; are diagnosed with dissociative identity disorder or multiple personality disorder. One of these three participants also shared: “See it’s a funny question you’re asking me ...because I think it’s always effective, but you do different things depending on where someone’s at.”

Echoing this idea another participant said that she pays close attention to where a client is in the recovery process of a trauma, and does not use psychodrama if a client is “still reeling from the effects of the trauma.” Another participant echoed her earlier statement about the importance of the right psychodramatist with the right techniques and not about the type of trauma. One participant spoke about his belief that psychodrama can help adolescents meet missed developmental challenges, and stated the he does not see it as more or least effective. One participant stated that she could not think of any types of trauma that psychodrama would be least effective with. She followed that statement with “cause again I think it’s more kind of how you do the work.” And figuring out where and when the client is ready to go.

Evidence of effectiveness. Participants were next asked “How do you decide if the psychodrama treatment you are using is effective, and what evidence do you look for?” Five participants mentioned client reporting as evidence for effectiveness. A client will report that they have had a decrease in symptoms, or will share an epiphany or new idea they are having as a result of the drama. One participant however cautioned the use of self reporting by stating that when you are eliciting reports from clients you are only getting a snap shot of their view on the treatment within that moment.

Three participants stated that they look for role expansion within clients. Are clients able to expand their roles and create new roles both within the group and outside of the group? Three participants also shared that they look for changes in behavior, both reported by the client, other therapists, and observed within a psychodrama group. Another three participants spoke about affect change. One of these participants stated “So how do I know it’s effective? Somebody had no affect when they start and then they start crying and they have an epiphany.” One participant touched on assessing treatment goals within their answer.

Measuring success. The final question participants were asked was, “How do you measure the effectiveness of treatment?” Many answers in this section were similar, to the previous section. Only one participant reported using scientific tools to measure their effectiveness. These measurement tools are stated in a paragraph below. Two participants reported that they do not measure their effectiveness. Two participants stated that they would be interested in implementing a measure of effectiveness if I were to find one.

Three participants stated that they measure effectiveness by client reporting. One participant shared that client retention was a way she measured her effectiveness “Over 90% of people in one group have come back to work with me year after year.” She also stated that this was a study conducted by one of her clinical students.

One participant stated that he used sociometry, the study of group dynamics, in order to measure effectiveness. This same participant also suggested the use of commonly used mental health questionnaires. However he also cautioned this as an effective tool because “you couldn’t necessarily even then say that it’s the group that’s making that difference. Someone’s life stressor of being divorced might be may [*have actually come through, or*] the person may be on

top of the world because they've met somebody new and they're totally in love and they can't wait for their new life to start, and their inventories are going to be way different."

Another participant shared that his program used to use a common mental health assessment for children, however after discovering that the children hated the questionnaire came up with his own tool. This participant shared that he used Role Assessments, to measure the effectiveness. He also shared that instead of using paper questionnaires to complete the inventories, inventories were done in action through Sociodramas. Through action clients were asked to rate how good they felt they were at different roles in their lives on a scale of 1-10, at several points throughout treatment. In an example provided by the participant, they might say "The role of good student, I only get a two on that, the role of caring friend -- I give myself a nine on that, I'm really good at that." Effectiveness was measured by an increase report in clients feeling good at their positive roles, and a decrease in clients feeling they are good at their negative roles.

Qualitative Themes

Several themes emerged from this study. The most salient of them was the importance of safety. Other themes included the use of role reversal and doubling, voluntary participation, client reporting, and individualized treatment.

Every participant in this study mentioned the importance of safety at one point or another. Although only four participants mentioned safety in direct correlation to effectiveness, all three other clinicians also touched on its importance. Participants shared that safety was one of the most important components of psychodrama, and that a feeling of safety needed to be achieved for clients in order for the psychodrama to be successful.

Five participants spoke about the use of Doubling and Role Reversal as important psychodramatic tools that implemented effectively can be very powerful for clients, and elicit powerful thoughts and epiphanies. One participant shared that she was working with a male client who was unable to tolerate a 45 minute session with his father, however after doing a psychodrama that had him role reversing into his father's role, he was able to hypothesize and understand some of his father's feelings, which in turn lead him to being successful in a 45 minute session with his father. Other participants also talk about the use of doubling being very grounding for clients who are partaking in dramas related to their trauma.

Voluntary participation, client reporting, and individualized treatment were also themes. Six participants mentioned having voluntary clients. Only one client mentioned the possibility of clients being non-voluntary. Five participants mentioned that client reporting was a large part of how they knew their treatment was successful, other clinicians also mentioned client reporting as a contributing factor within their work. Three clinicians directly mentioned the importance of individualized treatment; however other clinicians also alluded to the importance of following the client's lead, and going where the client is ready to go.

Overall participants expressed their belief that psychodrama is an effective treatment for adolescents who have experienced trauma. With this said however, only one of the respondents reported measuring the effectiveness with scientific tools. Other participants spoke about client reporting as their primary measure of success. One issue to consider is even if you do measure effectiveness through scientific tools, or client reporting, you are only getting a snap shot of how that person is feeling/presenting in the moment, and it is difficult to attribute change directly to the psychodrama treatment. It is also important to remember that all respondents spoke about

their clients being voluntary participants, and therefore their inability to assess the effectiveness of psychodrama with mandated clients.

While the findings of this study are supportive of the effectiveness of psychodrama as a treatment for adolescents who have experienced trauma, it is important to note that the study is very limited by the number of participants, as well as the lack of diversity within participants. This study was also limited by difficulty with participant recruitment. It's important to look closely at the literature to truly assess the general status of effectiveness. In order to do this we need to look at the literature on adolescent trauma and look at where there are similarities in what the study and the literature are saying, and where they differ. The Discussion (Chapter 5) will include this comparison.

Chapter 5

Discussion

The purpose of this study was to research the possible effects of psychodrama as a treatment for adolescents who have experienced trauma. This study researched this topic through qualitative questions of clinicians who practice, or practiced, psychodrama with adolescents. This study provided an expert perspective on this topic because all participants were trained in the field of psychodrama.

The first part of this discussion will compare the study findings to the literature review, specifically looking at whether or not psychodrama can help adolescents reach goals that are set out in the literature on adolescent trauma. This section will be followed by a look at study limitations, and areas for further research.

Adolescent Trauma and Psychodrama

The literature defines adolescent trauma in the following way: “Traumatic experiences are those that are *overwhelming*, invoke intense negative affect, and involve some degree of loss of control and/or vulnerability. The experience of trauma is *subjective* and *developmentally bound*” (Blaustein and Kinniburgh, 2010). It was interesting to see that several participants stated that they believed adolescent trauma was no different from trauma for adults. Participant responses would lead me to wonder if participants believed in a developmental trauma model, and it would have been great to include a question around this as a follow up. It would also be

interesting to understand how psychodramatists are trained in trauma, or if they even are specifically.

According to the research, trauma can impact development in the areas of attachment, biology, affect regulation, dissociation, behavioral regulation, cognition, self-concept, perception, and academic performance (Cook et al., 2005; Cohen et al., 2012). In order to treat trauma we must aim our interventions at treating these impairments (Perry, 2009; Blaustein & Kinniburgh, 2010).

Neurosequential Model of Therapeutics (NMT), Trauma Focused – Cognitive Behavioral Therapy (TF-CBT), Attachment Self Regulation and Competency (ARC), and Psychodrama all speak to safety being the first step of trauma work with adolescents. If a client does not feel safe they are not able to access the part of the brain necessary to do the repair work. The TF-CBT model speaks about building safety as the first and most important component to the work (Cohen et al., 2012). All participants spoke about the importance of creating safety when practicing psychodrama through a trauma lens. Three participants spoke about using tools from the Therapeutic Spiral Model as a measure to achieve safety. The TF-CBT model extends this goal of safety to creating secure attachments with permanent adult figures in the adolescent's life.

Throughout all of the research on childhood and adolescent trauma, attachment seems to be the most important piece of treatment. The NMT, TF-CBT, and ARC models all focus extensively on the importance of engaging the client in healthy secure attachments with adults. In order to achieve this, ARC stresses working closely with the caregiver as well as the child in order to foster a securely attached relationship. The NMT model talks about the importance of positive adult relationships, and correlates these with the ability for the child to experience

success in treatment. Perry says that children and adolescents who have positive adult relationships are more successful than children or adolescents who do not.

One participant spoke about using psychodrama to work on attachment with a client. This was done through psychodramatic role reversal, where the client role reversed into the role of his father. Through this he was better able to understand his father and in turn began to build a more successful relationship with his father. This example speaks to the ability psychodrama has to put a person into another person's shoes, and to help them begin to understand the world from the other person's point of view. However, throughout the study findings this was the only mention of attachment work by participants. Similarly, only one participant mentioned the use of psychodrama during family sessions, which included caregivers.

Behavioral Regulation, referred to as self-regulation in NMT and ARC, is also a very important step in trauma recovery for children and adolescents. Working on this area usually involves teaching healthy coping skills and improving stress tolerance (Perry, 2009; Blaustein and Kinniburgh, 2010). Two study participants mentioned using psychodrama to teach coping skills, and one participant mentioned using psychodrama to practice those skills in a stressful environment. The surplus reality which one enters during a psychodrama helps train the brain to withstand stressful situations, and practice coping skills.

Self-Concept is another large piece of trauma recovery work for children and adolescents, NMT and ARC both speak about the importance of finding things or activities that children and adolescents are good at, and then using the successes within those things as activities to begin to create a positive self image. Many participants spoke within this study about psychodrama's ability to help an adolescent shift their view of themselves. One participant in particular spoke

about using the Role Assessment tool to measure how clients felt about themselves in specific aspects of their lives.

Perry talks about how trauma affects the brain, as well as the developmental effects trauma has on a child or adolescent. Perry also talks about meeting the child or adolescent where they are developmentally, and also about skills such as drumming, dance, and martial arts that can help a child or adolescent catch up developmentally as well as biologically. Perry talks extensively about ways that drumming, yoga, and martial arts can be used to help develop the stress response system, as well as to regulate elevated heartbeats in children and adolescents who have experienced trauma. Through NMT Perry also talks about individualized treatment and using interventions that are suited for a child or adolescent's developmental age (Perry, 2009 & 2006).

Within the findings of this study, two participants spoke about the effects that trauma has on the brain and development. They also spoke about their belief that psychodrama can help an adolescent catch up on those missed developmental milestones. Other participants spoke about the importance of individualized treatment, and meeting the client where they are. Participants did not speak about the possible effects of psychodrama on the biological body, and given that, this study cannot draw conclusions on whether or not psychodrama can be used to treat brain impairments.

It was interesting to see that only two participants mentioned the developmental impacts of trauma on adolescents. It was also interesting to notice that neither of the participants who mentioned the developmental impacts of trauma mentioned the Cycles of Healing model, which shares a developmental perspective of trauma. In fact not a single participant mentioned this

framework at all. It was also interesting to hear only three participants reference the Therapeutic Spiral Model as well.

Cognition, perception and academic performance were spoken about less within each of the trauma informed theories/frameworks and this was true with study participants also. As these topics were not touched upon it is not possible to assess the effectiveness of psychodrama in targeting these areas.

Both TF-CBT and ARC talk about trauma integration as the final step to treating adolescents who have experienced trauma (Bluestein and Kinniburgh, 2010, Cohen et al. 2012). However, although both models use some form of trauma integration as their final step, they also both mention that this step is often not achieved with adolescents, as sometimes clients are not ready to take that final step.

There was debate within the findings about whether or not trauma integration was an appropriate step for adolescents who have experienced trauma. Some participants felt that psychodrama was a great way to confront a childhood abuser, or to re-experience something traumatic in an empowering way, and some clinicians who said this also felt that this work was better done with older adolescents or adults. Many clinicians also said that they do not usually do trauma reenactments with an adolescent, and some participants were so forceful as to say that they never do them with adolescents, and instead they work on building skills and positive roles.

Overall the findings and the literature seem to agree, and the issues on which they differed were minimal. These differences were most apparent when participants were asked to define trauma, as most participants did not differentiate between adolescent and adult trauma. Literature differentiates between trauma experienced as an adolescent and adult by differentiating the way in which trauma effects the brain at either stage of development, stating

specifically that trauma affects a person at a younger age greater, due to their developing brain. These differences were also apparent when participants talked about the impacts of trauma on the development of the brain. Only two participants spoke about the developmental impacts of trauma and both of the participants who did spoke about it only briefly making it unclear how much their work in psychodrama is informed by the biology of brain development.

One more difference found within the literature and findings was the discussion of using psychodrama to teach Dialectical Behavioral Therapy (DBT) skills. DBT was not discussed within the literature review of this study, and therefore its ability to treat adolescents who have experienced trauma is not able to be evaluated within the study. What can be said is that several participants believe in using psychodrama to teach skills from the DBT framework.

Finally the literature and findings differed in the area of fostering attachment. All three frameworks talk about fostering attachment as being the most important step in helping adolescents who have experienced trauma to heal. As mentioned earlier, only one participant spoke about the ability of psychodrama to foster a secure attachment with a client and their caregiver and it is unclear whether or not other participants believe that psychodrama could be used in this way.

Limitations.

One limitation within this study is the lack of research found on the effectiveness of psychodrama. Although many participants were well versed on current literature and treatment recommendations pertaining to adolescent trauma, none of the participants spoke about evidenced based research that could prove the effectiveness of psychodrama in achieving these goals.

Another limitation of this study was created through questions asked by the researcher. Looking back on the study it seems it may have been helpful to have a question that specifically addressed psychodrama's ability to foster secure attachments with caregivers and other adults. This seems pertinent because adolescent trauma literature clearly identifies this as one of the most important steps for trauma recovery. Perhaps other questions could also have been better crafted around specifically treating the areas of trauma impairment.

It is also important to remember that nearly all participants spoke about the effectiveness of psychodrama through a voluntary participation lens. Only one clinician spoke about psychodrama being used in an involuntary setting; however that participant could not speak to its effectiveness when involuntary.

It would have been useful to interview participants who collected some sort of data about the effectiveness of their treatment. I was surprised to speak with only one person who used questionnaires or inventories to measure success. Without these tools this study is based purely on the participants' belief that their treatments are effective, and since all study participants practice psychodrama, their opinions are already biased towards its effectiveness.

The final limitation of this study is the size of the study, because only seven participants were interviewed and the findings of this study only represent the opinions of those participants. More research would be needed to see if the findings within this study are an accurate representation of psychodrama's effectiveness.

Areas for Further Study

It was interesting to hear several participants tell the researcher that they would be interested in using a measurement tool if one was discovered or created. One way to follow up this study would be to create and run a study involving a tool of scientific measurement. This

tool could include both self reporting from clients directly about the effectiveness, as well as a way for the psychodramatist to include thoughts on progress for each client. Several participants mentioned that one of the ways they measure success is through role expansion, and it would be revealing to create a tool where they could quantify data about clients' role expansion, and further explain how role expansion correlates with effectiveness.

Conclusion

Overall this study was informative about the effectiveness of psychodrama as a treatment for adolescents who have experienced trauma. According to this study psychodrama excels at focusing on safety, personal strengths, self image, and coping skills. It is clear through these findings that psychodrama can be an effective treatment for adolescents, who have experienced trauma, it is also clear that there are varying ideas on how psychodrama can be used to achieve this.

One area that does not seem clear is whether or not psychodrama is useful in fostering secure attachments with positive adults. Given that all other frameworks studied state that fostering these relationships is the key to successful trauma recovery more research is needed in this field. Given this unknown it is difficult to say whether or not psychodrama on its own would be enough or whether supplemental treatment would also be needed.

This study confirmed the researcher's hypothesis that psychodrama is an effective treatment for adolescents who have experienced trauma. One of the most important things learned though this study is that psychodrama seeks to meet clients where they are in the recovery process, and that there are many ways a director can use psychodrama as a treatment. This fact, coupled with the individual focus, leads the researcher to believe that psychodrama is

an effective treatment for adolescents who have experienced trauma, when the director meets the adolescent where they are, and when the adolescent is willing to participate in the treatment.

This study benefits the field of social work because it delivers concrete research on the effectiveness of psychodrama for adolescents who have experienced trauma. To this date no other studies have looked at this topic, however as stated in the literature review, there are many psychodrama frameworks designed for use in treating trauma. In assessing the effectiveness of this framework it is hoped that psychodrama will be looked at in the social work field as a legitimate treatment for willing participants, similar to other researched frameworks mentioned within this study. It is the researchers' hope this study will lead to further studies on the effectiveness of other expressive therapies

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Appendix A

E-mail to Colleagues and Classmates as well as Facebook Posting

Hello Colleagues and Classmates,

I am writing you to ask for your help in recruitment for my thesis through the Smith College School for Social Work. I am studying the possible benefits of psychodrama as a treatment modality for adolescents who have experienced trauma. Psychodrama is the use of theater and drama within therapeutic treatment. For the purpose of my study, I am defining adolescents as people ages 12-22. In order to research this topic, I am completing a qualitative study interviewing clinicians who have practiced psychodrama with youth about their opinions of the benefits for adolescents who have experienced trauma.

I am looking for study participants who match the following criteria: master's level clinician or higher with a degree in Social Work, Psychology, Counseling or other related field; training in psychodramatic techniques; practiced psychodrama within the last five years, and experience practicing psychodrama with adolescents either currently or in the past.

If you fit this criteria and are interested in learning more about my study, or if you have any questions please contact me directly. If you know someone you feel may be interested in the study please consider forwarding this e-mail to them. If you believe you have received this e-mail in error please let me know.

I can be reached at the following e-mail address: cmertz@smith.edu

Thank you in advance for you recruitment help!

Corrine Mertz

Appendix B

E-mail for Clinicians Identified Through Psychodrama Website

Hello,

My name is Corrine Mertz, and I am a MSW Candidate at the Smith College School for Social Work. You are receiving this e-mail because I am looking for clinicians who practice or have practiced psychodrama to participate in my thesis study. I obtained your contact information from the data base on psychodramacertification.org.

I am studying the possible benefits of psychodrama as a treatment modality for adolescents who have experienced trauma. Psychodrama is the use of theater and drama within therapeutic treatment. For the purpose of my study, I am defining adolescents as people ages 12-22. In order to research this topic, I am completing a qualitative study interviewing clinicians who have practiced psychodrama with youth about their opinions of the benefits for adolescents who have experienced trauma.

I am looking for study participants who match the following criteria: Participants of this study must be a master's level clinician or higher with a degree in Social Work, Psychology, Counseling or other related field; participants must have training in psychodramatic techniques; participants must have practiced psychodrama within the last five years, and must have some experience practicing psychodrama with adolescents either currently or in the past.

If you fit this criteria and are interested in learning more about my study, or if you have any questions please contact me directly. If you know someone you feel may be interested in the study please consider forwarding this e-mail to them. If you believe you have received this e-mail in error please let me know.

I can be reached at the following e-mail address: cmertz@smith.edu

Thank you for your time, and I hope to hear from you soon.

Corrine Mertz

MSW Candidate Smith College School for Social Work

Appendix C

E-mail for Expressive Therapies Professors Identified through Lesley Professor Directory

Hello,

My name is Corrine Mertz, and I am a MSW Candidate at the Smith College School for Social Work. You are receiving this e-mail because I am looking for clinicians who practice or have practiced psychodrama to participate in my thesis study. I am writing you specifically because you have been identified as a professor in the Expressive Arts program at Lesley University, and as the university teaches psychodrama within this program I believe that you may know someone who practices psychodrama. I obtained your contact information from the faculty and staff directory on Lesley's website.

I am studying the possible benefits of psychodrama as a treatment modality for adolescents who have experienced trauma. Psychodrama is the use of theater and drama within therapeutic treatment. For the purpose of my study, I am defining adolescents as people ages 12-22. In order to research this topic, I am completing a qualitative study interviewing clinicians who have practiced psychodrama with youth about their opinions of the benefits for adolescents who have experienced trauma.

I am looking for study participants who match the following criteria: Participants of this study must be a master's level clinician or higher with a degree in Social Work, Psychology, Counseling or other related field; participants must have training in psychodramatic techniques; participants must have practiced psychodrama within the last five years, and must have some experience practicing psychodrama with adolescents either currently or in the past.

If you fit this criteria and are interested in learning more about my study, or if you have any questions please contact me directly. If you know someone you feel may be interested in the study please consider forwarding this e-mail to them. If you believe you have received this e-mail in error please let me know.

I can be reached at the following e-mail address: cmertz@smith.edu

Thank you for your time, and I hope to hear from you soon.

Corrine Mertz

MSW Candidate Smith College School for Social Work

Appendix D

Linkedin message for searched members

Hello,

My name is Corrine Mertz, and I am a MSW Candidate at the Smith College School for Social Work. You are receiving this e-mail because you came up in a search I completed looking for folks who practice psychodrama. I am looking for clinicians who practice or have practiced psychodrama to participate in my thesis study, and I thought you might qualify/be interested in the study or that you may know someone who might be.

I am studying the possible benefits of psychodrama as a treatment modality for adolescents who have experienced trauma. Psychodrama is the use of theater and drama within therapeutic treatment. For the purpose of my study, I am defining adolescents as people ages 12-22. In order to research this topic, I am completing a qualitative study interviewing clinicians who have practiced psychodrama with youth about their opinions of the benefits for adolescents who have experienced trauma.

I am looking for study participants who match the following criteria: Participants of this study must be a master's level clinician or higher with a degree in Social Work, Psychology, Counseling or other related field; participants must have training in psychodramatic techniques; participants must have practiced psychodrama within the last five years, and must have some experience practicing psychodrama with adolescents either currently or in the past.

If you fit this criteria and are interested in learning more about my study, or if you have any questions please contact me directly. If you know someone you feel may be interested in the study please consider forwarding this e-mail to them. If you believe you have received this e-mail in error please let me know.

I can be reached at the following e-mail address: cmertz@smith.edu

Thank you for your time, and I hope to hear from you soon.

Corrine Mertz

Appendix E

Talking Points for Recruitment Conversations with Colleagues, Classmates, and Possible Study Participants.

- I am an MSW Candidate from the Smith College School for Social Work.
- The purpose of this study is to research the benefits of psychodrama as a treatment modality for adolescents who have experienced trauma.
- I am exploring this question through interviewing twelve clinicians who have used or currently use psychodrama with adolescents.
- For the purpose of this study, I will define clinician as any person with a master's level degree or higher in a Social work, Psychology, Counseling, or related field.
- I am looking for study participants who match the following criteria: Participants of this study must be a master's level clinician or higher with a degree in Social Work, Psychology, Counseling or other related field; participants must have training in psychodramatic techniques; participants must have practiced psychodrama within the last five years, and must have some experience practicing psychodrama with adolescents either currently or in the past.
- My interviews will consist of five questions and will take around 20-30 minutes.
- All participants' confidentiality will be protected, and research will be kept according to federal guidelines.
- I will complete my interviews via phone, Skype, or in person.
- Data from this interview may help inform clinicians about the benefits of psychodrama and may possibly inspire further research into this field.

Appendix F

E-mail to Possible Study Participants

Hello,

My name is Corrine Mertz and I am an MSW candidate from the Smith College School for Social Work in Northampton, MA. You are receiving this e-mail because you have been identified as a possible study participant for my research. I am studying the potential benefits of psychodrama as a treatment modality for adolescents who have experienced trauma.

Psychodrama is the use of theater and drama within therapeutic treatment. For the purpose of my study, I am defining adolescents as people ages 12-22. In order to research this topic, I am completing a qualitative study interviewing clinicians who have practiced psychodrama with youth about their opinions of the benefits for adolescents who have experienced trauma.

I am looking for study participants who match the following criteria: a master's level clinician or higher with a degree in Social Work, Psychology, Counseling or other related field; training in psychodramatic techniques; practiced psychodrama within the last five years, and experience practicing psychodrama with adolescents either currently or in the past.

If you fit this criteria and are interested in learning more about my study, or if you have any questions please contact me directly. If you know someone whom you feel may be interested in the study please consider forwarding this e-mail to them. If you believe you have received this e-mail in error please let me know.

I can be reached at the following e-mail address: cmertz@smith.edu

Thank you for your time, and I hope to hear from you soon,

Corrine Mertz

MSW Candidate Smith College School for Social Work

Appendix G

Informed Consent

Dear Participant,

My name is Corrine Mertz, and I am a graduate student at Smith College for Social Work in Northampton, MA. I am conducting research for my Master's thesis. My thesis aims to explore the potential benefits of psychodrama as a treatment modality for adolescents who have experienced trauma. My study focuses on answering this question through the perspective of clinicians who practice or have practiced psychodrama with adolescents.

Participants of this study must meet the following criteria: a master's level clinician or higher with a degree in Social Work, Psychology, Counseling or other related field; training in psychodramatic techniques; practiced psychodrama within the last five years, and must have some experience practicing psychodrama with adolescents either currently or in the past.

This study is a qualitative study and participants in this study agree to a Skype, phone, or in person interview with me directly. This interview should last between 20 and 30 minutes. At the beginning of the interview you will be asked demographic questions about your gender, race/ethnicity, ethnicity, and professional training. You will then be asked five questions directly related to your opinions about the benefits of psychodrama for adolescents who have experienced trauma. The interviews will be audio recorded with a digital recording device, and then transcribed and coded for data analysis using a computer coding program. The data you provide for this study will be viewed by me, as well as my research advisor. When sharing the data with my research advisor and when discussed within my thesis all identifying information will be disguised in order to protect your confidentiality. Data, including audio recordings, and e-mails will be stored on a password protected computer for three years, in accordance with

federal regulations, at which time the data will be destroyed. If that data is needed beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed. If for any reason paper notes are created or data are printed it will be stored in a locked file cabinet for three years, upon which time it will be destroyed.

Because I will be asking you about your direct opinions related to psychodrama as a treatment for adolescents who have experienced trauma, there is a small risk you may feel negative emotions during the interview process, if this happens for you I hope you will feel comfortable letting me know. The benefit of participating in this study is that you may gain insight into your own practice, further the field of Social Work's knowledge about the use of psychodrama as an effective treatment modality, and help to promote further research on the topic.

Participation in this study is voluntary, and you have the right to refuse to answer any question I ask. You also have the right to withdraw your participation in the study any time before April 30, 2013. If you wish to withdraw from the study please get in touch with me via either of the contact modes provided below. If you choose to withdraw, all of your information and data will be immediately destroyed.

Please contact me directly if you have any questions that I can answer cmertz@smith.edu, or (XXX) XXX-XXXX. Should you have any concerns about your rights or any aspect of the study, you are encouraged to contact me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Sincerely,

Corrine Mertz, MSW Candidate Smith College School for Social Work

PLEASE SIGN AND DATE IN THE SPACE BELOW TO INDICATE THAT YOU HAVE READ THE INFORMED CONSENT AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature: _____ Date: _____

Please return a signed and dated consent form to me by mailing a copy to me at Corrine Mertz X
XXXXXXXX, XXXXXX or by bringing a copy to the interview.

Appendix H

Questions for Interviews with Participants

Probes:

Tell me more about that...

I am wondering what you meant by that...

Can you explain further?

Could you clarify?

Let me make sure I understand you correctly, are you saying...(repeat or paraphrase something participant just said.)

1. Tell me about the type of psychodrama that you practice?
 - a. What types of clients do you work with?
 - b. How do you decide to practice psychodrama with particular clients?
2. How do you define adolescent trauma?
3. How effective have you found psychodrama to be with adolescents who have experienced trauma? Please explain.
 - a. What types of trauma is psychodrama most effective with?
 - b. What types of trauma is psychodrama least effective with?
4. How do you decide if the psychodrama treatment you are using is effective? What evidence do you look for?
5. How do you measure the effectiveness of treatment?

Appendix I
HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 25, 2013

Corrine Mertz

Dear Corrine,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett' followed by a flourish.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Vice Chair, Human Subjects Review Committee

CC: Claudia Bepko, Research Advisor