

A cry for help: Dramatherapists can intervene to change the language and environment in mental health care by engaging critically with the new diagnostic category of Complex PTSD

Dramatherapy

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journals.sagepub.com/home/drt**Lee-Anne Widnall** 

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Abstract

In funded healthcare settings, access to dramatherapy and other arts therapies is limited. Patients suffering the long-term emotional effects of childhood or prolonged trauma are often not helped by short-term funded therapies. These therapies that engage in the diagnostic model of suffering with disorder specific research speak little to those suffering multiple traumas. This leaves dramatherapists unable to reach those most in need of their skills. At the same time, survivors are left bewildered and shamed again as they ‘fail’ to benefit from the limited symptom management approaches on offer. While the diagnostic model of suffering may be approaching obsolescence, what still seems a long way away is a major overhaul of the mainstream understanding of suffering and mental health that could fuel a reorganisation of how services are delivered and research conducted. In this context, the new diagnostic criteria of Complex Post Traumatic Stress Disorder in the International Classification of Diseases-11 provides an opportunity and perhaps even a rallying cry for dramatherapists to evidence how our skills can provide a framework and method for survivors to re-imagine themselves and understand and claim their place in the world by loosening the chains of fear and shame.

Keywords

Arts therapists, complex PTSD, diagnostic classification, dramatherapy, mental health care, trauma

A cry for help

The context for this therapist moving from dramatic and therapeutic spaces to paper is the hope that perhaps some stars are aligning. That, perhaps, there is a glimmer of hope

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for those searching in the darkness of mental health services. The ability of those who have experienced trauma in childhood, or those who have experienced prolonged trauma has been the driving force for dramatherapists to challenge the diagnostic view of suffering. A model that too often hampers our ability to support others through journeys of unbearable suffering to voyages of renewal. It seems we have journeyed to a place where survival adaptations to socially created cruelty have become medicalised and ‘treated’, or more often not even ‘treated’, leaving survivors and those who travel with them baffled, confused, humiliated and shamed again.

There does seem to be a path out of the siding we have arrived at, albeit not on a fast train. Those who have been walking and still walk this path, such as Judith Herman and Bessel Van der Kolk (2015) attest to its long and winding nature (Herman, 1992). Their work, among others, in asking simply that the mental health effects of childhood and prolonged trauma be understood and recognised by the psychiatric community have been instrumental in the introduction of the new diagnostic category of Complex Post Traumatic Stress Disorder (PTSD) in the 11th edition of the International Classification of Diseases as well as changes to the description of PTSD in the Diagnostic and Statistical Manual version 5 (American Psychiatric Association, 2013; Cloitre et al., 2013; Herman, 1992; Van der Kolk et al., 2005; World Health Organization, 1992).

Those living with the effects of childhood trauma, or adult prolonged trauma (hereafter referred to as complex trauma), together with therapists working outside of the diagnostic framework may view this diagnostic battle as irrelevant. Trauma both within and without healthcare systems has virtually replaced suffering as a descriptor, shifting the dialogue from suffering endemic to brutal social economic systems to traumatic events that supposedly stand outside of those systems (see Roberts, 2018). As a practitioner working in the National Health Service (NHS) in the UK ‘patients’ would often arrive in therapy having been ‘diagnosed’ with complex trauma or complex PTSD long before such a diagnostic category existed. Understandably, those suffering would arrive confidently expecting the evidenced-based treatment. Shame then is often heaped on shame when the brief therapies detailed in the National Institute for Health and Care Excellence Guidelines for use within the NHS fail to chink the armour of adaptive survival strategies formed in the context of terror, oppression, disgust or humiliation (National Institute for Health and Care Excellence, 2020). Many cocooned within these protective strategies are invited to venture out of them in a 12–20 session intervention designed for the existing diagnostic categories of PTSD, depression or agoraphobia. Only then to feel the weight of another supposed personal failure when they are supported to understand the protective processes but are unable to yet let them go. No doubt this process of shaming again within healthcare settings is replicated in many other countries through different models of brief self-help interventions.

These brief self-help interventions have enabled the expansion of healthcare for those who have managed to adapt to the social system in which they live and have been lucky enough to avoid the worst of its brutality. But what of those abused in childhood, brought up in violent homes, denied love, care and safety, racially abused and oppressed? Or in adulthood, controlled, humiliated and abused within a relationship, tortured at the hands of violent regimes, trafficked, raped and ostracised. Sadly, not an exhaustive list. This is their cry for help. Artists and therapists around the globe attend to the cry through a vast

array of charities and community projects and they know that their projects are so often an island; a moment in time and healing has not yet begun. Dramatherapists remain divided in their organisations and within themselves as to whether their healing art belongs within a healthcare environment and psychological therapy or within alternate co-created and witnessed environments of healing through theatre (see Doktor, 1992; Jones, 2012; Langley, 1995; Williams-Saunders et al., 1997).

This ambivalence has made it difficult to engage in a mental health environment based on a diagnostic model. It has been particularly difficult to engage in diagnostic models that pathologise strategies to survive abuse and trauma as disorders of personality, predominantly ‘Emotionally Unstable Personality Disorder’ in International Classification of Diseases (ICD-10) (World Health Organization, 1992: 126) or ‘Borderline Personality Disorder’ in Diagnostic and Statistical Manual (DSMV) (American Psychiatric Association, 2013: 1341). Yet children, young people and adults struggling to make sense of themselves and the world following trauma often do feel that they are going ‘mad’ and do seek help from mental health services. By engaging more fully with and against this diagnostic model dramatherapists are well placed to provide the playful, embodied, role rehearsing, metaphorical and imaginal environment in which the experiences of trauma can begin to be approached and synthesised. In order to challenge this model, dramatherapists need to find their way into it.

The recent announcement of the broadening of psychotherapy training opportunities for Improving Access to Psychological Therapy (IAPT) Services perhaps provides one opportunity (Health Education England, 2021). Engaging with the medical and psychiatric community is perhaps another, as they grapple with providing effective support for those who have suffered so long. New models of community and rehabilitative mental health care are emerging to meet this need since Community Mental Health Teams have moved to a model of brief rather than long-term care. These models, such as the ‘Life Rooms’ in Merseyside, perhaps provide an opportunity for dramatherapists to engage and be part of the construction of new models of mental health care (MerseyCare, 2021).

The new ICD-11 diagnostic category of Complex PTSD provides an opportunity to research the effectiveness of dramatherapy in engaging with traumatic stories and healing. I was privileged to work in IAPT services in areas of high social deprivation and resettlement areas for asylum seekers. Adapting the proscribed IAPT models for this community demanded high levels of creativity. As a dramatherapist, and a clinical supervisor in the service, I was equipped and able to share what we know about creative engagement and exploration. My approach often involved creating a place of safety and familiarity within a place of uncertainty and unfamiliarity that was often also hostile and threatening. Where cognitive restructuring, exposure, safe place imagery and person-centred approaches failed for me in this context, stories provided the holding environment. By bringing stories of safety, identity, place and community to life again through character development, enactment and narrative synthesis, clients began to find an anchor for their current precarious existence. Through marking formational places and people in the client’s journey with a sense of time and place in these stories, their meaning could be integrated to provide strength and hope for the new emerging life journey. These stories were enacted, sung, written and illustrated so the clinic room became the client’s stage and the therapist both witness and stagehand. For one client creating her

childhood story and enacting the key role of mother enabled her to share her darkest secret; the belief that telling her mother her trauma story had killed her. A secret so unspeakable for this client that it had never been told.

If dramatherapists can engage in this opportunity to develop an evidence base for Complex PTSD those seeking help from mental health services will have access to the therapeutic opportunities we can provide. The International Society for Traumatic Stress (ISTSS) brought together those working in trauma and mental health services advocating for improved treatment. In a healthcare environment, this required a new diagnostic category that would reflect the long-term effects of repeated, prolonged and childhood trauma. In 2012, the ISTSS published guidelines for the treatment of Complex PTSD that stated that ‘the introduction of emotion regulation strategies, particularly those focused on somatic experience, facilitates PTSD reduction’ with key tasks being ‘to strengthen the individual’s capacities for emotional awareness and expression’ (Cloitre et al., 2012: 7–9). The authors also stated that ‘Successful trauma memory processing approaches vary, but have in common an organised recounting of the events, primarily through language but sometimes supported through other media such as artwork or other symbols of remembrance and reappraisal’ (Cloitre et al., 2012: 7–9). Since publishing these guidelines, the ISTSS, following Karatzias et al.’s (2019) meta-analysis, point to the absence of treatment evidence for all the Complex PTSD specific symptom clusters as described in ICD-11 (ISTSS, 2021).

Extrapolating from the ICD-11 symptom clusters the ISTSS have defined the main therapeutic tasks as addressing: emotional regulation, negative self-concept and disturbances in relationships (ISTSS, n.d.). It seems clear that dramatherapists in combining different mediums of emotional expression, exploring roles and re-imagining relationships in group scripting and re-scripting, have the multi-faceted skills to work with these tasks. It should be noted also that in the case of interpersonal trauma, one of the major therapeutic tasks is to enable people to feel safe with others again. Two groups I recently ran with a women’s charity both stated that the dramatic metaphorical space we created to play, loosen fixed roles and create different narratives had enabled them to feel safe with others again. Having also run psychoeducation groups in IAPT I know this does not always happen in groups but is rather a function of the playful ‘transitional’ space dramatherapists create (Winnicott, 1986). Dramatherapists rehearse being with others through our skills in working with relational narratives in groups through many different mediums, movement, dialogue, remembrance and imagination. As can be seen from the example of just one client above, the tasks outline by the ISTSS are not technical tasks, if they were they would have been easily resolved already by the skilled and committed workforce within mental health services. These tasks of exploring our shadow and finding our compassion among cruelty have been addressed through the ages by storymaking, metaphor and drama, through aesthetic distance (Bullough, 1912).

There is an opportunity here for expanding the integration of dramatherapy into mental health care. But what of the diagnostic model itself? Here is another aligning star with potential to change the constellation not only of mental health care but also health care providers’ conceptualisation of mental suffering. For most dramatherapists, the diagnostic model of mental suffering can present a barrier to being able to engage our communities in joining together to create pathways to understanding, integration and social

change. However, there is perhaps an opportunity for us to enter the reconceptualisation of mental health that the psychiatric community itself is being driven to do by advances in neuroscience and genetics as well as the now universal understanding of the impact of Adverse Child Experiences (Felitti et al., 1998; for a discussion on the diagnostic classification systems of mental health, see Boyle and Johnstone, 2014; First et al., 2018; Hengartner and Lehmann, 2017; Jablensky, 2016; Maj, 2018; Owen, 2014). In addition, the exponential growth of the mental health care industry along with its persistent ineffectiveness for a large minority, if not majority longer term, poses a frontal challenge to the current configuration of mental health care and the diagnostic system it is based on. Even IAPT in the United Kingdom, targeted at those with ‘mild to moderate mental health difficulties’ only just pushed past its own 50% target recovery rate nationally for the first time in 2018–2019 with areas of high social deprivation having much lower rates, around 39% (NHS Digital, 2019).


To meet this growth in suffering, the diagnostic manuals keep expanding and as they do so, the overlap between symptoms across different diagnostic categories renders these classifications too similar to be of either treatment or research utility (Allsopp et al., 2019). Allsopp et al. also cite Read and Mayne’s (2017) findings that these broad classifications fail to capture the specificity of human experience rendering treatment research based on these classifications inapplicable in practice (Allsopp et al., 2019). Of course, dramatherapists have not been alone in describing the limitations of the diagnostic systems of mental health care, but what is new is that the criticism is now being acknowledged by the psychiatric and health care communities and alternatives sought. Read and Mayne (2017) focus on the different responses to different traumas in different contexts in childhood. The authors note therefore that these multitude of possible responses render manualised approaches inapposite. The authors also point to the fact that traumatic experiences underlie a vast range if not most categories of mental health ‘disorders’.

The diversity of skills of dramatherapists in working with narrative, emotional expression and roles, along with our ability to bring people together in a safe exploratory space, enables the profession to meet the needs set out in the ISTSS guidelines. This coupled with the wide range of contexts we work in situates us naturally to enter these debates with expert opinion; and it is important that we do so. The reconfiguration of mental health care in the United Kingdom is beginning to provide the environments which we can join, provide expertise, challenge and research. In the past, finding a way into raising the limitations of the diagnostic model has led many to simply work outside of it. The current alignment provides an opportunity to shape a new language and imagine a new space to reintegrate and re-orientate individuals and their social context following trauma.

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Author biography

Lee-Anne Widnall qualified as a dramatherapist in 1992 and began her career working in mental health charities, repertory and community theatre and adult education with students with learning disabilities. In 2002 Lee-Anne joined Child and Adolescent Mental Health Services in the National Health Service where she worked for 16 years in different roles before moving to Improving Access to Psychological Therapies where she worked for 3 years. Lee-Anne is now a counselling and psychotherapy lecturer at Edge Hill University and continues to work as a dramatherapist in a research capacity.