

Master's Dissertation:

A Thematic analysis: how dramatic techniques can be applied in therapy to facilitate clients in regaining an integrated sense-of-self after experiencing interpersonal trauma.



By Kim Mirjam Seppälä

36580

Universidade Fernando Pessoa

Faculdade de Ciências Humanas e Sociais

Clinical and Health Psychology

2019

Tutor: Dr. Pedro Cunha

Abstract

This qualitative study explores the process of integrating fragmented identity after relational trauma within the context of psychodrama. Previous research shows that many trauma survivors struggle with their self-identity. While the causes and consequences of trauma have been studied extensively, the process of integrating the fragmented identity requires further research. This study contributes to the fields of trauma treatment and psychodrama by offering a functional definition of integration from a psychodramatic perspective, and by studying how dramatic techniques can be used to help clients in their process of integration. Data was collected through seven semi-structured, in-depth interviews with psychodrama practitioners and therapists. The transcribed data was interpreted using Thematic Analysis after Braun and Clarke (2006). The resulting themes describe integration as a process that is intrapsychic, interpersonal, somatic and spiritual. The data suggests that all four levels of the process are significant, and that the foundation for the whole process is developing safety. The findings suggest that integration means autonomy & choicefulness, self-love & self-care, and authenticity & spontaneity. The findings imply that integration is synonymous with healing from interpersonal trauma and that psychodrama – when practiced safely – is an excellent therapeutic method for supporting this process.

Key words: integration, identity, psychodrama, interpersonal trauma/relational trauma, sense of self, dramatic techniques, healing from trauma, inner parts.

Dedication

This paper is dedicated to those who walk the path of healing.

"What is needed is the constant unmasking of ego's strategy."

- Chogyam Trungpa

Acknowledgments

I would like to thank the participants for sharing their wisdom and their experiences for the purpose of research. Also heartfelt thanks to my tutor, Prof. Pedro Cunha, for guiding the research process. Kiitos Pekalle tuesta ja vinkeistä!

Table of Contents

Chapter 1: Introduction	1
Chapter 2. Literature Review	6
2.1 Literature Search Strategy	6
2.2 Theoretical Foundation and Conceptual Framework.....	8
2.3 How Trauma Impacts Identity: Previous Research.....	12
2.4 Healing Trauma: the Limits of Talk Therapy	17
2.5 Research on the Benefits of Utilizing Creative and Experiential Methods in Trauma Treatment.....	19
2.6 Historical and Current Examples of Therapeutic Theatre	23
2.7 Therapeutic Models and Clinical Practices that Integrate Drama-based Processes with the Treatment of Trauma.....	47
2.8 Summary and Conclusions	56
Chapter 3: Research Method.....	57
3.1 Research Design and Rationale	57
3.2 Methodology.....	61
3.3 Pilot Interview.....	69
3.4 The Instrument	69
3.5 Data Analysis Procedures	70
3.6 Validity and Reliability	76

3.7 Ethical Considerations	78
3.8 Summary	80
Chapter 4: Findings and Discussion.....	82
4.1 Introduction	82
4.2 Theme One: Safety as a Stage of Healing.....	85
4.3 Theme Two: Integration is a Psychological Act	94
4.4 Theme Three: Integration is a Social Act.....	101
4.5 Theme Four: Integration is a Physical Act	106
4.6 Theme Five: Integration is a Spiritual Act.....	111
4.7 Theme Six: Integration means Autonomy and Choicefulness.....	114
4.8 Theme Seven: Integration means Self-love and Self-care.....	118
4.9 Theme Eight: Integration means Authenticity & Spontaneity	120
4.10 Summary of Findings	122
Chapter 5: Conclusion and Implications	124
References	129
Appendix A: Contact Letter	148
Appendix B: Information Sheet and Consent Form.....	150
(English version)	150
Appendix C: Information Sheet and Consent Form	152
(Finnish version)	152
Appendix D: Interview Schedule.....	154

(English version)	154
Appendix E: Interview Schedule	156
(Finnish version)	156
Appendix F: Example of initial coding	158

Chapter 1: Introduction

To those unfamiliar with the subject, theatre and therapy might seem to have little in common. And yet, psychological healing and drama share the same roots in ancient shamanistic practices, where mask work and storytelling were used for psychological healing (Casson, 2016). In the contemporary world, both drama and psychotherapy deal with the inner dimension of being human; both explore human behavior and the invisible drives behind it; both the actor and the psychotherapist share the aim of bringing these intrapsychic dynamics into visible expression and awareness.

The central research question of this study is: *How dramatic techniques can be applied in therapy to facilitate clients in regaining an integrated sense-of-self after experiencing interpersonal trauma.* There is a reason why dramatic techniques are the focus of this research: Intellectual understanding alone is not enough to heal deep trauma; a client is well aware that the traumatic event is in the past and therefore not a real threat. The client knows that his or her reactions and fears are irrational, and yet they are very real physiological reactions (seemingly) beyond the person's control. Research shows that while cognitive methods can be useful, they are sometimes not enough to heal complex trauma (Wiener, 1999; van der Kolk). Because trauma is not rational, a person healing from trauma cannot merely think themselves into a better place, and empowerment cannot be achieved through mere talk and logic (Levine, 1997; van der Kolk, 2014). Rather, a new understanding of empowerment needs to be rehearsed and embodied. A

person recovering from trauma needs full-body experiences of feeling safe and whole – for example through the medium of drama, which naturally connects the mind and the body. This is the context of the study and explains the rationale for exploring integration from a psychodramatic perspective.

While many subjects related to healing trauma have been researched extensively, the topic of healing the fragmented identity of trauma survivors has only gained visibility in the past 15 years (Fisher, 2017; van der Hart, Nijenhuis, & Steele, 2004; 2006). Previous literature on the consequences of interpersonal trauma reveal that the most challenging part for the survivors is the damage to self-identity and self-esteem, which in many cases lingers for a long time after the traumatic experiences (Matheson et al., 2015). As Layton stated in 1995, in the aftermath of trauma, the question of identity becomes acutely conscious and even painful.

Studies like these indicate the complexity of relational trauma: Abuse is a form of identity violation. This implies that in order to gain a better understanding of optimal trauma treatment, we must first understand the process of identity integration. *Note: 'Identity integration' is a term used in this paper to refer to the process of healing the fragmented or wounded sense of self.*

Although identity (re)construction is often a part of psychological healing, it is especially significant in healing relational trauma: Precisely because trauma often limits the survivor's sense of self, the healing process must also address the sense of self.

Because interpersonal trauma always involves powerlessness and lack of choice, healing involves reconstructing the identity in a way that expands freedom and choice. Hence, this research seeks to understand: how to support clients recovering from trauma to expand and liberate their self-concept in a way that is empowering.

This study focuses on the process of healing from 'relational trauma' or 'interpersonal trauma'. Relational trauma, sometimes also referred to as 'Complex PTSD', encompasses violation of human connection (Herman, 2015). In this study, the focus is narrowed to relational or complex trauma, since these can have a more damaging effect on identity compared to "simple" PTSD (Dayton, 2015).

In trauma literature, the concepts of dissociation and fragmentation have been groundbreaking, elucidating our understanding of the causes and consequences of trauma: It is clear that fragmentation is at the root of many PTSD and Complex PTSD symptoms (Fisher, 2017; Lyons-Ruth et al, 2006; Solomon & Siegel, 2003; van der Hart, Nijenhuis & Steele, 2004; 2006). Such studies have brought awareness to the importance of 'integration' – which is generally seen as the opposite of dissociation and fragmentation – and therefore, can be assumed to be the key to healing trauma. Even so, what integration actually means in practical terms is unclear; until now, there is no agreed upon clinical definition of psychological integration or identity integration. For example, the APA dictionary defines *integration* thus:

"the coordination or unification of parts into a totality. . . For example, the integration of personality denotes the gradual bringing together of constituent traits, behavioral patterns, motives, and so forth to form an organized whole that functions effectively and with minimal effort or without conflict."

This definition offers a starting point, yet the clinical practitioner is still left to determine what the indicators of an integrated identity are; how can a clinician tell that a person healing from trauma has reached a place of integration? Moreover, is integration an ideal state of perfection or is it tangible and achievable? Since personality integration is an intrapsychic process, how does it manifest on the level of behavior?

The matter is even more confusing due to the fact that the word 'integration' in the context of trauma treatment is used to refer both to integration of fragmented memory (a theme for neuropsychology), but is also used to refer to the fragmented personality that is a common consequence of interpersonal trauma (Fisher, 2017). Integration can also refer to social integration. A cursory glance through the Internet reveals that psychologists and clients use the word 'integration' quite frequently yet referring to a wide variety of subjects.

Thus, one of the main aims of this study is to gain deeper understanding of the process of identity integration after trauma, as well as provide a definition of integration from a psychodramatic perspective. For this purpose, semi-structured in-depth interviews were conducted with seven psychodrama practitioners with professional experience with trauma clients. The transcribed data was analyzed and interpreted using Thematic

Analysis after Braun and Clarke (2006; 2012). The resulting themes and their implications are presented in detail in chapters 4 and 5.

The next chapter, the Literature Review, will outline the theoretical framework of this study, review previous literature related on the topic and discuss assumptions relevant to the study. In addition, the Literature Review will also consider the significance of the study.

Chapter 2. Literature Review

In this chapter of the dissertation I will review theories that perceive the self as consisting of many subparts, and discuss how this concept relates to trauma healing. In the literature review I will also examine the theoretical underpinnings of therapeutic theatre and Psychodrama, and their application for healing relational trauma. I will review current and seminal literature on the topic of identity integration and consider its significance for clients who are healing from relational trauma. I will also review already existing therapeutic modalities that combine dramatic processes and identity work. The literature review will shed light on the scope and depth of literature already available on the topic, provide a theoretical framework for the research, and help to sharpen the research question.

2.1 Literature Search Strategy

The main library databases accessed for searching literature were the university online library, the SAGE Journals online database, Google Scholar and for clinical definitions the APA Dictionary of Psychology online. The search terms were different for each sub-chapter of the literature review, and included: *Multiple self theory; Inner parts and trauma; Internal Family Systems therapy; Trauma and dissociation; Trauma and fragmentation; Trauma and integration; Trauma and perspective of self, Trauma and self, Trauma and identity; Trauma and self-organization; Trauma and self-esteem;*

Trauma and recommended treatment; Trauma, treatment modalities and efficacy; Trauma, efficacy and experiential methods; Trauma and action methods; Trauma and psychodrama; Trauma and somatic therapy; Trauma and drama therapy; Trauma and theatre; Trauma and therapeutic theatre; Dramatic process and psychological healing; Drama, identity and psychological healing; Drama, identity and therapy; Role play, identity, therapy; Therapy model, drama and trauma; Therapeutic Spiral Model; Relational trauma and theatre; Relational trauma and psychodrama; Identity integration; Identity integration and trauma.

The search for literature focused both on current research and seminal studies. Where possible, both qualitative and quantitative studies were included. In cases where current literature was not found or was very limited, findings from seminal literature are discussed. Overall, many studies and journal articles were found that touch upon the subject, there are no clear empirical findings on the source of efficacy of Psychodrama for treating trauma - although individual elements or techniques have been empirically tested for efficacy. Also the question of how a change in a client's self-concept relates to recovering from trauma has been studied by a handful of researchers yet needs further clarification. Below is a summary of the theoretical and conceptual framework that served as a guide for the literature review.

2.2 Theoretical Foundation and Conceptual Framework

In the first part of the literature review, the theoretical foundation and conceptual framework of the study will be outlined. Specifically, this sub-chapter seeks to explain how identity relates to the process of healing trauma and why the topic of identity is part of the research question of this study. Since the question of identity is complex and has been defined in countless ways over the centuries and discussed by philosophers, social psychologists, psychotherapists and others extensively, this sub-chapter also presents my conceptual assumptions about identity and presents the theoretical foundation underpinning this perspective.

2.2.1 The Self as consisting of multiple parts

"There is no one 'she' or 'he' with whom the therapist can work . . . Not only is the therapist confused by these shifting states of mind, so too is the client."

(Fisher, 2017, p. 34)

In recent years, the traditional perspective of viewing human personality as consisting of a single self has been questioned. An increasing number of researchers, social psychologists and trauma therapists prefer '*a multiple self theory of the mind*' as Lester has termed it (2010). The theory that personality is made up of multiple selves, or multiple subpersonalities, has been proposed especially by John Rowan (2009) and by Lester (2010). Also conflict and negotiation researcher Riskin (2013) has written about the importance of understanding the inner conflict of one's subpersonalities. Riskin

(2013) maintains that the key to resolving outer conflicts is an understanding of inner conflicts, which requires a 'multiplicity of personality' perspective.

In the field of psychotherapy, a therapy modality utilizing a 'multiplicity of personality' -perspective is Schwartz's (1995; 2001) *Internal Family Systems* (IFS) approach. Tom Holmes (2007) has coined the term 'Parts Work' to describe therapeutic approaches that focus primarily on healing the intrapsychic conflicts between subparts of the self. While IFS is not the only therapy modality based on Parts Work, it is arguably the most well-known.

According to IFS theory, every individual has many inner 'parts' that can get stuck in rigid roles or patterns, similar to the way in which family members can get stuck in certain roles (Schwartz, 1995; 2001). In this approach, the goal of therapy is not to eliminate the difficult parts, but to develop a harmonious internal system where communication flows between the inner parts. The theoretical foundation of IFS therapy also provides the conceptual framework for this paper in the sense that healing from trauma is seen as a reorganization of the client's intrapsychic system: Whereas most psychotherapy theory focuses on interpersonal relationships, this paper seeks to explore how and why an intrapsychic focus is essential to healing from trauma¹.

In parallel to IFS, yet independently, other therapeutic modalities have also been developed. Especially significant to this research is Hudgins' *Therapeutic Spiral Model*

¹ This is not to undermine the importance of early attachment and its effect on development or trauma. Rather, the conceptual foundation of this paper is that even trauma

(2002), which is a trauma-informed Psychodrama model that focuses primarily on reorganizing the client's intrapsychic system. This model will be examined more closely in a subsequent sub-chapter of this literature review. Other therapeutic modalities that could be placed under the umbrella-term of Parts Work are *Ego-state Therapy* after Watkins & Watkins (1993), and *Schema Therapy* (Young, Klosko, & Weishaar, 2003).

This perspective of viewing identity as multiple and consisting of many sub-personalities provides the conceptual basis for this research paper; this concept is the connecting thread throughout the research: If we acknowledge how each personality is inherently made up of multiple parts that can either work together to create a harmonious intrapsychic system or be in conflict with each other resulting ambivalence and internal splitting, we can then understand why and how a Parts Work approach can be helpful in the process of psychological healing: Parts Work approaches seek to repair the internal conflicts and the internalized attachment patterns, rather than approach healing from the outside in.

2.2.2 The concepts of 'dissociation' and 'fragmentation'

In the past two decades, trauma has become one of the most researched areas of psychology, as advancements in neuroscience and findings from clinical practice shape our understanding of it. Two key concepts emerging from seminal trauma research are *dissociation* and *fragmentation*. Although the topic of identity/sense of self undoubtedly is important in the treatment of most psychological disorders, it bears particular

significance in the healing of relational trauma. The explanation for this can be found in the understanding of dissociation and fragmentation.

According to Van der Hart, Nijenhuis & Steele's *theory of structural dissociation* (2004; 2006), which is grounded in neurobiology, 'dissociation' is an instinctive coping mechanism in the face of repetitive trauma, which enables a person to adapt to the traumatic situation. Although this coping mechanism is important to survival in the moment of the traumatic event, in the long-term it often leads to fragmentation and to chronic dissociative symptoms commonly seen in posttraumatic stress disorder (PTSD) and Complex PTSD. The most extreme symptoms of dissociation are seen in the clinical diagnosis of Dissociative Identity Disorder (DID).

'Fragmentation', which is closely related to dissociation, can refer to the fragmented memory of the traumatic event, but it can also refer to the fragmentation of personality as a result of trauma (Fisher, 2017). Fragmentation of personality is also termed 'personality disintegration' (APA dictionary, 2018), 'internal splitting' or 'self-alienation' (Fisher, 2017).

Trauma expert Janina Fisher (2017) explains how dissociation and fragmentation are mechanisms of psychological distancing used by human beings in the face of inescapable threat. Attachment research has also supported the theory of an innate instinct to fragment under stress (Lyons-Ruth et al, 2006; Solomon & Siegel, 2003; Solomon & George, 1999). Dissociation and fragmentation are subconscious attempts to disconnect from unbearably painful parts of one's personality. While disconnecting from

certain parts of the self might be the safest way to survive the traumatic experience, this coping mechanism prevents self-acceptance and self-care after the threat of trauma is long past (Fisher, 2017). Thus, for survivors of relational trauma, identity integration² is the very key to the healing process - a necessary and inevitable aspect of unraveling the psychological consequences of trauma.

2.3 How Trauma Impacts Identity: Previous Research

Provide an exhaustive review of the current literature that includes the following information: Relational trauma leaves a psychological impact on the survivor's sense of identity. Much of the existing literature on this topic focuses on the cultural identity, ethnic identity, or other group identity in cases where certain groups have been victimized (see: Eyerman, 2001; Kidron, 2003; Mobasher, 2006; Wistrich, & Ohana, 2014). Less studied is the effect that trauma has on the individual sense of self. Research focusing on how trauma experienced by an *individual* impacts the person's sense of self is scarce. This sub-chapter outlines relevant literature found on the topic.

Addelson (2002) shares a feminist perspective on this topic: When the trauma is intentionally inflicted by another human, it damages the connection between the self and the rest of humanity. In Addelson's view, the self exists fundamentally in relation to others. When this relation is an abusive one, it impacts one's sense of identity: If a person

² Brewer (1976) offers the following definition of integration: "Within the context of psychotherapy, this term seemed to describe what happens as individuals come to experience themselves more fully by re-owning parts that have been previously alienated" (p. 17).

internalizes the perpetrator's perspective of oneself (as worthless), then being a victim is not merely a temporary experience, but becomes part of one's self-perception.

A recent study from South Africa (van Schalkwyk, Boonzaier, & Gobodo-Madikizela, 2014), analyzed how women exposed to IPV transition from 'victim' to 'survivor' identity. The study concluded that women who manage to leave the violent relationship continue to fluctuate between positioning themselves as 'victim' or 'survivor' in the aftermath of the relationship, struggling with an ambivalent sense of identity. Furthermore, the findings show that the experience of victimhood rarely ends with the conclusion of the abusive relationship, especially in cases where the women were financially dependent on their partners. This suggests that the victim self-concept can be tied to the issue of financial freedom.

In her narrative research, Lutgen-Sandvik (2008) studied the process of identity reconstruction in the midst of emotional trauma. Her study focuses on an area of interpersonal trauma that is less studied, that of workplace bullying. She points out that workplace bullying is especially stigmatizing, and as such has an intense impact on self-identity. By interviewing 20 adult workers (all were Caucasian from the US, 10 men and 10 women) who reported being bullied at work, and analyzing their narratives and self-perceptions, she identified the workers' attempts to reconstruct identity during and after experiences of bullying. The findings show that workplace bullying threatens identity, seriously damaging workers' self-perceptions, as well as their reputation at work.

During the phase of bullying, participants suffered from what Lutgen-Sandvik described as a deep "disruption of one's ontological security, including shaking/destroying important values and beliefs about the world in which one lives" (p.105). Post-bullying participants reported from experiences of loss of identity as 'good worker' and long-term loss of belief in personal power. Lutgen-Sandvik concludes that bullied workers struggle and spend considerable time and effort in consciously adjusting self-perceptions in response to workplace bullying. Bullying is traumatic in part *because* it disrupts an identity that was previously in a state of equilibrium. She states: "Self-narratives are, in a sense, anchors that ground human actors in a world that is in constant flux. When this narrative is deeply disrupted, persons lose their moorings and are cast adrift." (p.116).

In a less recent humanistic paper Jaffe (1985) presents a creative approach to self-renewal after extreme trauma, highlighting how active self-definition with the help of a facilitator can be a way to reconcile with the pain following trauma. Jaffe's article contributes several noteworthy ideas: Firstly, that healing from trauma is a process of self-renewal and self-definition. Whereas trauma happens to a person, and as such is a passive experience, healing from trauma stems from the person's willingness to participate actively in the healing process; it is not enough that the psychotherapist sees the person's potential for an empowered self, but the reconstruction of identity is above all a process of *self*-definition.

Another interesting point presented by Jaffe (1985) is that self-renewal after extreme trauma is not only a matter of survival, but can be viewed - and is viewed by many survivors - as an opportunity to emerge as more whole, creative, alive and stronger than before. In other words, Jaffe studied the phenomenon of post-traumatic growth (PTG) long before Tedeschi and Calhoun coined the term in the mid-1990s. Jaffe's study supports the hypothesis assumed in the present study that therapeutic processes focusing on PTG and deeper healing require some form of remedial identity work; healing from complex trauma is not only a matter of reducing symptoms but a deep transformation of self. It is also evident that while therapeutic processes developed to reduce PTSD-symptoms are numerous and well-researched, therapeutic processes that focus on post-traumatic growth and deeper healing are less studied. Jaffe's study is a valuable contribution, yet there is a need for current research on the topic.

While the client's active role is essential to transforming the sense of self, also the therapist's role is key. What has long been assumed by psychotherapists, has now been scientifically proven by attachment researchers: Identity is partly formed through internalized interaction patterns with attachment figures and other close relations (Cozolino, 2014). This brings us back to the question of how trauma impacts identity. When trauma is experienced within the context of primary attachment, the impact on identity is especially deep. The most obvious internalization of a traumatic experience is usually that of the victim-role: If an individual has repetitive interpersonal experiences with others who were dominating and oppressive, a likely effect is the identification with

being victimized and submissive. Just as abusive relationships impact the sense of self, so too can safe relationships - for example between psychologist and client - provide a corrective experience and eventually lead to a new sense of self.

Trauma researchers have also found that victims of violence often internalize the role of the perpetrator by becoming aggressive or violent themselves, or by adopting self-harming habits (Naisen Väkivalta organization, 2019). Another role that might be internalized through trauma is that of the abandoning authority. Experiencing complex or continuous trauma usually implies that the experience involved an abandoning authority, whether it was a parent, a neighbour or a police officer who didn't rescue the victim. Trauma expert and Psychodrama-therapist Kate Hudgins (2019) concluded after decades of clinical observation that many survivors have internalized the abandoning authority role, which can manifest in various self-abandoning patterns.

In summary, existing literature on the topic suggests that interpersonal trauma can, and often does, lead to identity confusion, inner conflicts of self-perception and/or to an ambivalent and often fragmented sense of identity. The literature also suggests that remedial identity work is helpful and recommended in the process of healing from interpersonal trauma. In addition, the literature refers to two sides of remedial identity work: 1) The work related to self-definition and self-renewal, and 2) interpersonal identity work, such as corrective experiences in the context of a therapeutic relationship or group therapy. Most of the research on the topic is qualitative and small-scale.

2.4 Healing Trauma: the Limits of Talk Therapy

Numerous researchers have addressed the limits of talk therapy in terms of accessing and processing traumatic memories. The inability to express feelings verbally appears to be relatively common in patients with PTSD, as Krystal, Giller, & Cicchetti found out already in the 1980s. Especially for survivors of relational trauma during childhood, the most challenging aspect of healing trauma seems to be the ability to access and express a traumatic memory through verbal language (Herman, 1992; Roth & Friedman, 1998; van der Kolk & Fisler, 1995).

Consistent findings in affective neuroscience support such theories, especially findings related to the hemispheric lateralization of emotional memories (Högberg, Nardo, Hällström, & Pagani, 2011; van der Kolk, Burbridge, & Suzuki, 1997). On a neuro-biological level, dissociation causes the trauma memory to be organized in the brain as sensory fragments and overwhelmingly intense emotional states that may remain separated from a coherent narrative as they are beyond linguistic organization (van der Kolk, Burbridge, & Suzuki, 1997). Furthermore, MRI studies show that the corpus callosum area (which connects the two hemispheres) is smaller in PTSD patients compared to control groups, explaining why talking about traumatic memories is difficult for many clients: Whereas one part of the brain feels the memory, another, more or less disconnected part, is in charge of talking about memories (Villarreal et al., 2004).

Trauma expert Peter Levine, who developed an approach to trauma healing called *Somatic Experiencing*, argues that trauma is "locked" in the body, and therefore must be

accessed and healed through somatic techniques (Levine, 1997). He explains that PTSD is basically a highly activated, biological response to threat, frozen in time (1997). Moreover, Levine argues that the origin of PTSD does not lie in the traumatic event itself, but in the helplessness and inability to fight or flee the traumatic situation. He believes that trauma survivors can heal by regaining the lost capacity to be present in their bodies again, and through learning in therapy how to regulate the nervous system. Levine's research has contributed to the field of trauma treatment by bringing awareness to the importance of including the body in the process of healing.

The interpersonal neurobiology-research and its implications for trauma treatment started in the mid-1990s with the seminal study of Rauch, van der Kolk, Fisler, Alpert and colleagues (1996). In the past decade, especially research by Siegel (2012) and Cozolino (2016) has continued the growing understanding of how early attachment styles relate to trauma on a very visceral and biological level. These findings suggest that when it comes to healing trauma, talk therapy is in several ways limited. Another implication arising from such studies is the efficacy of experiential and action-based methods when treating psychological trauma. The findings indicate that experiential, somatic or action-based methods are especially recommended when treating complex PTSD, relational trauma and childhood abuse. This leads us to the following sub-chapter about the benefits of including creative and experiential methods in trauma therapy.

2.5 Research on the Benefits of Utilizing Creative and Experiential Methods in Trauma Treatment

For clients who find it difficult to talk about their emotions, experiential therapies provide an obvious advantage: They allow clients to express themselves through a variety of non-verbal, symbolic and somatic channels. Johnson, Lahad & Gray (2009) have reviewed the advantages of using creative arts therapies in the treatment of trauma: What sets creative arts therapies apart from other modalities are the experiential, creative and symbolic elements of these modalities which help to access implicit memory systems. In this way, avoidance strategies may be decreased and traumatic memories accessed more easily. More research on the exact source of the therapeutic benefits of the creative arts therapies is required³, however, clinical case studies as well as recent findings in affective neuroscience suggest that experiential therapies are the treatment of choice for clients recovering from trauma - either as the primary treatment or in conjunction with other psychotherapy modalities (Cozolino, 2016; Hudgins & Kipper, 1998; Siegel, 2012; van der Kolk, Burbridge & Suzuki, 1997).

Johnson, Lahad & Gray (2009) state that many of the key components of creative arts therapies are empirically supported. One therapeutic element commonly found in

³ Although there is little empirical research on the topic, most practitioners of Drama Therapy and Psychodrama agree that the key change agent in drama-based therapeutic interventions is spontaneity and creativity (Carnabucci, 2014; Jones, 2007).

creative arts therapies for trauma is that of *imaginal exposure*. Techniques of creative imagination and representation of the trauma scene through the artistic medium not only help to access traumatic memories, but also to process them and concretize them (Johnson, Lahad & Gray, 2009). Use of guided imagery in Psychodrama was already demonstrated by Moreno in the 1940s and 1950s and continues to interest researchers. For instance, this technique has been applied to Cognitive Behavioral Therapy methods for treating PTSD (Keane, Fairbank, Caddell & Zimering, 1989; Krakow et al., 2001).

The creative arts therapies have been used to treat many types of trauma. Increasingly frequent are cross-cultural interventions utilizing creative arts therapies with survivors of war, torture and disasters (Baker, 2006; Callaghan, 1993; Gray, 2001, 2002; Hardi & Erdos, 1998; van der Velden & Koops, 2005). Creative arts therapies have also been utilized to help clients with chronic PTSD address issues of demoralization and hopelessness (Dintino & Johnson, 1997).

For clients with PTSD, two main areas of improvement have most often been noted by creative arts therapy practitioners: 1) primary symptoms of PTSD and 2) global clinical improvement (Johnson, Lahad & Gray, 2009). Specifically, the creative arts therapies have been cited as effective in reducing alexithymia (Duey, 1991; James & Johnson, 1996), increasing emotional control (Cohen et al. 1995; Slotoroff, 1994), improving interpersonal relationships (Carey, 2006; Dintino & Johnson, 1997), decreasing dissociation and anxiety (Duey, 1991; Greenberg & van der Kolk, 1989; Jacobson, 1994), and decreasing nightmares and sleep problems (Daniels & McGuire,

1998; ernández-Ruiz, 2005; Morgan & Johnson, 1995).

In addition, creative therapeutic approaches can help to restructure cognitions; although the therapeutic process is often less cognitively oriented compared to traditional talk therapies, the effect of creative arts therapies on cognitive and neurobiological processes may be just as high (Johnson, Lahad & Gray, 2009). This implies that experiential modalities do not need to be set in contrast with Cognitive Behavioral Therapy and other cognitive therapy modalities, but can be seen as mutually supportive: Experiential approaches can support the integration and embodiment of new skills, behaviors and cognitive structures acquired in verbally-based therapies. Experiential therapies - like Psychodrama and Drama Therapy - can help the body to catch up with the new perspectives gained in talk therapy.

A survey of the existing literature demonstrates that empirical studies of creative arts therapies in the treatment of trauma are few. Most evidence of efficacy is currently derived from clinical reports and case studies. After reviewing the literature, it seems there is currently no meta-analysis on the effectiveness of Drama Therapy or Psychodrama with PTSD populations. However, Hudgins & Drucker showed in their quantitative study from 1998 that the first clinically modified Psychodrama intervention designed specifically to increase self-regulation and containment for clients with PTSD, resulted in significant decreases in depression, anxiety, dissociation and general symptoms of PTSD over merely three individual therapy sessions. The results remained effective according to the six-month follow up interviews. In the same year, Greenberg,

Watson, & Lietaer (1998) demonstrated that experiential psychotherapy is equally effective as cognitive behavior therapies and psychodynamic therapies - and increasingly effective with treating trauma.

When it comes to creative arts therapies, the only meta-analysis found on the effectiveness of creative arts therapies for treating trauma was the systematic review: 'The Effectiveness of Art Therapy in the Treatment of Traumatized Adults' (Schouten et al., 2015). After reviewing six controlled, comparative studies, Schouten and colleagues concluded that there is an urgent need for further research on the topic.

The creative arts therapies - like all psychological treatment - require cautious application when utilized with trauma survivors. Although Carey (2006) and Cohen, Mannarino & Deblinger (2006) claim that any risks to creative arts therapies can be prevented through specific structuring techniques within the session, many clinicians have noted that Psychodrama and Drama Therapy can easily trigger clients recovering from trauma and even re-traumatize them (Dayton, 2015; Hudgins, Culbertson & Hug, 2009; Kellermann & Hudgins, 2000), especially since Psychodrama and Drama Therapy techniques are considered particularly intense: While they can be very effective in healing trauma, they are also under risk of overwhelming clients when accessing traumatic material too quickly. Like with all therapeutic modalities, the creative arts therapies come with side-effects and risks that need to be considered.

2.6 Historical and Current Examples of Therapeutic Theatre

"The theatre cures the actors. It can also cure the audience."

(Evreinov, 1927, p. 126)

In order to understand how dramatic processes can be applied for psychological healing, it is necessary to examine the basic elements of the dramatic process. Next, I will discuss theoretical and practical models used in drama therapy and psychodrama for the purpose of inner parts work and identity integration. Later, I will present therapeutic models developed in recent years that apply dramatic processes specifically for a trauma population, and consider in what ways these models comply with the recommended guidelines for trauma treatment.

Below I will introduce the basic elements of theatre, and discuss how each element can be and has been applied in a therapeutic context. Drawing from previous literature, including both recent and seminal references, this sub-chapter seeks to explain how and why theatre can be therapeutic. This sub-chapter introduces those core elements of theatre that have been considered therapeutic in the past, including references outside the fields of modern drama therapy and psychodrama.

2.6.1 Core elements of the dramatic process and their use in psychological healing

Interestingly, psychological healing and theatre share the same roots in the ancient practice of ritual theatre (Casson, 2016). Upon closer examination, theatre and psycho-

therapy share many commonalities: Both are concerned with exploring human nature, and with bringing awareness, visibility and expression to intrapsychic experiences. One century ago, the Russian pioneer and founder of *theatrotherapy* (1927), Evreinov, studied the therapeutic properties of theatre. According to Evreinov, the need and desire to transform the self is a basic human need; To Evreinov, acting is the art of self-transformation (in contrast to the more common view where acting is seen as a skill of pretending to be something other than the self). From Evreinov's perspective, the link between theatre and psychotherapy is the quest for self-transformation.

Many of the ideas of *theatrotherapy* underlie the basic tenets of later drama therapy. For example, one of the basic principles of drama therapy is the idea that the relationship between a person and the art itself is therapeutic (Jones, 2007). Indeed Evreinov wrote that "an actor's ailment is overcome by the 'transfigurative energy' of the role he enacts" (1927: 125). Below I will describe the core elements and qualities found in dramatic processes, and how each element contributes to the healing or 'transfiguration' of the participant.

The role. Dramatic processes generally include the element of character, or role. The self can assume different, even fictional identities. This is the basis of role work in the context of drama therapy (Jones, 2007). Essentially, the role represents a metaphor for identity. Evreinov wrote: "Play a role well, and you will live up to it" (1927, p. 125). Thus, role work is not merely a conduit for expressing the self, but also a vehicle for

transforming or developing one's identity. Jones (2007) explains that playing an imagined role can have very real effects linked to auto-suggestion and behavioral learning.

Focus on the therapeutic effects of role work has also been emphasized by the founder of psychodrama, Moreno (1987), by social psychologists such as Goffman (1959), theatre practitioners like Boal (1995) and anthropologists, like Turner (1982). Role work provides particularly useful processes when working with identity integration: In a recent paper Jakovina & Jakovina (2017, p. 151-152) state that the practical and therapeutic function of roles in psychodrama "enable people to (re)consider their perceptions of themselves". Role-based processes in relation to identity integration will be discussed further in the following sub-chapter.

Storytelling. Like in narrative therapy (White, 1998), storytelling is a basic element of drama. Drama is a form storytelling. In the context of therapy, the story becomes a metaphor for the meaning a client gives to his or her experiences. The way in which a story (an experience) is narrated can create new meanings to past experiences. The client's narrative is his/her perspective of lived experiences. Therefore, the conscious re-telling of a story can transform the client's self-perception. Storytelling can thus be (and has been) applied to trauma interventions and identity work. An example of using storytelling to heal from past experiences is Dunne's *Narradrama* (2010), an approach that integrates narrative therapy with drama therapy.

Visibility. Drama is action made visible. In psychotherapy, the focus is generally on the intrapsychic events of the client: the cognitions, the affect and the meanings given to external events - most of which are invisible events. Whereas in talk therapy the psychotherapist seeks to gain access to a client's inner world through language, dramatic processes provide a wider range of communication channels. Most dramatic processes contain some form of physical expression. For example, Innes (1993) writes that through enactment, internal experiences are not only talked about, but they are given a visible form. This allows both the client and the therapist to see in a tangible way what goes on within the client.

Unmasking. Grotowski's experimental theatre provided an early influence of therapeutic theatre. Especially his Para-Theatre continues to influence modern drama therapy (Mitchell, 1992). Grotowski was concerned with theatre's ability to help participants reveal, uncover and discover a self beyond cultural and conditioned masks. Through his theatrical experiments, he found that the therapeutic factor in theatre lies in its effect of 'disarming' the participant: Through organic improvisation, and other spontaneity-strengthening dramatic processes, the social masks and defense systems can be disarmed, enabling a more direct and authentic expression of the self (Mitchell, 1992).

Mitchell (1992, p. 64) cites Grotowski in 1980:

"Para-Theatre is not an imitation, depiction or invocation of any other reality than that experienced literally. In Para-Theatrical activities there is no division into performers

and observers: all present, are active participants." Here Grotowski raises an interesting point: Theatre is not only therapeutic because it can play with fantasy and potential realities. It is also therapeutic because it can reveal internal reality; what might be covered up by socially conditioned roles in daily life, can be uncovered in the theatrical space.

Embodiment. Drama is not only visible, but also embodied - it engages the whole body. Dramatherapists and psychodrama practitioners place importance on the physical body as the embodiment of consciousness (Dokter, Jennings & Holmwood, 2016; Jones, 2005). This can be seen in the wide range of techniques employed by dramatherapists that involve movement and mime. These practitioners emphasize the importance of physicality: As humans, we experience life through the senses of the body; even emotions are felt as physiological reactions. In talk therapy, the somatic aspects of the self can easily be neglected, as most of the focus is on the thinking mind. However, in trauma therapy specifically, somatic work has proven to be of great importance (Levine, 1997). Due to their physical nature, dramatic processes can help a client recovering from trauma to gain more body awareness, which in turn helps to prevent dissociation (van der Hart, van der Kolk, & Boon, 1998).

Emotional expression. Drama, like other art forms, provides a medium for expressing emotions. Talking about emotions does not automatically lead to feeling,

expressing, or to releasing overwhelming emotions. Many clients who have experienced trauma find it difficult to express their emotions verbally, without dissociating (Levine, 1997). The stage, whether in a theatre or in a psychotherapist's office, offers a playful and contained platform for expressing emotions.

One common example from clinical practice is the 'Empty Chair technique' from Gestalt Therapy. This role-play based technique is applied to give clients the opportunity to resolve 'unfinished business' and find resolution by giving voice to previously unvoiced feelings. The empty chair, originally borrowed from psychodrama, can be described as an example of a dramatic process incorporated into psychotherapy. In a study from 1995 (Paivio & Greenberg), 34 clients with unresolved feelings towards a significant other were randomly assigned either an experiential, empty-chair based intervention or to a psychoeducational group. Results indicated that the empty-chair based intervention achieved clinically meaningful benefits for most clients and significantly greater improvement compared to the control group on all outcome measures. Today the Empty Chair technique is applied in various therapeutic modalities.

Within the discipline of drama therapy, many techniques are established to help the client express his or her emotions. One key technique is 'dramatic projection', which allows participants to project their feelings onto a role or object (Jones, 2007).

Aesthetic distance. Like other creative processes, drama provides aesthetic distance. This is one of the primary advantages that creative arts therapies contribute

compared to talk therapy. Theatre pioneer Brecht (1936) studied this element in depth, and called it *Verfremdungseffekt*. Whereas Brecht used this concept to explain a particular technique of acting, modern dramatherapists often refer to the *aesthetic* or *therapeutic distance* that is inherent to dramatic processes (Johnson, & Emunah, 2009). Aesthetic distance enables clients to approach real, often painful, feelings in a creative or imagined setting. The therapeutic implication is that clients feel safer confronting their inner shadow parts when the part is portrayed in a made-up setting, like an enacted drama (Glass, 2006).

According to Scheff (1981), aesthetic distance allows for what he calls 'optimal distance' from emotions, a state during which the client is simultaneously and equally a participant of an experience and the observer. This has also been called 'double vision' (Scheff, 1981). When a person is able to observe the emotion *while* feeling it, the emotion is contained and therefore less overwhelming. Dramatherapist Levy describes a case vignette with a client called Grace:

"On one hand, Grace is at a distance from herself when she embodies the characters physically and as such increases her fantasy: she becomes someone else's identity. On the other hand, this distance allows her to experience herself in a different way. She starts observing herself and being empathetic with her pain and hurt." (Jones, 2007, p. 220).

Perspective. One of the elements specific to drama is that it allows a person to

perceive something from multiple perspectives: The staged event can be perceived from the perspective of the audience (the external observer), the storyteller, the actor, etc. The element of perspective is also related to roles; a scene that includes many roles can therefore be perceived differently through each role. Therefore, dramatic processes can help the client to perceive his or her own experiences from a multitude of perspectives. Again, we find a parallel between therapy and theatre: Both attempt to offer new perspectives to the client/audience. Naturally, the element of perspective is closely linked to the element of storytelling. Jones (2007) describes a case vignette where dramatherapist Christine Novy reflects on the effect of drama on her clients' self-perception:

"People's lives and identities can be represented in different ways and from varying perspectives; that the stories we or others tell about us are creations and, as such, they can be created or constructed differently. . . 'The everyday, usual ways of experiencing the self and events are altered by the use of dramatic language'" (Jones, 2007, p. 122)

Transformation. Therapy is essentially concerned with transforming suffering into wellbeing. Albeit for a different purpose, also the work of the actor is based on transformation: The actor's task is to transform herself into the character she is playing. This can provide a metaphor for the client whose task it is to transform the old, suffering identity into a healed self. Whereas the actor goes through a temporary and artistic

metamorphosis, the aim of the client is to go through a lasting, psychological metamorphosis. In the context of psychotherapy the main vehicle for creating change is the therapeutic alliance, while in theatre it is engagement with the dramatic art itself that creates change. Modern dramatherapists acknowledge both the art form and client-therapist relationship as mediums of change (Jennings, 2013).

Imagination. Evreinov (1927) considered imagination of reality to be the medium of change: Through imagination and acting, the self can be given new forms; imagination allows a person to explore different parts within himself/herself and to choose which part to play at any given moment in real life. In modern dramatherapy and psychodrama, imagination and imagery play an important role (Gersie, 1996; Carnabucci, 2014).

Spontaneity. Like any artistic and creative expression, theatre and drama have the potential to strengthen a person's innate spontaneity. Dramatic improvisation in particular has been linked to increased spontaneity (Johnstone, 2012; Sawyer, 2000). Similar to most action-based methods, spontaneity is an essential element in both psychodrama and drama therapy. In classical psychodrama, spontaneity and creativity are defined as the goal of therapy and the method of change (Carnabucci, 2014).

Rehearsal for life. Drama is enacted life, and therefore can be used to practice specific behaviors, reactions, interactions, or approaches that the client faces in real life.

For example, drama provides a medium for the client to rehearse self-soothing actions. When these actions are not merely talked about in therapy, but are literally enacted, or practiced, it will be easier for the client to transfer this learning into real-life situations. It could be claimed that no other artistic or therapeutic medium is so well suited to practicing interactive behaviors as role-play.

There are countless clinical applications of this element, especially in behavioral therapies, in Gestalt Therapy, and in skill-training orientations to therapy (Goldfried & Castonguay, 1993; MacNeilage & Adams, 1979). For example, practicing assertiveness through role-play has been found to lead to significant improvements compared to control group (Kazdin & Mascitelli, 1982).

The audience/witness. Drama not only enables something to be expressed, but it also allows for something to be seen and witnessed. Whether the drama is being perceived by an audience, or by the therapist, there is a witness. Many clients of psychotherapy feel that one of the most healing factors of psychotherapy is the experience of being seen and heard (Jackson, 1992; Taipale, 2016).

While the therapist fulfills an important function in bearing witness to the client's transformation, a client can also learn to observe himself and his own experiences. For example, by experiencing a scene from within a role while observing it like an external observer would, the client can learn how to connect the experiencing self (the emotional self) and the observing self (the thinking self). According to trauma experts, it is this

ability to engage the prefrontal cortex (the thinking mind) while feeling strong emotions that helps traumatized clients to not dissociate when being triggered (Fisher, 2017). From a neurobiological perspective, the practice of connecting the observing self with the feeling self strengthens the corpus callosum, which in many cases is weaker in persons suffering from trauma (Villarreal et al., 2004). Dramatherapist Landy (2001) sums this up by describing the human condition as "one of living simultaneously within paradoxical realms of mind and body, thought and action, subject and object, actor and observer" (p. 380).

Dialogue. Although many elements of drama are non-verbal, dialogue is a verbal -yet creative - element found both in theatre and in psychotherapy. Dialogue has also inspired the emerging of new therapeutic modalities and techniques. One such modality is Voice Dialogue created by psychotherapists Hal and Sidra Stone (1989). Voice Dialogue is a method that enables one to understand, connect to and interact with the many selves that make up the human psyche (Stone & Stone, 2007). Thus, it is a therapeutic method based on inner parts work. In Voice Dialogue, the facilitator engages in a dialogue with a particular aspect of the client's self, with the therapeutic aim of bringing more awareness about this inner part. The aim of Voice Dialogue is to enable the client to make conscious choices in life rather than act from unconscious and automatic patterns.

Presence. Bella Merlin (2017), a scholar and teacher of the art of acting, claims that although acting techniques are many and varied, at the basis of every approach are the skills of being present and active listening. In the field of psychotherapy, mindfulness and other practices that promote the ability to 'stay present' are increasingly popular (Germer, Siegel & Fulton, 2016; Shapiro & Carlson, 2009). According to Fisher (2017), Follette, Palm and Pearson (2006), being present in the now-moment is a common challenge for individuals suffering from PTSD and complex PTSD. Indeed, The UK Psychological Trauma Society (2017) recommends professionals to include mindfulness practices in the treatment of Complex PTSD. In addition, Brown and Ryan (2003) found that being present has many benefits to general psychological well-being. It is no surprise then that many contemporary drama-therapists use dramatic processes to cultivate the skill of being present and purposefully combine mindfulness practices into their drama therapy (Gluck, 2013).

A drama can be seen as a multi-layered metaphor to the client's life experience, and the role provides a metaphor for the self. Theatre, like many art forms, perceives, presents and represents life, but also has the potential to transform it. This sub-chapter has demonstrated how many of the elements inherent to drama and theatre have been applied in therapeutic contexts throughout history. Just as theatre has drawn from the study of psychology, so too the psychology field has drawn techniques and influences from the world of theatre. Although the most obvious intersection between theatre and

psychological therapy is found in the fields of Drama Therapy and Psychodrama, elements of the dramatic process are found in other therapeutic interventions as well.

The underlying hypothesis of this study is that dramatic processes can be used as a tool in the therapeutic context to transform the client's personal experience of life. This study seeks to **explore** and **define** the details of how, and when, dramatic processes can be used specifically in trauma therapy, and how these processes can help with identity-work.

2.6.2 Dramatic Processes, Identity and Psychological Healing

The previous sub-chapter introduced the basic elements of theatre and considered how these elements are therapeutic. In the following sub-chapter, I will go a step deeper and demonstrate why and how dramatic processes are particularly helpful for the purpose of understanding and transforming the sense of self. As Jones states in his book (2007), identity is emphasized in Drama Therapy by the nature of the form of the therapy: especially the playfulness of this specific therapeutic modality, the transformative nature of theatre, and the idea of self as constructed thought roles are all factors that make Drama Therapy and Psychodrama naturally suitable for identity work. Moreover, Jones point out that in Drama Therapy identity is examined, reflected upon and transformed not only verbally, but through action and in relation to someone or something. It is this aspect of physicality and embodiment that is unique to action-based therapies.

As was discussed earlier, re-negotiating one's identity is an important aspect of

healing for individuals who 'feel stuck' in a victim-role following trauma. The following sub-chapter revolves around the question: What are the benefits of using dramatic techniques in therapeutic identity work? Specific theories and techniques from Drama Therapy and Psychodrama will be outlined in relation to identity work. *Identity work* will be used synonymously with the following terms in this chapter: *transformation of self-organization; inner parts work; transforming the sense of self.*

2.6.2.1 Role Theory in classical Psychodrama

Role theory provides the basis of countless techniques and processes used in Psychodrama. The founder of Psychodrama, J. L. Moreno, has been credited with the conception of Role theory, although he did not create a refined theoretical model (Blatner, 2000). Moreno's Role theory is an example of a pluralistic model of personality, according to which each person plays many roles that can be identified and modified.

According to Moreno's view, every person plays various roles in life that are not inauthentic expressions of the self, but natural functions within the social environment. As Jakovina and Jakovina (2017) point out in a recent paper, roles - whether in life or in Psychodrama - include both a private (intrapsychic) dimension and a collective (social) dimension.

In classical Psychodrama, the Self is seen as emerging from the roles, rather than roles emerging from the self (Moreno, 1987). Moreno conceptualized personality as the role, or collection of roles, with which a person identifies the most. Based on this

perspective, identity, or the sense of self, can be directly influenced by consciously choosing which roles the individual plays in different situations.

Furthermore, in classical Psychodrama the measure of psychological wellbeing is the ability to move freely and fluidly through various roles (Blatner, 2000). Here we come back to the element of spontaneity that is considered essential in Psychodrama. It is important to note that in Psychodrama, multiplicity of self is not seen as problematic but as inherent to the human condition and a prerequisite to 'wholeness'. Along the same line, Schechner (1988) highlighted that in contrast to other animals, humans carry and express multiple and ambivalent identities simultaneously. This concept is at the basis of Role theory and one of the main reasons why role play has therapeutic possibilities: We can consciously observe, relate to and reflect upon the different parts of our identity, and express ourselves through them.

A seminal example of psychodrama theory is Stephen Karpman's (1968) 'drama triangle' that describes three roles relevant to trauma recovery: persecutor, rescuer and victim. Karpman discussed the complex inner world of trauma survivors and explained that trauma clients often involuntarily switch between the three roles. Liotti (2004) extended this theory by sharing his psychodynamic perspective that switching between drama triangle roles is a symptom of disorganized attachment. Karpman's 'drama triangle' is an example of Psychodrama theory that is particularly relevant to both identity work and to trauma treatment.

Role theory and role play are at the core of Psychodrama and are used widely in

Drama Therapy, in Gestalt Therapy and many other therapeutic modalities. Although the Empty Chair is the most wide-spread role-play technique, role play is a very versatile tool that can be applied within therapy in nearly unlimited ways. Most Psychodrama techniques that are used for identity work are variations of role play, or are built upon on Moreno's role theory.

2.6.2.2 Role play in Drama Therapy

Drama Therapy systematically uses dramatic processes to achieve therapeutic goals of symptom relief, emotional and physical integration, and personal growth (Couroucli-Robertson, 2001). Although Drama Therapy and Psychodrama are independent disciplines, they share the same roots and overlap in regard to many theories and practices.

In Drama Therapy, a role refers to a created dramatic identity (Jones, 2007). However, like in Psychodrama, a role can also be seen in the wider context of a personality aspect or a role-function within life - such as daughter, husband or employee. Drama-therapist Landy (1994) describes a role as a container of the thoughts and feelings of an aspect of self, as a basic 'unit' of personality. The purpose and process of role work depends on the client's needs and therapeutic goals (ibid.).

Jones (2007) summarizes three principle ways of using role work within Drama Therapy: 1) The client can assume a fictional identity or enact another person (interrelational work). 2) The client role-plays a specific experience from the past,

present, future or fantasy situation (intrapsychic or interrelational work). 3) The client deliberately isolates a specific aspect of themselves or their identity (intrapsychic work).

2.6.2.2.1 Landy's Role Method.

Drama-therapist Landy (1994) created Role Method (also referred to as the *role-counterrole-guide* technique) based on Moreno's Role theory. In Role Method, the client explores his or her conscious self (the 'role'), the unconscious shadow aspect (called 'counterrole') and the 'guide' (which can act like a bridge between the role and the counterrole). In a case example Landy (2003) demonstrates the use of this method with a client called Roger - an adult who, after witnessing the terrorist attack of 9/11, remembered traumatic events from his childhood. Through Role Method, Roger discovered a child-part of himself that felt helpless (the 'role'), remembered how terrifying his mentally-ill father had been (the 'counterrole') and understood how shutting down and forgetting his trauma had been a helpful survival mechanism. In this case, the 'guide' was seen symbolically as the part of himself that had numbed the pain to help him cope with the trauma. Through play and therapeutic re-enactment, Roger discovered how he could play the role of the caring and mature father to his own inner child.

This example demonstrates how fluid the line between intrapsychic roles and interpersonal roles can be: In order to heal interpersonal trauma, often the relationship between internal parts of the self needs to be addressed. Furthermore, Landy (2003) explains that one understanding of trauma within this theoretical construct is that the

internal guide of the traumatized client is missing, in which case the therapist must act in the role of the guide until the client is ready to internalize and re-own his or her internal guide (Landy, 2003).

For Landy, the philosophical assumption of the self as plural and multifaceted provides the basis for Drama Therapy theory and gives significance to the use of 'role' in Drama Therapy practice: "In a culture of multiple choices one needs a way to think about or play out the different parts. One way is through role" (Landy, 1994: 21-22). Drama-therapists see the self as reflexive: Whereas in theatre the actor acts and reacts to situations and the audience observes the action, in Drama Therapy one part of the self can observe and reflect upon the actions of another part of the self.

2.6.2.3 Other functions of role play.

Drama-therapist Jones (2007) describes the therapeutic effect of role-work thus: "A relationship is set up between the enacted fictional self and the client's usual identity, and this dynamic, active relationship is seen as the basis of therapeutic change in role-based work within dramatherapy" (p. 192).

Role-work can be used for numerous functions within Drama Therapy. For example, role-work can be used in the following ways therapeutically:

- To become aware of how various parts of the self interact within the internal system.
- To express a specific part of self. For example, to express socially

unaccepted emotions.

- To discover and practice a potential role that the client wants to adopt. For example, the role of the 'future self' who is empowered.
- To experiment with or practice a specific role or interactive behavior, such as being assertive.
- To explore and experiment with specific intrapsychic skills, such as soothing self-talk.
- To internalize a new role or a new perception of self, such as the 'compassionate self'.
- To rewrite an old perception of self.
- To disarm from our cultural and conditioned roles in order to allow a more authentic and spontaneous expression of self.

(Johnson, & Emunah, 2009; Jones, 2007; Mitchell, 1992)

Although dramatherapy theorists display various positions on the nature of identity, the predominant belief within Drama Therapy, like in the humanistic approaches to psychotherapy, is in the existence of a 'primary self' at the core of the individual, that is inherently good, whole, and self-healing (Jones, 2007). The goal of therapy and the result of healing then is the uncovering of this core self. What Rogers or Maslow call a movement towards self-actualization, Drama Therapists and Psychodrama practitioners might call a movement towards spontaneity and authenticity. At the same time, most

drama therapists see identity as multifaceted and as reflexive, meaning that one part of the self can be a witness to another part.

The above discussion demonstrated that Drama Therapy provides versatile role-based processes that are especially suitable for inner parts work and identity integration. In addition to such processes and techniques, the philosophical underpinnings of Drama Therapy itself make this therapeutic modality easily applicable to identity work. Next, I will outline some empiric examples of how Drama Therapy and Psychodrama have been used for therapeutic identity work.

2.6.2.4 Previous research on using dramatic processes for identity work

This sub-chapter presents examples from qualitative and quantitative studies around the subject of how Drama Therapy and Psychodrama have been applied for identity work. These examples from previous research provide some pointers regarding what results to expect from this current study. The examples picked for this literature review include mostly studies published in recent years.

In a qualitative study, Newman (2017) researched how two individuals participating in Drama Therapy re-created identity through role work while recovering from addiction. Findings from this multiple case study showed that the 'role of the addict' was often replaced with symptom roles of 'liar', 'failure', and 'depressed'. The study concluded that while Drama Therapy can assist the re-creation of identity post-addiction, the process is rarely brief or simple. Moreover, the study showed that the roles an

individual identifies with during recovery are, in many cases, attempts to cope with difficult emotions. This suggests that deep healing and re-creation of identity post-addiction can only occur fully after the individual has learned to cope with emotions in a healthy way and after symptoms have been reduced significantly. Although the aforementioned study explored recovery from addiction, not trauma, substance abuse is a frequent comorbidity found in trauma clients (Ouimette & Brown, 2003)

McMullian and Darci (2017) discuss how Drama Therapy can be applied in psychoeducation to create new meanings about what it means to live with mental illness. Their essay (titled 'I am more than my disease') demonstrates that the application of Drama Therapy theories can help clinical populations discern identity from illness. This is especially relevant to clients healing from trauma, who often feel ashamed of their PTSD-related symptoms (Leskela, Dieperink & Thuras, 2002). McMullian & Darci's paper suggests that identity work can start already in early stages of recovery through psychoeducation.

On a related topic, Ørjasæter, Stickley, Hedlund & Ness researched in a recent (2017), but small-scale (n=11), qualitative study how participation in a music and theatre workshop helped participants with mental health problems to explore narratives and transform identity. This phenomenological study from Norway identified three main themes: (1) becoming a whole person, (2) being allowed to hold multiple identities and (3) exploring diverse perspectives. Furthermore, the study concluded that participants' identity was transformed both on a collective and an individual level, that they developed

a broader picture of themselves through the creative involvement, and that they expanded their narratives. Although their method of data collection differs from this study, the topic is closely related, and it is to be expected that the results from this present study bear similarities.

Roy and Ladwig (2015) discuss the use of drama - in particular the use of masks - as a pedagogical tool to support identity development in adolescence. According to Roy and Ladwig, masks are helpful tools for allowing identity exploration, for increasing self-awareness and self-confidence, and for developing mental health. This article implies that theatrical identity work can act as preventive mental health care. Although the article focuses on identity work in adolescence, similar techniques and tools might be applicable in the context of trauma healing.

Another example from an educational context is the Master thesis of Werner (2017), where she proposes that drama encourages students to envision a wider range of possibilities for their future selves by questioning dominant discourses within society. The author makes the case that identity can be re-created by embodying new narratives and becoming conscious of language use in relation to identity.

Gembus (2018) published an article about his six months of ethnographic research about the impact of theatre on identity. The study examined how young 'second-generation' Somalis in London use performance to explore and express often contradictory registers of self and belonging through writing, practicing and performing plays. He concluded that drama transformed community places into 'safe spaces' that

open dialogue on the intergenerational conflicts experienced around identity.

Many theatre practitioners and drama therapists have noted the benefits of using theatre to explore cultural identity (Grehan, 2001; Llewellyn-Jones, 2002; Ross, 2001). Such authors emphasize that in intercultural contexts, theatre is most potent when it acknowledges the cultural identity of its participants. The implication is that drama therapy in India, for example, might use different dramatic texts and cultural references from drama therapy practices in England.

In the book *Creative arts therapies and clients with eating disorders* (Heiderscheit, 2016), Laura Wood shares an approach of combining the use of Internal Family Systems and Drama Therapy to help understand the protective function of clients' eating disorders. Internal Family Systems therapy can be seen as a form of identity work, as it is predominantly concerned with the clients' sense of self and the function of various personality parts. Whereas most approaches to eating disorders focus on the dysfunctionality of the disorder, IFS theory can help to understand what maintains the dysfunction: the part of the self that holds on to the eating disorder plays a protective function, such as protecting the client from feeling overwhelming emotions. By understanding the role and function of self-harming parts of the personality, new solutions can be found. Similarly, self-harming parts may play a coping role in clients who are struggling with PTSD or complex PTSD. Based on the insights of Wood, one expected result from this present study is that every part of the client's personality carries a specific function. The implication is that the wounded identity can only be re-created or

healed once the functions of the wounded and dissociated aspects are brought to awareness.

The above examples demonstrate some ways of using dramatic processes for identity work. The examples show that dramatic techniques can be used in various settings (such as educational, community, and therapeutic settings) to help individuals examine, understand or develop identity. While most of these examples were not specific to a trauma population, the findings might be applicable to clients recovering from trauma. Some commonalities arising from these diverse examples from literature are that conscious examination of identity is beneficial, if not essential, to mental health. Another recurring finding is that dramatic processes can, in various ways, provide a safe space for bringing inner conflicts of identity into awareness and even help to embody a new sense of self. It seems that a natural affinity exists between Drama Therapy/Psychodrama and identity work.

This chapter looked at how Drama Therapy/Psychodrama practice and theory can be applied for the purpose of identity work within the context of psychological healing. The philosophical and theoretical underpinnings have been outlined, along with examples from recent studies that demonstrate how these theories have been applied. It is evident that there are very few existing studies about how dramatic processes can be used for re-creating the identity of clients recovering from trauma. While there are many therapeutic models and approaches to Drama Therapy and Psychodrama, there are only a couple that have been developed specifically for a trauma population. These will be discussed below.

2.7 Therapeutic Models and Clinical Practices that Integrate Drama-based Processes with the Treatment of Trauma

While action-based experiential modalities are the treatment of choice for trauma - as confirmed by up-to-date neurobiological research (Cozolino, 2016; Siegel, 2012) - it has also been noted in the clinical field that Psychodrama and Drama Therapy can cause re-traumatization in clients. Since 1992, psychodrama-experts and researchers have started to create new drama-based approaches that are trauma-informed. One model that came out of this research is the *Therapeutic Spiral Model* (Hudgins, 2002).

2.7.1 The Therapeutic Spiral Model.

The Therapeutic Spiral Model (TSM) was developed by Certified Psychodrama Trainers and experienced clinicians Kate Hudgins and Francesca Toscani. This model is an integrative treatment modality combining elements of classical Psychodrama, attachment theory and recent advances in interpersonal neurobiology and trauma theory. Central to this stage-process model is the use of action-based methods in a way that provides additional safety and prevents re-traumatization (Hudgins, 2002).

Unlike most Psychodrama models, TSM makes a conscious turn from interpersonal work to a focus on inner parts of self. TSM is a trauma-informed model to

change self-organization⁴ of people affected by trauma using experiential psychotherapy. In TSM, the focus is not merely on coping with trauma symptoms, but also on post-traumatic growth (PTG). Like IFS Therapy and most approaches to Drama Therapy and Psychodrama, TSM sees the plurality of self as normal. The goal of TSM then is to help the client, in a safe and contained manner, to re-organize old views of self so as to become more resilient. (Hudgins, 2017, 2002)

Research on TSM since 1998 has demonstrated its efficacy in treating trauma: An initial quantitative study on the 'containing double' (one technique used in TSM designed to increase containment and self-regulation in clients with PTSD) showed statistically significant decreases in dissociation, depression, anxiety, and other symptoms of PTSD over just three individual therapy sessions. Results lasted according to follow-up interview six months later.

In 2009, Hudgins, Culbertson & Hug presented the effectiveness of TSM when combined with literature, music, and public speaking in leadership training in a community following violence. More recently, Perry, Saby, Wenos, Hudgins & Baller (2016) showed that the TSM action protocol for a three-day weekend workshop leads to increases in self-esteem for women who served in Afghanistan and Iraq.

⁴ In this context, self-organization refers to the person's identity, sense of self, or the dynamic between inner parts of self.

2.7.1.1 The Trauma Survivor's Internal Role Atom (TSIRA) - A clinical map for trauma-informed experiential psychotherapy with inner parts

TSIRA is the clinical map used in TSM, designed as a practical guide for trauma-informed Psychodrama. The aim of this clinical map is to help trauma clients make sense of the often chaotic self-organization following trauma. TSIRA is comprised of a process with 3 stages, and can be applied to both individual therapy and group settings. Each stage includes specific techniques and roles, as introduced below. (Hudgins, 2019).

Stage 1. The first stage focuses on increasing containment, safety and self-regulation in order to prepare for trauma work. At this stage, the TSM uses 'prescriptive roles' that are prescribed by the director (the therapist) for the purpose of self-observation, restoration and containment. Self-observation is the first role explored in TSM through the role of the Observing Ego. Work with this role increases the person's window of tolerance and develops the capacity to witness emotions in a more neutral way. Roles of restoration include roles that build the person's creativity, internal resources and interpersonal strengths. These roles help to increase resilience following trauma. Lastly, the roles of containment include the Containing Double and the Body Double, which help the client to become aware of body sensations and stay present, to increase self-soothing behaviors, and to decrease dissociation. This stage is complete once the client can access these roles autonomously and with spontaneity. (Hudgins, 2019).

Stage 2. The next stage uses the TSM trauma triangle to understand the internal

battle between inner parts that were internalized as a result of the trauma. In TSM, the classical trauma triangle from Psychodrama has been re-modified, and the three roles are: Victim, Perpetrator, and Abandoning authority. Each of these roles could have been internalized by the person who experienced trauma, and are often manifested in the form of self-harming behaviors, self-abandoning patterns and/or low self-worth. The clinical reason for consciously re-experiencing the victim role in TSM is to move it from a frozen state or a chaotic state to the role of the wounded child, while supported by the prescriptive roles practiced in Stage 1. The internalized perpetrator role is examined so as to bring awareness to any repeated patterns of violence toward self and/or others. The abandoning authority role helps to bring awareness to any patterns of internalized self-abandonment, and how previous experiences of neglect or dysfunctional attachment might be affecting the client's current relationships. (Hudgins, 2019).

Stage 3. The last stage is the part where new, empowered narratives are created that guide corrective emotional experiences and support post-traumatic growth. Here roles of transformation are explored: The Sleeping-awakening child role is the part of self that holds the person's innate healing potential, or what has been called 'the autonomous healing center' in classical Psychodrama. Healing occurs as both the wounded child and the sleeping-awakening child are integrated in a new, compassionate view of self. In Stage 3, also the Appropriate authority role is practiced, which provides corrective emotional experiences, and teaches the client to use boundaries in a conscious way to stand up and stop a traumatic situation. The last transformative role is that of the Ultimate

authority role, where post-traumatic growth is explored further by examining how these new narratives of empowerment might contribute to others. (Hudgins, 2019).

Thus, TSM is a detailed theoretical and practical model that helps both clinicians and clients to understand the trauma survivor's complex and often chaotic self-organization. The Therapeutic Spiral Model is a specific therapeutic modality that is very closely related to the subject of this study, as it incorporates the elements of Psychodrama, trauma-informed intervention, and places a particular focus on *intrapersonal* identity work. Therefore, it would be interesting to include interviews with TSM practitioners as part of the data collection; it is likely that TSM practitioners have extensive clinical experience of applying dramatic processes for healing trauma and transforming the dissociated sense-of-self following trauma. Furthermore, the results of this current study are likely to overlap with many of the theories from TSM.

2.7.2 Tian Dayton's Neuro-psychodrama.

A similar approach that also combines neuroscience, attachment theory and Psychodrama for the treatment of relational trauma is Tian Dayton's *Neuro-psychodrama* (2015). Her model of *Relational Trauma Repair* (RTR) (Dayton, 2015) is especially designed for use in Psychodrama groups with individuals recovering from relational trauma. This strength-based approach aims to teach clients how to self-regulate emotions and bring themselves back to balance. The RTR model can be used in various settings and incorporated as part of different psychotherapy modalities or Psychodrama groups.

Like TSM, this approach is based on the assumption (derived from current neuroscience) that physiology plays an important role in the healing of psychological trauma, and that trauma treatment ideally includes experiential, somatic and action-based elements. Psychodrama, as an experiential method, is a way of bringing the body into the therapeutic process. (Dayton, 2015).

In her book (2015), Dayton explains the complexities of healing trauma, and why clients have difficulties with accessing emotions and often experience ambivalence or resistance to feeling painful emotions. Furthermore, she outlines factors that are important for psychodrama-practitioners to consider when working with trauma clients, in order not to re-traumatize or overwhelm them. Her work is an important contribution to the discussion of how to make Psychodrama safe for clients recovering from relational trauma. Much of her work overlaps with the Therapeutic Spiral Model.

2.7.3 Other therapeutic models that incorporate drama for the purpose of healing trauma.

There are a handful of other models or approaches that purposefully combine Drama Therapy or Psychodrama with trauma-informed interventions.

1. Lahad, Farhi, Leykin & Kaplansky (2010) present an integrative model (SEE FAR CBT) that combines Cognitive Behavioral Therapy (CBT) with the use of imagination and creative re-narration as an approach to treating symptoms of PTSD. Re-narration and the use of imagination can be seen as dramatic processes in the context of

therapy. Since their preliminary study in 2010, Lahad and colleagues (2016) adapted the model to create a single intervention protocol for schoolchildren (SEE FAR CBT-C). The study consisted of 25 school-aged children with significant clinical PTSD, and results showed that compared to school-based intervention, SEE FAR CBT-C produces stronger therapeutic effect on PTSD symptoms and enhances ego-resiliency over time. This study is an example of combining drama-based intervention with a mainstream psychotherapy modality.

2. In the book *Expressive and Creative Arts Methods for Trauma Survivors*, Judith Glass (2006) demonstrates how Drama Therapy can be an effective way of preparing adult survivors of trauma to undergo exposure therapy or CBT. Specifically, she explores how the therapeutic tool of *aesthetic distance* (a central concept in Drama Therapy) can be useful when working with trauma clients. In the same book, Diane Frey (2006) shares her experiences of using puppetry interventions (a subcategory of Drama Therapy) for traumatized clients. According to Frey (2006), especially traumatized children often find it difficult to vocalize the traumatic experiences; the symbolic use of puppets helps these children to express themselves in a way that is playful and non-threatening. These two examples show that specific elements or techniques taken from Drama Therapy can be integrated or combined with psychotherapy.

3. In a qualitative case study, Hirakata & Buchanan-Arvay (2005) explore how therapeutic enactments (a drama-based action method) can be used to give voice to fragmented memories of childhood sexual abuse. The researchers concluded that

therapeutic enactments can act as a "bridge" between the wordless, fragmented memories and the need to express the traumatic experiences. The therapeutic enactments were facilitated in a small group setting of four women, and the results showed an overall positive and reparative effect. Four themes emerged from the qualitative case study: *re-connection to self and others, reclaiming voice, empowerment, and corrective re-experiencing*. It will be interesting to note whether there are similarities between the themes of this present study and the study of Hirakata & Buchanan-Arvay.

4. The Omega Transpersonal Drama Therapy organization provides workshops and trainings for therapists on using Drama Therapy and Psychodrama with trauma survivors. The organization is led by Drama Therapy pioneer Saphira Linden. Specific to her approach is the integration of Jungian psychotherapy and transpersonal psychology with Drama Therapy and Psychodrama. According to Linden, transformation is about uncovering a person's source of strength (2013). In this approach, the spiritual or transpersonal aspect of a person plays an important part in healing (Linden, 2013).

5. In 1992, Mooli Lahad (1992) designed the *six-part story method* that uses creative narrative technique to help clients achieve healthy coping responses. The method has been applied widely in community stress prevention settings, disaster relief and in psychotherapy.

6. David Johnson and colleagues (Dintino & Johnson, 1997; James & Johnson, 1996; Landers, 2002) have applied a technique called *developmental transformations* that utilizes improvisational role playing to gradually guide clients through recalling traumatic

experiences.

As part of the literature review, also the book 'Trauma-informed drama therapy', edited by Sajnani & Johnson (2014), was surveyed. According to Sajnani and Johnson, the most significant advancement in the field of trauma-informed Drama Therapy is the development of drama-based models that are specifically designed for trauma treatment, whereas in the past general models were applied for this population. However, Sajnani and Johnson confirm that there are not many such models, listing the aforementioned models by Dayton (2015) and Hudgins (2002) as examples. Another example mentioned in their book is the Creative Alternatives of New York (CANY), an organization that has pioneered the use of drama therapy for trauma-affected populations since 1983. Unfortunately, however, CANY closed down its services this year.

Much of the existing literature focuses on how Psychodrama, Drama Therapy or other drama-based processes are applied for the healing of collective trauma of particular groups (Leveton, 2010). For example, sociodrama (Kellermann, 2007) and Drama Therapy (Johnson, & Emunah, 2009; Landy, 2010) have been successfully used in many parts of the world for healing collective trauma. Research about the effectiveness of applying dramatic processes for healing trauma on an individual level is scarcer.

From the literature overview we can see that some drama-based therapy modalities and models already exist that have been designed specifically for trauma survivors. It is also evident that the fields of Psychodrama and Drama Therapy are still emerging and shifting, and that more empirical research on the topic is needed.

2.8 Summary and Conclusions

The literature demonstrates that there are many benefits and advantages to applying experiential methods and creative arts therapies for treating trauma. It is evident that more empirical research on the effectiveness of Psychodrama and Drama Therapy for treating trauma is needed, as is a better understanding of the underlying source of therapeutic benefits of these methods. Currently there are two known clinical models that combine elements from Psychodrama with trauma-informed treatment: Kate Hudgins' Therapeutic Spiral Model and Tian Dayton's Neuro-psychodrama. In addition to these more structured models, there are individual therapists who specialize in using Psychodrama or Drama Therapy with trauma survivors. While many experienced clinicians are convinced of the healing potential of experiential therapies, additional research is important so as to comprehend exactly why, how and when dramatic methods - such as Psychodrama and Drama Therapy - are effective in healing trauma.

Another gap in the literature concerns the understanding and clinical definition of 'integration'. While there is plenty of literature regarding dissociation and dis-integration due to trauma - with groundbreaking findings in affective neuroscience emerging in the past 15 years - the concepts of integration and healing from trauma is less well defined. This study strives to contribute to this conversation from a psychodramatic perspective. The next chapter outlines the methodology applied for this purpose.

Chapter 3: Research Method

The purpose of this study is to investigate how dramatic processes, like those used in Psychodrama, can be applied to help clients with relational trauma reconstruct a *wholesome sense of self*. The aims of the research are to 1) **describe the process** of identity integration in clients who have experienced fragmentation of identity in consequence to relational trauma, from a psychodramatic perspective; 2) to **define** integration in clients who have experienced relational trauma; and 3) to **explain** how psychotherapists use dramatic processes for the purpose of healing trauma.

This chapter describes the research design and rationale, the steps of the methodology, the participants and the sampling procedure, the data collection procedure, the pilot interview, the approach to data analysis, issues related to validity and finally ethical considerations.

3.1 Research Design and Rationale

The study will be a qualitative inquiry, based on semi-structured in-depth interviews conducted with a purposefully collected sample. The data will be interpreted using Thematic Analysis after Brown and Clarke (2006, 2012). The overall timeframe of the study is 4-6 months. What follows is a discussion on the rationale for choosing a qualitative design.

The study design will be a qualitative one, for several reasons: 1) The researcher is concerned with studying the quality of a phenomenon, in this case the meaning and quality of integration after trauma. 2) A qualitative design allows for the study of more complex and in-depth questions, such as how psychodrama can be applied to help clients in the process of identity integration. 3) A qualitative thematic analysis is suitable for the purpose of defining and describing psychological processes, for it provides a way of organizing subjective experiences. 4) Lastly, a qualitative design allows for the emergence of new insights through the interplay between participants' experiences and definitions, and the researcher's analysis and interpretation.

Next, the underpinning theoretical framework is considered, since it influences the choices made regarding the methodology.

3.1.1 Theoretical Framework and Assumptions

As Braun and Clarke (2006, 2012) emphasize, Thematic Analysis can be used together with various theoretical frameworks and epistemological orientations, as long as these are explicitly discussed and considered. According to Braun and Clarke (2006), the research epistemology needs to be aligned with the process of data analysis, because it informs how meaning can be theorized from the data.

Epistemological Stance

This study's epistemological stance can be placed in-between a realist and a relativist position: For example, the study's aim to understand what integration really

means and looks like, can be called what Willig describes as 'a realist ambition' (2012). My role, as a researcher, is to generate valid and reliable knowledge about the psychological process of integration, in other words to reflect and describe (psychological) reality. Thus, the descriptions of clinical events narrated by the interviewees are assumed to be accurate descriptions of clinical events; the interviewees' accounts are taken at face value. In this sense the study operates within a realist or essentialist paradigm.

At the same time, I acknowledge that my interpretation of the data contributes to the construction of the definition and meaning given to 'integration'. In other words, the themes drawn from the data do not "emerge" by themselves, but are defined through an interpretive process; in order to understand reality, it needs to be interpreted, organized, or otherwise made sense of. In this sense, the study operates within a relativist or interpretive framework. Hence, the study is neither naive-realist, nor can it be placed at the extreme end of radical relativism (Madill, Jordan, & Shirley, 2000). This kind of in-between position has been described as a 'critical realist approach' (Willig, 2013).

Ontological position

Similarly, my ontological position as the researcher falls in between the realist and relativist position: In this study it is assumed that there are certain patterns in reality that can be identified and explained. At the same time, as the researcher I acknowledge that there is a constant interaction between a person's inner psychology and external

(social and physical) environment. Therefore, my ontological position could be summarized thus: While a reality is "out there" with certain recognizable patterns, reality is also perceived through a subjective lens or perspective.

Reflexivity

As a qualitative researcher I also acknowledge the role of reflexivity: For example, my assumption that integration is an essential aspect of healing from trauma has shaped both the research question and the formulation of the interview questions. Thus, it is clear that the findings of this research are to some degree directed by my personal interests and biases. Equally, the results of this study have also had an effect on my views: Whereas before I considered that integration is central to the process of healing from trauma, I now consider that integration is practically synonymous with healing. This is an example of how the data also reshapes my perspective.

Also epistemological reflexivity plays a role: The choice to interview psychodrama-therapists rather than clients themselves, for example, led to a particular definition and understanding of integration. Had I interviewed psychodrama-clients about their definition of integration, the findings could have been different. In addition, the study explores the phenomenon of integration from a psychodramatic perspective; it is clear, that the definition and understanding of integration can be different from the perspective of other schools of therapy. For instance, a CBT therapist might not consider integration in the same way.

Critical language awareness

In this study language is used as a tool to describe the research findings. Since this study follows a 'critical realist' approach, a mostly straightforward and unidirectional relationship is assumed between experience and language (Potter & Wetherell, 1987). In other words, language is not analyzed deeply to look for latent meanings, like in some approaches to qualitative research. The interviewees' words are considered as a way to describe their clinical knowledge and experience; they are not analyzed for possible subconscious meanings. Nonetheless, language awareness was applied in the design of the interview questions (the instrument): Because the wording of the interview questions influences the findings of the study, I deliberately and carefully worded the interview questions in a particular way.

3.2 Methodology

Below the methodology of the study is described in detail.

3.2.1 Sampling Strategy and Recruitment Procedures

The target population for this study was a small number of professional psychodrama and drama therapy practitioners with experience in the field of trauma therapy. Before choosing the target sample, I considered whether to interview therapists or clients themselves. There are several advantages to both options. An important

question was: who gives a more valid account of the client's healing process - the therapist or the client? The therapist is more objective and an expert of the healing process, and therefore can be said to understand the healing process better. On the other hand, the client has a first-person subjective experience of healing, and therefore can be said to understand the healing process better. However, since experienced therapists have accompanied and witnessed hundreds of clients in their healing process, whereas the client usually has only personal experience of healing, experienced therapists were chosen as the target participants for this study.

The target population size was ten participants, because anything more than that would likely result in an amount of data that is difficult to handle by one researcher considering the time constraint of the whole study. Ten participants was also considered to be a large enough sample to produce a meaningful amount of qualitative data.

Participant recruitment procedure followed a purposeful method:

1) Through an Internet search, suitable clinics and private practices were found. This included clinics and private practices that facilitated psychodrama-groups, and those that worked with individual clients. The original plan was to interview both psychodrama and drama therapy practitioners, however, no drama therapy practitioners volunteered for the study.

2) In order to respect data protection laws, I started by contacting the clinic or center via email/an online contact form. In cases of private practice, I contacted the therapist directly through the official contact email provided on their website. (*See*

Appendix A for the CONTACT LETTER used for this purpose). The first contact involved asking clinics to see if there are psychotherapists in the clinic who are interested in participating in the study.

3) The next step was to make sure that all volunteers met the participation criteria. The participation criteria was as follows: A) participants must have three or more years of professional experience with clients recovering from trauma, B) participants must speak English **or** Finnish; C) participants must have expertise in Psychodrama or Drama Therapy. Age, gender and nationality were not considered as relevant regarding inclusion or exclusion. Volunteers who had experience in only psychodrama or only trauma therapy were excluded, as their experience would not be relevant to the research question. In order to find an adequate number of participants, volunteers were sought from several countries. The language requirement was for logistical purposes.

4) The next step was to arrange a Skype or telephone meeting with volunteers who met the participation criteria.

5) Before the scheduled date for the interview, I sent participants an INFORMATION SHEET (*see Appendix B*) outlining the purpose and process of the study, and the CONSENT FORM (*Appendix B*). Each participant was asked to read and sign the form, scan it, and send it back with signature before the interview took place. For Finnish participants, the forms were translated into Finnish (*see Appendix C*). Participants were also asked to decide if they preferred a Skype video-interview or a phone interview. The next chapter describes the participants of the study.

3.2.2 Participants

Below is a basic description of the participants of the study. Despite the target size of 10, only seven volunteers were found who met the participation criteria (plus one participant for the pilot interview). In the table below, all names are pseudonyms to protect the identity of the participant.

Name (pseud.)	Country	Background	Work Setting
Kay	US	Psychodrama trainer and practitioner, trauma specialist and TSM researcher	Works as a TSM-trainer and workshop facilitator, in clinical and educational settings internationally.
Miranda	US	DBT and CBT-therapist and psychodrama practitioner	Facilitates group psychodrama for trauma survivors and holds individual sessions in a private practice setting.
Rachel	Australia	Psychodrama practitioner, Integrative Body-Mind therapist and trauma specialist	Facilitates group psychodrama for trauma survivors as well as individual sessions in private practice.
Steven	US	Trauma specialist, experiential therapist and TSM practitioner	Facilitates group psychodrama in a trauma and addiction centre, and holds individual sessions in a private practice setting.

Robin	Finland	Gestalt psychotherapist with theatre background	Applies psychodrama techniques in his work with individuals and couples in a psychotherapy clinic.
Henrik	Finland	Gestalt psychotherapist with theatre background, psychodrama practitioner	Works with individuals, couples and groups combining Gestalt therapy and psychodrama, in private practice and as part of a personal growth organisation.
Laila	Finland	Psychotherapist and psychodrama trainer and practitioner	Facilitates psychodrama groups with adults and young adults, as well as individual sessions in private practice. Also uses psychodrama to train facilitators for a personal growth organisation.

As the table above shows, the participants present a variety of backgrounds, yet all have experience of working with trauma survivors as well as applying psychodrama in their therapy practice. Several of the interviewees have actually specialized in using psychodrama with trauma survivors, making them experts of this study's research topic.

3.2.3 Data Collection Procedure

The method chosen for data collection was the semi-structured in-depth interview. The interview was chosen as the suitable instrument as it allows each participant to share his or her perspective in a flexible way. The semi-structured format was chosen as it allowed for a set of predetermined questions, but also enables the participant to determine the direction of the conversation to some extent. The participants were free to question or correct the researcher's assumptions. This adds validity to the research, as Willig (2013) states.

The semi-structured interview was chosen as a method for several other reasons, also: Firstly, An in-depth interview allows for enough time and multiple questions to go deeply into the subject matter. The interview is a more in-depth format than a focus group, for example. Secondly, it allows for direct one-on-one contact with the participant, without other distractions. Thirdly, the researcher is free to formulate the questions in a way that maximize validity and are relevant to the research question. From an ethical standpoint, the interview is practical as it allows for participant anonymity. From a logistical standpoint, interviews are quite easy to organize even without funding, as they can be conducted online (for example via Skype) or over the telephone. Last, but not least, interviews are a suitable method for conducting Thematic Analysis. Thus, the interview was seen as a suitable method for collecting informative, useful and accurate data in alignment with the research question.

Before choosing method of data collection, several issues were considered:

1) **Reflexivity**: It is clear that an interview is a creative and interactive method, a conversation between the interviewer and the interviewee. As the researcher, I acknowledge that the research questions and the conversation in general influence what the participant chooses to share. I conducted the interviews myself, adopting an open-minded and non-judgmental attitude in the interviews to encourage participants to share their experiences openly and authentically.

2) **The interview agenda**: The interview questions were designed by myself, in alignment with the research question and the aims of the research. The interview questions were considered thoroughly before starting the interviews (Willig, 2012).

3) **Language**: Participants were interviewed in their native language. Thus, for the Finnish participants the interview agenda was translated. In addition, the interviews were transcribed verbatim in Finnish, and subsequently translated into English. It was important to interview participants in their native language, since it presumably allowed for more flexible and accurate expression.

4) **Length of the interview**: The interviews were planned to last about an hour per interviewee, since one hour was considered long enough to discuss the topic in depth and with sufficient detail, but short enough to be quite practical and manageable. However, the time limit was not fixed, and participants were allowed to end the interview sooner or later. In actuality, the length of the interviews ranged from 40 to 80 minutes.

5) **Briefing**: All participants were informed about the aims of the study before the interviews. Participants were also informed about ethical issues. Participants were given the option to choose between a video-interview (on Skype), and a telephone interview. Six participants opted for the video-interview, and one participant for the telephone interview.

6) **Method of recording the interviews**: All interviews were audio-recorded with permission of the interviewees. Simple computer software was used for this purpose. Note taking during the interview was kept to a minimum so as not to distract the interviewee or the interviewer.

7) **Method of transcribing the data**: All interviews were manually transcribed verbatim. However, pauses, intonations and volume of speech were not transcribed, as they were not considered significant in relation to the research question. As Braun and Clarke (2006) explain, it is important to transcribe data in a way which reflects its original nature. Punctuation, for example, was used in a way that best reflected the original expression of the interviewee. For accuracy, the transcripts were checked back against the original audio recordings, and corrected where necessary. Similarly, the translated transcripts were checked against the original audio recordings.

8) **Protection of stored data**: All audio-recordings, as well as transcripts of the recordings, were saved on a password-protected computer. The researcher was the only person with access to the recordings and transcripts.

9) *Data collection timeframe*: 1-2 months were planned for the data collection procedures, however, due to logistical issues and difficulties in finding sufficient participants, data collection and translation procedures lasted three and a half months.

3.3 Pilot Interview

In order to test the interview agenda and to prepare for the interviews, one pilot interview was conducted. The pilot interview was conducted with a psychodrama practitioner via Skype, and lasted 40 minutes. Due to the relatively short duration, two extra questions were added to the interview agenda. In addition to the interview questions, a few prompts were used, such as: "Could you give an example of this?" or "Could you talk more about this topic?" or "What do you mean when you use this word?" These prompts eased the flow of the conversation and helped to get a clearer picture of the participant's meaning. Overall, the interview agenda proved effective in the pilot interview: The participant understood all questions and was able to talk about the subject in detail. The audio-recorder, as well as the Skype-program, were also tested during the pilot interview, and proved to be effective.

3.4 The Instrument

The aim was to formulate interview questions that were specific enough to keep the conversation on topic, yet open enough to allow for novel insights and redefinition of

concepts, as suggested by Willig (2012). The interview schedule can be seen in the *Appendix D* (English version) and *E* (Finnish version).

The interview started with a "warm-up question" and gradually went deeper into the subject. The last question ("Is there anything else you feel is important to mention about this topic?") gave participants the opportunity to mention something that wasn't addressed directly during the interview but that they considered important regarding the topic. It also gave participants an opportunity to say something that they forgot to mention earlier, or to emphasize points that they considered particularly important. This last question proved to be useful in terms of data analysis.

During the interview, the interviewees were often asked to illustrate their meaning using examples to encourage the production of comprehensive and rich data. The interview questions included descriptive questions and structural questions, as suggested by Willig (2012). Although the interview questions were set in advance, the actual conversation during the interviews did not always follow the schedule strictly. For instance, participants sometimes answered questions before they were asked.

3.5 Data Analysis Procedures

The data was analyzed using Thematic Analysis after Braun & Clarke (2006, 2012), who offer a clear yet flexible tool for analyzing qualitative data in psychology. According to Braun & Clarke (2006), a theme represents a patterned response or meaning within the data set and captures something important about the data in relation to the

research question - what matters more than its size in the data is its significance in relation to the overall research question (2006). For this research, rather than providing a rich thematic description of the entire data set, the aim was to provide a group of themes that relate to two specific questions or areas of interest within the data: 1) Themes that describe the **process** of integration in psychodrama, and 2) Themes that give a detailed and nuanced account of the interviewees' **definition(s)** of integration. Thus not all aspects of the data were analyzed, but only the ones that relate to the research questions. This means that also the process of coding was more analyst-driven, and codes were determined in the light of the research question. It could be said that the data was already 'shaped' to some extent even before the process of the data analysis, since the interview questions directed the data to some extent. This was intentional.

In this study, the themes were identified at a mostly semantic/explicit level, meaning that the data focuses on the content of what a participant said. In the case of a more semantic study, such as this one, interpretation was limited to the semantic content of the data.

Below is an account of the step-by-step process of this study's thematic analysis, which was conducted after Braun and Clarke's (2006, 2012) guide.

With this research, the literature review was conducted before the process of data analysis. The rationale for this is that the research is more deductive in its approach, and therefore the data analysis was informed by certain theories already existing in literature. For example, the assumption that integration is an important aspect of healing from

trauma was derived from previous literature and influenced the processes of data collection and data analysis.

3.5.1 Step One

The first step was to **familiarize myself with the data**. This step included repeated - active - reading of the transcripts. According to Braun and Clarke (2006), the process of transcribing the interviews is also an interpretive act, since it involves paying close attention to the data and already forming ideas about patterns that emerge in the data. Similarly, the process of translating the Finnish transcripts into English could be seen as a phase of familiarizing, interpreting and analyzing the data, as it involved understanding the exact meaning of each word and sentence.

3.5.2 Step Two

2) The second phase involved **generating initial codes**. This was the first step of organizing the data. At this point, I had generated an initial list of ideas about what appears as significant within the data (*See appendix F* for an example of the initial codes). Codes can be defined as 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon' (Boyatzis, 1998, p. 63). Unlike themes, which are usually broader, codes are smaller units of analysis (Boyatzis, 1998).

For this research, coding was done manually. The initial codes were then collated, or matched up with different data extracts that demonstrated that code. As Braun and Clarke (2006) write, a particular extract of data may be uncoded, coded once, or coded

many times, according to what is relevant. Therefore, these initial codes differ somewhat from the final coding.

3.5.3 Step Three

After all data had been initially coded and collated, the **searching for themes** began. This involved sorting the codes into potential themes. At this point, the themes were not final, but represented an initial idea of how the data may be organized. Below is an illustration of the initial thematic map:

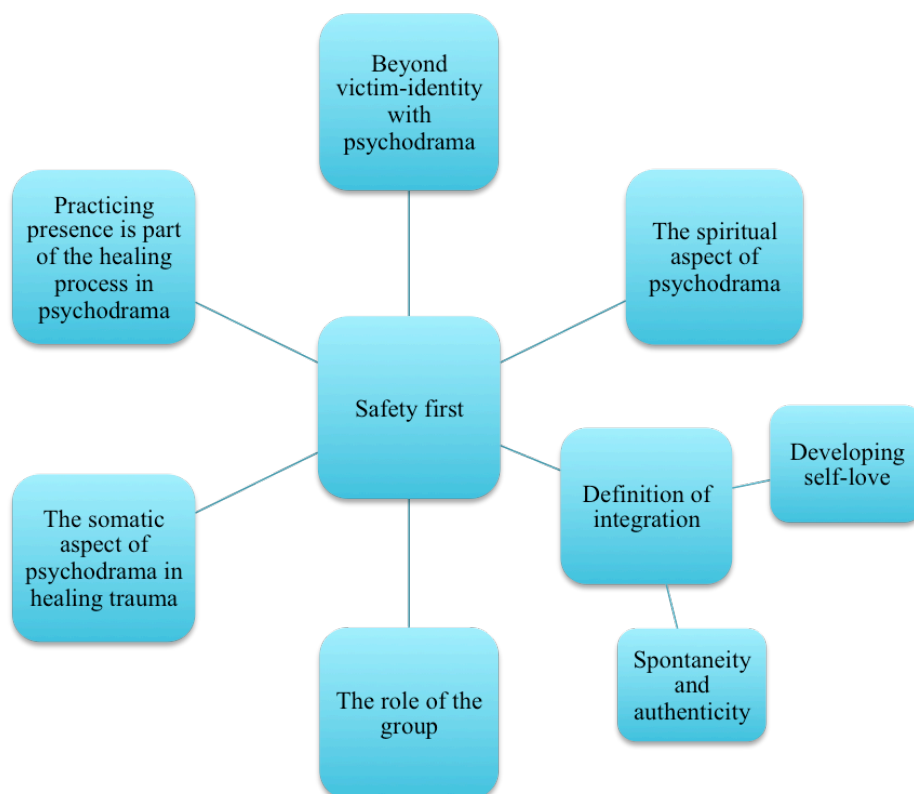


Figure 2: Initial thematic map showing seven main themes and two sub-themes

3.5.4 Step Four

The next phase was about **reviewing themes**. At this stage, the themes were reviewed in relation to the overall research question, and in relation to each other. Some of the themes that were initially separate themes were grouped together as one theme: For example, the themes 'practicing presence' and 'the somatic aspect of psychodrama' were regrouped under the same theme: 'the somatic level'. In other cases, an initial theme was broken down into separate themes: For example, 'spontaneity and authenticity' became a major theme instead of a sub-theme. The theme 'beyond the victim-identity with psychodrama' was dissolved, as it became evident that this topic was part of all themes. The codes from this theme were re-organized under the new themes.

With new candidate themes in mind, the entire data set was re-read, as suggested by Braun and Clarke (2006), so as to re-evaluate the codes in relation to the themes. At this point, a new thematic map was created (*see figure 3*). The thematic map shows what the main themes are. Looking at the pyramid, it has two levels of themes: The bottom layer, showing five themes, describes the process of integration. The top layer, showing three themes, provides a definition of integration. Thus there are eight main themes, that together create a picture about the process and definition of integration (within the context of psychodrama).

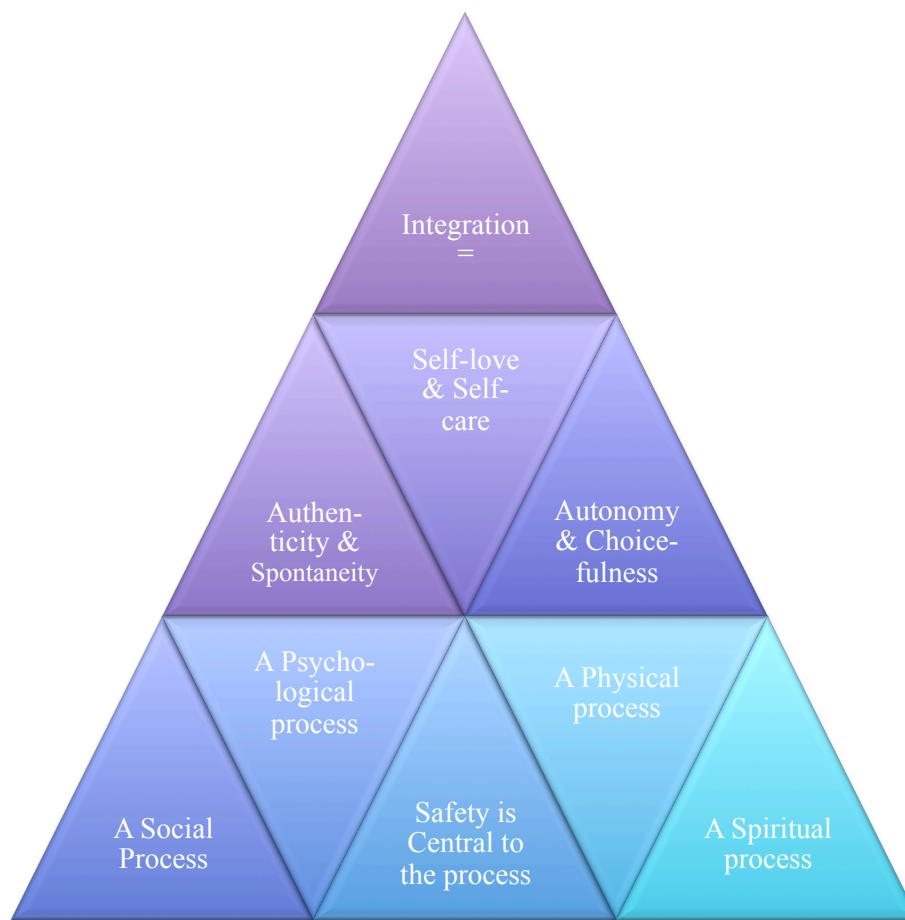


Figure 3: Revised thematic map, showing eight main themes related to the process and definition of integration.

3.5.5 Step Five

The next stage of the data analysis was to **define and name the themes**. At this stage the essence and meaning of each theme was defined (Braun and Clarke, 2006). This stage involved writing a detailed analysis of each theme and determining their relation to each other. For example, the names of the themes were refined, so as to capture the

significance and meaning of the theme. At this stage the writing of the Findings and Discussion chapter was started, as the scope and content of each theme was defined.

3.5.6 Step Six

The last stage of the data analysis was producing the report. According to Braun and Clarke (2006) the process of writing-up the report is part of the interpretation and analysis. Braun and Clarke define a successful report as one that provides a 'concise, coherent, logical, non-repetitive, and interesting account of the story the data tell - within and across themes' (2006, p. 23). As suggested, extracts from the data were embedded within the analytic narrative. In addition to describing the data, an attempt was made to demonstrate how the data tells a story in relation to the research question; i.e. interpreting the meaning and significance of the data.

3.6 Validity and Reliability

3.6.1 Questions of Validity

Validity was considered during different stages of the research process. As discussed before, the first step was to make sure that the target population was in alignment with the research question. To make sure that the interviewees' experiences were valid enough to provide data in answer to the research question, special inclusion and exclusion criteria were determined for participating in the interviews.

Another way to ensure validity was to design interview questions that were relevant to the research aims. For example, the interview included several questions

related to the process of integration using psychodrama, and one question specifically asking the interviewee's definition of integration after trauma.

Willig (2013) talks about the relationship between reflexivity and validity, saying that continuous and transparent reflexivity promotes validity in qualitative research. Therefore, reflexivity is discussed in various parts of the methodology chapter.

3.6.2 Reliability

Different research theoreticians debate how relevant the question of reliability is to qualitative research, and whether there is a way to measure it in the first place. However, in an attempt to provide reliable results, the methodology of this study is described in detail, so that the study could be repeated. Nonetheless, if the same data was to be analyzed and interpreted by different researchers, it is still likely that the findings would differ somewhat from the current ones, as interpretation is always a creative and subjective act to some extent. While the essence of the findings would likely be the same, the way themes are defined and narrated depends on the style of the individual researcher.

3.6.2 Representativeness

As this study is a qualitative research, it makes no direct claims regarding representativeness. Thus the findings are not intended to offer a generalized explanation or prediction, as is evident from the small number of participants interviewed. However, the study's intention is to reveal something valid and reliable about the process of integration, and what the implications are for individuals healing from trauma who

participate in psychodrama. As Haug expressed in 1987, 'if a given experience is possible, it is also subject to universalisation' (p.44). Thus it could be argued that the data does reveal something about the phenomenon of integration that is relevant to many, if not representative of all. As Willig (2013) points out, even though a qualitative study cannot tell us *how many* people experience something (for instance, integration after trauma), it can tell us what is possible. A qualitative study can also shed light on what is advisable in particular circumstances, according to psychotherapists who have extensive experience in the area: For example, this study sheds light on what is advisable when applying psychodrama with clients healing from trauma. Thus, while not representative in the way that quantitative research is, studies like this can serve functional purposes.

3.7 Ethical Considerations

Before starting the data collection, the study proposal was sent to the UFP Ethics Committee and institutional permission to conduct the study was granted. In addition to this, several ethical considerations guided the research process, as suggested by Elmes et al. (1995).

- Potential participants were contacted via a Contact Letter (*see appendix A*) that was sent to the official e-mail of the clinic or private practice.
- All potentials participants were given an Information Sheet (*see appendix B and C*) outlining the aim of the research, their rights should they participate, and the interview procedure.

- Before the interview, each participant gave his or her informed consent to participate. This involved sending a Consent Form (*appendix B and C*) to the participant before the scheduled interview, asking them to read it and sign it before the interview. Participants were also asked if they had any questions regarding the research procedure or research aims.

- This study involved no deception of participants; each participant was aware of the purpose and procedure of the research.

- The participants were informed of their right to withdraw from participation in the study at any point without consequences.

- The participants were informed about the fact that participation was on voluntary basis, and that participation would not result in any monetary reward.

- The participants will receive access to the finished study. No other form of debriefing is considered necessary for this study.

- Throughout the research process, participants were encouraged to contact the researcher via e-mail should they have comments, questions or doubts regarding the research process or research aims.

- Confidentiality regarding any information about participants was maintained throughout the research process. This was ensured by keeping the data anonymous and by using pseudonyms when referring to the participants. Similarly, any information in the raw data that would reveal the identity of a participant was not included in the published data extracts.

- Confidential data, such as the participants' names and email addresses, were protected by using a private, password-protected computer; the researcher being the only person with access to the raw data. All materials used for data collection (including audio-recordings, emails, transcribed documents and translations) are stored in a secure and password-protected computer, and will be destroyed after conclusion of the study.

The data will not be used for any purpose outside of this study.

- In this study, the subject of the interviews is not considered to be of a sensitive nature, as it relates to the interviewees' professional views and experiences, rather than their personal experiences or beliefs. Therefore, no questions were asked about interviewees' personal experiences regarding trauma or integration, merely their professional experiences of treating clients healing from trauma.

- Anonymity was also chosen to protect the clients who were spoken about in the interviews. Some participants shared examples from their practice and described specific situations with clients that may have been identifiable if the name of the therapist was known. Therefore, the pseudonyms also protected the clients/patients of the interviewees.

3.8 Summary

This chapter has described the qualitative research design and rationale, including the theoretical framework that influenced many methodological choices. Next, the methodology was described. This included outlining the sampling strategy and

recruitment procedures, describing the participants and the data collection procedure. The results of the pilot interview were summarized. Next, the instrument for collecting data was presented, following an outline of the data analysis procedure according to Braun and Clarke (2006, 2012). Issues regarding validity, reliability and representativeness were also reviewed, and finally the ethical considerations were examined. Where relevant, any changes to the study's original plan were discussed. The subsequent chapter presents the results of the data analysis, and a discussion on their relevance in light of the research question.

Chapter 4: Findings and Discussion

4.1 Introduction

The data reveals that psychodrama practitioners who work with clients recovering from interpersonal trauma are very familiar with the process of integration; in fact, they often consider it to be central to their psychodrama work with people healing from trauma. For example, one of the participants said: 'When we're talking about mental health, integration equals health' (Steven).

The same participant also shared his view on how psychodrama is ideal for supporting the process of integration, because it addresses different levels of integration: 'I find psychodrama to be perfect in that it really addresses all four of those layers: It allows us to look at the internal psychology, it's inherently social because it's a group therapy, it's a body-oriented approach and it came from Moreno's spiritual views.' This extract from the data gave the idea for organizing the themes in a way that reflect these various levels. Although the original research question focuses on 'identity integration', or what could be called 'psychological integration', the data revealed that psychological integration is interlinked with social integration, with physical and physiological integration, and with spiritual integration. This insight is reflected in the presentation of the themes.

The following chapter presents the findings of the study, and the results of the thematic analysis of the data. Issues under the following themes were identified, described and analyzed:

1. Safety as a stage of healing
2. Integration is a psychological act
3. Integration is a social act
4. Integration is a physical act
5. Integration is a spiritual act
6. Integration means Autonomy & Choicefulness
7. Integration means Self-love & Self-care
8. Integration means Authenticity & spontaneity

(see figure 4 for a visual overview of the themes)

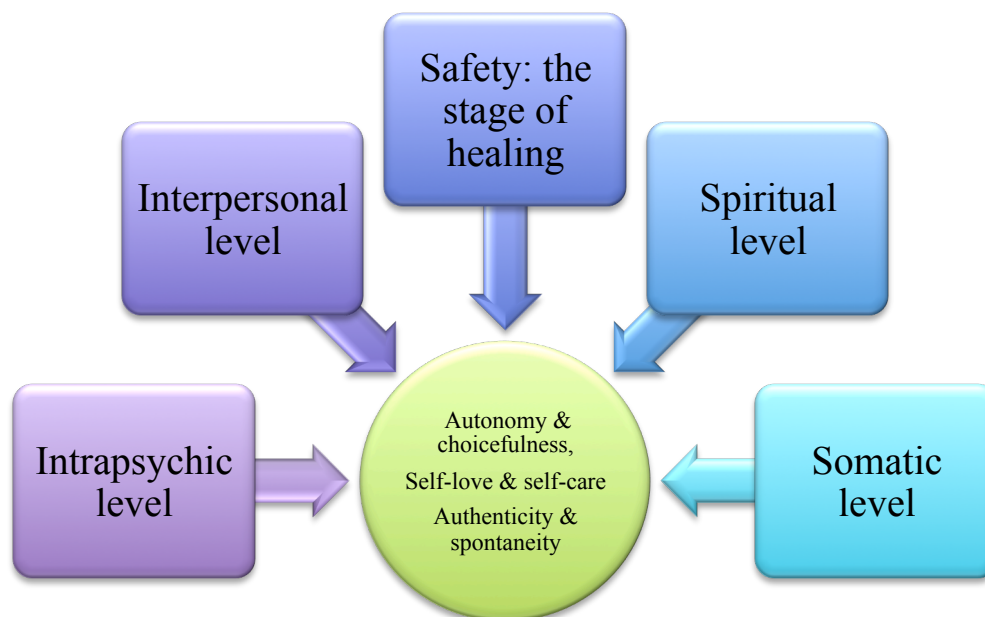


Figure 4

Before discussing the individual themes, their relation with each other will be described briefly (*see figure 5*): The first five themes (themes 1-5) present the data in relation to the following research question: What are the essential elements in the process of integration when using Psychodrama for healing trauma? The first five themes thus describe the process of integration and define the most important elements of this process, from the perspective of the psychodrama practitioners who were interviewed.

The last three themes (themes 6-8) present the data in relation to the research question: What is the definition of integration after trauma according to psychodrama practitioners and therapists? In addition to providing a theory about the definition of integration, the data presents a practical answer to the question: How can you tell when a client with traumatic experiences has reached a place of integration and healing? Whereas the first part of the thematic analysis focuses on the process of integration, the second part focuses on the outcome of integration.

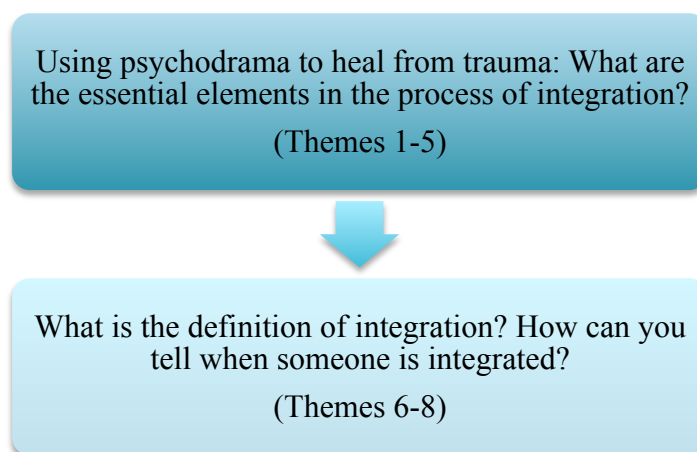


Figure 5

In the ensuing discussion the themes are further elucidated. Note: In this chapter, the direct quotes from participants are in *italics*. All names mentioned in this chapter are pseudonyms.

4.2 Theme One: Safety as a Stage of Healing

The first theme describes the role of safety in the healing process when using psychodrama with trauma clients, from the perspective of the participants. The theme reveals why safety is central to the integration process and describes participants' own experiences and recommendations about how to practice psychodrama safely. In this context, 'practicing safely' refers to practicing psychodrama in a way that does not lead to emotional overwhelm or further dissociation, and does not re-traumatize clients. The participants were clearly aligned in their shared perspective about the importance of safety.

The theme is divided in three sub-themes, titled: 1) Safety plays a central role in the process of integration, 2) How to avoid re-traumatization in psychodrama, and 3) When is it safe to use psychodrama with trauma clients.

This topic is presented as an individual theme, yet it clearly overlaps with the other themes. The reason for presenting it as a distinct theme is the weight of the material about this topic (in terms of quantity and significance). All participants talked extensively and even passionately about this theme. Interestingly, this topic was the most emphasized

of all the topics discussed in the interviews. The diagram below demonstrates how this theme relates to themes 2-5: This theme is at the centre of and overlapping with the other themes.

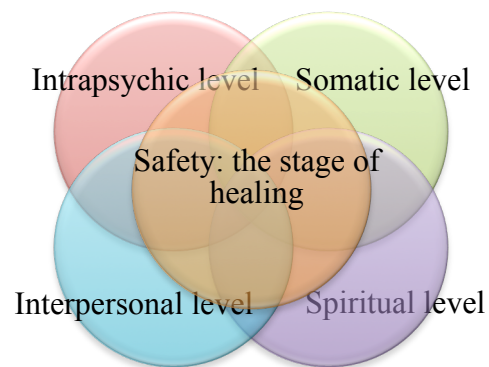


Figure 6

4.2.1 Safety plays a central role in the process of integration

As powerful as it is, it can also be dangerous

The participants shared the perspective that *safety has to come first* (Steven). This sub-theme shows why safety is so important when using psychodrama with clients recovering from trauma. To begin with, all interviewees acknowledged that while psychodrama is a *powerful* (Robert, Kay), *potent* (Laila) and *provocative* (Rachel)

method, it is also *potentially dangerous* (Rachel, Kay), *re-traumatizing* (Henrik, Steven), or *harmful* (Robert), and *can lead to emotional overwhelm, flooding* (Miranda) and *dissociation* (Rachel) if not used safely. Miranda explained: *Every role has the potential to be overwhelming and triggering, even "positive" roles*. Laila also pointed out that because psychodrama is so *evocative*, there is a risk that it breaks the client's defenses in a way that safety doesn't remain intact. Kay shared that her passion and focus in her career has been on how to make psychodrama safe for vulnerable clients.

The stage is a vulnerable place

The data shows that there are several reasons why psychodrama in particular has a high risk of causing re-traumatization. Henrik, who has extensive experience in the world of professional theatre, explained that the stage, whether a theatre stage or a psychodrama stage, is not necessarily a safe place: *The stage is a place where people are very vulnerable. It can be embarrassing or shaming*. It could be said that although vulnerability is part of most therapeutic modalities, it can be especially intense in psychodrama; on the stage, people are not only heard, but also seen - possibly more than in traditional talk therapy. Also Robert talked about vulnerability, saying: *That's why we need to constantly check that we're respecting the client's boundaries*.

Bad experiences with psychodrama

Several of the interviewees described their own 'bad experiences' of psychodrama where safety was lacking. These accounts include the interviewees' experiences as psychodrama protagonists themselves, and interviewees' memories of training or starting out as a psychodrama practitioner. Below is one example, though there were other similar accounts. Miranda talked about her experiences:

I have seen, and have myself used psychodrama without awareness of the person's capacity to tolerate the method. No-one had ever in my training talked about a person's capacity to tolerate, it was just like the more drama the better. It's very seductive to have big dramas that are hugely emotional, cathartic, and to mistake that for progress - without necessarily seeing that the smaller, more subtle dramas are actually doing deeper work. And, just because a person is able to do really big dramas, doesn't mean that it's going to heal their brain.

In Miranda's account there are several interesting points: First, she describes the lack of trauma-informed understanding in her psychodrama training. In addition, she shares what she has learned through clinical experience, namely that catharsis and big dramas are easy to mistake for progress; but when it comes to integration, smaller steps and more subtle work is often more effective.

Developing safety is the foundation of trauma work

Another point evident in the data is that creating safety needs to come before starting deeper (more confrontational) trauma work. Nearly all participants talked about

strength-based work, referring to psychodrama exercises that *strengthen resilience* (Rachel) and *develop ego-skills* (Miranda). For example, Steven said: *Starting with strength-based roles and supportive roles really lays the ground work with the victim role, which is really later stage trauma work, in my opinion. . .* Steven raised an important point: Doing a psychodrama that directly addresses a traumatic experience is later stage trauma work, and focusing on strengths is (or should be) the preparation for that.

Also Kay talked extensively about strength-based work, and how the Therapeutic Spiral Model (TSM) uses specific *prescriptive roles* for this purpose. These are roles prescribed by the therapist for the purpose of building up a new, healthier sense of self that feels safe: *We resource them [the protagonists] by enrolling those strengths and embodying the containing double or the body double, so they are well-resourced in their adult mode before speaking to the wounded child* (Kay). Her perspective echoes that of Steven's. These accounts show that participants associate strength-based work with developing safety, in some cases talking about the two synonymously.

4.2.2 How to avoid re-traumatization in psychodrama?

Creating safety in group-settings

This sub-theme presents the participants' practical suggestions based on their clinical experience regarding how to avoid re-traumatization in psychodrama. The

participants talked about how to ensure safety in group settings: Rachel talked about *creating a safe container in the group, making sure people feel connected and feel some trust with other group members*. Also Laila talked about the importance of developing trust within the group. She described her experience with a group of young adults, saying: *The first year was really all about creating trust*. Steven talked about the importance of rules and boundaries in the group as a way of creating safety: *Rules about physical touch, rules about commitment to the group, about confidentiality and respect between group members*. He also considered *group cohesion* to be the basis of safety in the group. These extracts demonstrate the close relationship between group dynamics and feeling safe in psychodrama.

Slower is safer

Most of the participants recommended a slow pace in order to prevent re-traumatization. As Rachel said: *pacing is critical*. She added: *You know that the psychodrama is going too fast if the client gets dissociated, is not really present or is overwhelmed by feelings, flooded*. Along the same lines, Henrik stated: *I'm really careful in my approach when working with trauma. So approaching in a really gentle and sensitive way, in small steps*. Also other interviewees shared similar views: *Especially when starting out as a therapist, the temptation can be to get the client to feel and express as much as possible. To go deep and fast. But you need to be respectful and delicate,*

respect the client's boundaries (Robin). In general, participants agreed that a slower pace is safer when working with trauma clients.

How to do safe role-reversals

The participants were specific in their descriptions of how to do role-reversals in a safe way. For example, several interviewees talked about when and how to role-reverse a client into a victim role: *Never role-reverse somebody into a victim role in a psychodrama until they've demonstrated that they can rescue the victim from an adult-ego state. Until they've demonstrated that they can nurture and protect and show up for the victim* (Steven). Also Kay suggested this, saying: *We make sure that they can get themselves out of a regressed state before we put them into a regressed state*. Other participants suggested that safety is not just a matter of what tools are used in psychodrama, but how they are used.

Psychodrama tools that create safety

Most of the interviewees mentioned specific types of supportive roles they used in order to strengthen the clients resources. Rachel talked about the usefulness of archetypes for this purpose, and other types of mythical or historical role models. Also famous, empowered people could be used as role-models, for example Oprah Winfrey. Steven mentioned working with roles such as: *Courage, willingness to be vulnerable, social support, God or higher power, future self* describing three types of supportive roles:

Intrapsychic strength (such as courage), interpersonal strength (such as a good friend), and transpersonal strength (God or a higher power). Laila was the only participant to mention how the voice can be a great way to create strength and resources, especially in terms of practicing boundaries.

4.2.3 When is it safe to use psychodrama with trauma clients?

Most of the interviewees talked about the importance of assessing whether a client is ready for a psychodrama group in the first place: *It takes a lot of contemplation and assessing before you go into these deeper places where the lost parts of self are* (Rachel). Also Miranda said: *First thing is to consider whether they have the skill-set to tolerate provocative psychodrama*. Also Steven agreed: *It's about assessing their window of tolerance*. Several participants mentioned the importance of conducting a clinical interview or in-take session before admitting someone into the group in order to know how easily the person is triggered, even though this step *is quite often neglected* (Laila).

Robert, Laila and Miranda all agreed that while psychodrama is very effective in cutting through the cognitive defenses, it is particularly important to follow the client's lead. As Robert says: *We can't go about forcefully breaking the client's defenses!* Just because psychodrama can be used to tear clients' coping mechanisms down, it's never wise to allow that until the therapist is *absolutely sure that the client can tolerate their cognitive defenses being circumvented* (Miranda).

The general perspective seems to be that in cases where the client is very unstable and has not yet developed skills for self-soothing or containing emotions, it would be preferable to start with individual therapy, or to do individual therapy in parallel with participating in a psychodrama-group or psychodrama workshops. Another point raised is that even in psychodrama-groups it is possible to focus on work that is less cathartic and more stabilizing.

4.2.4 Summary of Theme One

Theme One displayed participants' perspectives about the role of safety in the process of integration: A role considered necessary and central by all participants. The insight of this theme is that safety - in addition to being an ethical and clinical precaution - is also a therapeutic tool and a prerequisite for healing and integration. The implication is significant: In psychodrama, creating safety seems to be an agent of therapeutic change for those recovering from interpersonal trauma. People recovering from interpersonal trauma have lost their ability to feel safe; learning to create safety again can be seen as an indication of integration. A theory emerging out of these findings is that psychodrama can be effective in healing trauma because it can teach clients how to feel safe again.

The psychodrama stage has not always been a safe space; ensuring that psychodrama is practiced safely with trauma clients requires appropriate training and conscious, careful application. Safety, like integration, is both an internal and an external matter; the following themes address these various levels of the process.

4.3 Theme Two: Integration is a Psychological Act

The second theme presents data about the intrapsychic aspect of the process of integration, based on the participants' clinical experience. This theme considers what the process of integration looks like on an intrapsychic level, and how psychodrama can be used to integrate split-off personality parts after trauma. This theme could be summarized by the words of Miranda: *All trauma treatment is about helping the client to identify, access and integrate the parts that have been split off. So the way that psychodrama does that is by enrolling those parts.*

This theme is divided into three sub-themes: 1) Shining the spotlight on inner parts, 2) Integrating cast out parts, and 3) Stepping into a new act. This theme makes most sense when viewed through psychodrama-theory: *In psychodrama, the self is seen as composed of all the roles that somebody holds in their life* (Steven).

4.3.1 Shining the spotlight on inner parts

This sub-theme outlines how the interviewees' have used psychodrama to shed light on the client's inner parts. Psychodrama has a unique quality: *it concretizes things that are in your mind, brings them on the stage and makes them visible* (Henrik). This visibility is very useful in bringing previously unconscious aspects of personality into awareness. As several participants stated, through enrolling, we can recognize the various parts within: *The person sees how she is acting, she can see how she is stuck in the victim*

role, so then we can ask: *How would you like to act instead?* (Laila). Miranda described the magic of psychodrama thus: *It allows your cognitive brain to make sense of the chaos within. And at the same time it circumvents the cognitive defenses.* Rachel also explained why psychodrama is both unique and effective in increasing awareness of one's psyche:

In psychodrama you can literally step out of the story and witness yourself. You see how you react to somebody, and you see your posture. You can see the helplessness, the collapse in the body. So they can see it all posturally and interactively and watch the conversation. . . Once you see what you are doing, it makes a much bigger effect than just naming 'I'm a victim'.

Robert shared his perspective on the importance of becoming aware of inner parts:

Psychodrama helps you become aware that you actually need different kinds of roles. A person is never just a victim or a perpetrator. So we can become aware of why we need a specific role. Why do I always return to the child mode? Because it's an unfinished experience, waiting for resolution. Only by becoming aware of these dynamics and by taking responsibility for them, can we become free.

Henrik who, like Robert, also has a background in Gestalt-therapy, shared a similar insight: *Awareness frees us. Integration means understanding that within me there are all kinds of aspects. The more you expand your self-perception, the less dominant the trauma is.* According to this participant, awareness of inner parts is freeing and empowering because it expands the self-perception. Whereas before the client might have

identified himself/herself as the victim, the process of integration is about expanding awareness: *'I can see that I'm more than just the wounded victim'* (Henrik).

Rachel gave an example demonstrating why increasing awareness of inner parts is important:

I have a [psychodrama] group that's particularly dealing with interpersonal trauma. These people usually have trouble in their current relationships, that's why they come to therapy. And they don't see the connection, they don't see that the thing that gets in the way in their relationships is oftentimes that they feel unsafe. They're not aware of that pattern of choosing a partner who is neglecting.

The interviewees described various psychodrama tools and techniques for increasing awareness of inner parts. In addition to popular techniques such as the empty chair and role-reversals mentioned by most of the interviewees, Steven described a tool called the *Role Diagram*: *It's like a social atom but looks at all the inner roles.* Furthermore, he explained that *roles are an easy way for clients to understand inner aspects of self.* Also noteworthy was Kay's explanation of TSM, a unique trauma-informed psychodrama model which specifically works with the intrapsychic level. TSM therefore includes many roles and tools that are specifically designed to increase the client's awareness about inner parts and inner dynamics.

4.3.2 Integrating cast out parts

Rachel described what integrating split-off personality parts means, according to her:

I see that building identity is a stepping stone process: It's first gathering the lost parts that have been split-off or neglected, and kind of laying them out for the person, through roles. When they have a healthy repertoire of roles and can see which ones are functioning, which ones just coping and which ones are destructive. But it's an ongoing process, a lifetime journey. . .It's really about rescuing the wounded parts in a gentle, caring fashion. And then slowly adding the adult self who can take care of that wounded child and bring him or her back to life. So all of these pieces come together.

In this account we can see how Rachel depicted the various stages of integration; it's not something that happens in just one session, but it includes many small steps and pieces, which eventually come together in wholeness.

Miranda also raised a point: *It's not that the part goes away, but it no longer needs to act out in the world in a way that's causing problems for you after it's integrated . . .It doesn't work to discard the role.* This suggests that there is a distinct difference between 'transforming a role' and 'discarding a role': Integration is transformative, but not discarding. As several participants noted, the victim-role, for example, was a necessary coping mechanism that helped the client to survive through trauma. Once the traumatic situation is in the past, the question becomes: How to transform this role that no longer

serves? According to the interviewees, integration involves becoming aware of these roles and giving them a new act.

Kay shared what this looks like within the framework of TSM:

The victim role transforms into the wounded child who then gets enough positive re-parenting, strength-building and resourcing. The internalized perpetrator who manifests as negative inner talk gets washed over with positive inner voices . . . In TSM, we also have the abandoning authority role, because if there was trauma, there was someone who didn't stop the trauma. And this role is usually internalized and leads to self-abandoning behavior. So this role is necessary to address in trauma work: How do you take responsibility for your inner child? How can you parent the inner child, and be an appropriate authority for it?

In TSM then, the process of integration of dissociated personality parts is represented through three specific trauma roles, as described above (the wounded child, the internalized abandoning authority and the internalized perpetrator). Kay, an expert of TSM, explained how these roles, originally external roles, are then internalized by the trauma survivor. According to TSM then, the intrapsychic level is the key to the integration process.

Laila shared a similar insight, that the process of psychological integration is simply about changing the relationship to self:

When the relationship to self starts to change, that's an important point in the healing process. First, the person remains stuck in the need for the parents to 'love me

whole', to repair the damage they caused. But that's not possible, because often the parents are not healed and integrated themselves. Then the point of transformation: When the adult self creates a conscious relationship with the inner child, takes custody of parenting it and starts to protect the inner child that has been harmed.

4.3.3 Stepping into a new act

In addition to retrieving lost and dissociated parts of self, integration includes practicing new roles and creating a new sense of self that is *psychologically flexible* (Henrik) and *empowered* (Robert). Miranda explained how psychodrama can be used for this purpose: *Through psychodrama you can add an empowered role that the client hasn't really developed yet. For example by having other group members model the role for the client, and then role-reversing.* Rachel used similar words: *Acting out in a new way gives you new options: 'I can do things differently. I don't always have to be the victim, I can ask someone to support me, or I can step out of this situation'. So we call that role-training for life . . . So it's building up a new kind of aspect within themselves that has not yet been fully developed.*

What's interesting is that both Miranda and Rachel pointed out how psychodrama can be used to build up a self that is not yet developed; at first, the role of empowerment is "just an act", but with practice and repetition it can become the new healthy way to act for the client. Also Robert mentioned that empowerment comes through practice.

As Steven described: *They can literally step out of their self, role-reverse into the role of somebody else or a different version of themselves, role-train a new sense of self; literally become somebody else in the session, and internalize these new experiences of self.* While it may be just pretending and playing a role in the beginning, acting a part is still a much more visceral and tangible experience of a possible future self than merely talking about what it would be like to be healed in the future. Thus, the intrapsychic process of integration involves practicing new ways to express the self.

4.3.4 Summary of Theme Two

Theme Two outlined participants' experiences of using psychodrama to help clients integrate fragmented personality parts. According to several of the participants, the intrapsychic level of integration is the key to the healing process.

Interviewees described how the process of integration takes place through increasing awareness of different inner parts and through action: by embodying, feeling, seeing, hearing and expressing those internalized roles. Participants emphasized that integration involves creating a conscious relationship with one's inner parts.

This theme demonstrates that psychodrama is especially useful for identity integration because it allows the client to express, embody, give voice to and observe various inner parts that might otherwise remain vague, intangible, confusing or dissociated. The central message of this theme is that the process of integration is one that starts from within.

4.4 Theme Three: Integration is a Social Act

The findings suggest that social integration is an important element in the process of integration after trauma. In Psychodrama, the group setting brings the social aspect into the process in a natural and practical way. This theme is divided into two sub-themes: 1) Psychodrama teaches relationship skills, 2) The role of the group. As Laila expressed, the social atom can be seen as an indicator of integration: *Integration is when a person is capable of creating healthy relationships.* However, in addition to being an outcome of integration, the interpersonal element is also an important part of the process.

4.4.1 Psychodrama teaches relationship skills

This sub-theme presents data about how psychodrama develops clients' relationship skills according to the interviewees. One of the topics discussed by the participants was trust: As Robert expressed,

Trust in the therapeutic relationship is really the basis of therapy. Because with most clients, especially trauma clients, there's deficiency in the primary attachment. And that leads to a lack of trust. There's no secure inner attachment. So the therapist often becomes the first secure attachment. That's why trust is such an important aspect in therapy. And then little by little, the client becomes more autonomous, as they become more secure internally.

Although the importance of trust is not specific to psychodrama, it is nonetheless worth mentioning. Robert's account also brings to attention the close link between the interpersonal level and the intrapsychic level of the process: While trust and attachment are in many cases first practiced interpersonally, the effect is (ideally) also intrapsychic: the person becomes more secure internally. Here we also see how the theme of safety impacts the process of integration: Social integration requires developing trust, which is created through experiencing safety in relationships.

Also Steven talked about attachment styles, saying that *attachment styles are a simple way of looking at psychosocial integration*. Again, from this sentence it is evident that the interpersonal level is closely linked to the intrapsychic level. Steven shares a case example where the client went through profound interpersonal integration within the course of year: *A client who scored for chaotic/disorganized attachment style went to individual therapy and participated in my psychodrama group for a year, and then took the assessment again and scored for secure attachment style*. Here we can see an example of psychodrama helping a client develop a new, healthy attachment style.

Miranda talked about how psychodrama can teach clients to become aware of projections:

Essentially what you're doing is helping them distinguish between what is coming from the past but feels like the present. So a patient might be upset with her boss, and have an outsized reaction. And the reason it's outsized is because the boss reminds her of her mother who was always having her under her thumb. And then we can consciously

switch to a new psychodrama with the hurt child. Often the patient can recruit their adult self, they have the skills, they just weren't able to access it as long as the wounded child was hyperactivated. So it's learning to recognize when the inner child mode is activated, and parenting that part from the adult self.

Here Miranda talks about how awareness of one's inner parts has a direct effect on relationships with other people: the more aware the client is of being triggered or slipping into the wounded child mode, the less dominant the projections are. Furthermore, she shares that role-reversals can teach a person to project less. She even considers a person's capacity to reverse roles without projecting as an indicator of integration.

The interviewees mentioned that these interpersonal skills can also be practiced using Psychodrama in individual therapy. Steven shared that he sometimes uses objects, empty chairs, scarves to represent roles when doing 1:1 therapy. This allows the client to practice relating and interacting with different roles even without a group setting. As a matter of fact, several of the interviewees explained that they preferred doing psychodrama in an individual setting with clients who are easily triggered or overwhelmed. The reason for this seems to be that the pace is slower and easier to control in individual therapy. Miranda also added that for clients who have not yet developed skills of containment and self-soothing, it can be shaming and embarrassing to be in a group where other group members have more capacity.

4.4.2 The role of the group

Several of the interviewees emphasized the role of the group as very supportive and important to the integration process. As in group therapy in general, also the psychodrama group offers peer support because there are others with the same goal of healing, and with similar wounds. This is especially the case when the psychodrama group is for people with similar experiences. For example, Rachel talked about a psychodrama group she facilitates for survivors of interpersonal trauma. Steven on the other hand facilitates a psychodrama group in a trauma and addiction treatment facility. One of the benefits of the group setting is that it allows for a deeper level of emotional involvement. As Steven explained, when the topic and protagonist of the psychodrama are sociometrically chosen, all group members can relate to the topic of the drama and feel involved: *On the surface, it's the protagonist's story, but one layer below that everybody is a protagonist. There's a level of emotional involvement that's much deeper watching somebody acting a psychodrama scene, than just hearing them talk about the experience.*

Laila described how the group helps with social integration: *Often the feelings of shame and guilt have an isolating effect, they separate the person from their social environment. But with the support and acceptance of the whole group, the protagonist is pulled back into inclusion.* Trauma is generally an isolating experience, and one that took place in isolation. As Laila points out here, healing from trauma therefore happens most effectively in an environment of inclusion. She mentions the feelings of shame and guilt,

which are known to be very common feelings for trauma survivors. She goes deeper into the topic, explaining how shame can be transformed through the support of the group:

You can show darker parts of yourself without being shamed for it. Even if your ego gets bruised, it's safe, because it's done in connection, in collaboration with other group members . . . You're not alone when facing the pain. It's a safe environment to practice and make mistakes. From this account we can see how social inclusion is linked with creating safety: At best the group can be a safe space for revealing hidden parts of self. In that way, the social aspect of the group can help with the integration of intrapsychic fragmentation.

4.4.3 Summary of Theme Three

Theme Three answers the question: In what ways is the process of integration a social act? The data shows that according to psychodrama practitioners, psychodrama teaches relationship skills and helps the client to adopt a healthier attachment style. In the case of trauma clients, especially people with complex PTSD, attachment and relationships are often a challenge, in many cases even the reason for seeking help. Although not exclusive to the modality of psychodrama, helping the client to develop trust is part of the work that the participants focus on in their psychodrama groups and in individual sessions.

Several of the participants also talked about the role of the group in helping to create safety and social inclusion. At best, the group can provide a safe space to face

challenging emotions, such as shame. The social aspect of healing from trauma seems to be closely linked with other themes, especially the psychological aspect of healing and the theme of safety.

4.5 Theme Four: Integration is a Physical Act

As Rachel stated, *psychodrama is a full-body experience*. The fourth theme highlights interviewees' experiences of using somatic psychodrama with clients recovering from trauma. This theme answers the question 'why somatic work is an essential part in the process of integration', and presents examples from participants' clinical practice. The data has been allocated into three sub-themes: 1) Finding safety in the body, 2) Connecting mind and body, and 3) Practicing presence. Together they give an overview of why and how integration is a physical act.

4.5.1 Finding safety in the body

Although somatic tools are commonly used in psychodrama with all populations, the physical aspect plays a particular role for people healing from trauma: *Because trauma lives on in the body, the somatic aspect is important* (Steven). Three of the interviewees talked specifically about finding safety in the body: Rachel noted that for trauma survivors,

The body is not always a safe place. It's a place that's been harmed, and a place where they don't like to dwell in, especially if they have been sexually or physically

abused. There's a disconnect from the body, and from the pain. They've learned how to step out of their bodies. So it's how to come back into a safe relationship with their bodies, that it can be a place of nurturing.

She continues to share how she does a lot of body work in her sessions to help the client regulate his or her nervous system and learn how to soothe themselves. Both she and Steven mentioned using yoga as a way to calm the body and help clients feel safe in their bodies. Steven talked about using touch safely in psychodrama: *We need to be careful with touch when working with trauma survivors. Asking permission before touching a client or a group member creates safety.* He added that 'finding safety in the body' can be a useful theme for a psychodrama.

Kay described two roles specific to the TSM, that help with finding safety in the body: *The Containing Double balances thinking and feeling, it assesses if a person is too much in feeling mode (flooded) or too much in thinking mode and dissociated from feelings. The Body Double keeps you out of dissociation and helps with feeling safe in the body, safe in the moment.* Although the Containing Double is not specifically related to the body, it's important to note that being emotionally overwhelmed doesn't happen only in the head, but also involves the body. As trauma experts have suggested, one of the reasons why trauma survivors find it hard to feel safe in the body is because they feel flooded and overwhelmed with difficult emotions that are felt with the whole body. Here we can see how the somatic level is interlinked with the emotional level of integration.

4.5.2 Connecting mind and body

The interviewees talked about how psychodrama helps to connect the mind and the body. For example, the physical aspect of psychodrama helps clients to become aware of their inner psychology: *Psychodrama is very physical, very corporeal. So experiencing with the body what it feels like to be a small child, or the future me, is very concretizing* (Henrik). *Psychodrama is a holistic, left and right brain experience that helps to connect mind and body* (Steven). Kay explained how the somatic aspect helps with learning new skills: *Because they're not just rehearsing something in their head, but their bodies were involved. They've had practice, so the new skills carry over to real life more readily.* Also Rachel talked about psychoeducation being most effective when the body is involved:

We can even do a psychodrama that's educational. So it's not just theory about the amygdala and blablabla, but we can do an enactment that shows them how it happens. So we actually bring to life the part that steps away and dissociates. So they understand concepts like flooding, but not just in their head, they can sense with the whole body what it feels like, what it looks like.

Also Steven talked about the benefits of embodying roles and how that relates to hope and empowerment: *It's one thing to just intellectually talk about what it might be like to be healed, but a whole other thing to become the healed self, to have an embodied experience of being healed. Because of the disconnect between body and mind in trauma, it's not enough to just talk about it or to just cognitively understand empowerment.* He also shares his experiences with clients who often understand cognitively that the trauma

was not their fault, yet they continue feeling shame and guilt: *So they need to have an embodied experience of not feeling shame.*

These accounts suggest that emotional healing involves connecting the mind and the body. One psychodrama tool for connecting mind and body is dialoguing with the body (Rachel). Rachel also shared another practical tool that she uses in her practice:

I have something called 'the body of trust'. Which is looking at where do you feel connected to your body, where do you feel safety in your body, where do you feel neutral (not activated or stressed) in your body. And then we look at where in the body it's safe to touch.

Such tools help create body awareness and become cognitively aware of emotional and physiological reactions.

4.5.3 Practicing presence

This sub-theme is about practicing presence in psychodrama to heal from trauma. According to Rachel, *psychodrama is all about being in the present moment. A lot of mindfulness.* One of the reasons why presence is particularly important in psychodrama is that a person can't be spontaneous without being present, as Steven pointed out. He also added: *Enacting a drama is always an experience happening in the here & now.* In slightly different words, Kay said: *Z. Moreno used to say: Have them bring the past into the present. So you're enacting things in the here and now.* This is quite interesting, because often with trauma clients the topic of the psychodrama relates to a past

experience. Yet those memories and feelings related to past events are enacted in the present moment.

Kay also shared that the Body Double from TSM helps with staying present; in fact, that supportive role was created specifically for the purpose of staying present. Kay explained that these kinds of roles are important as they help prevent dissociation. Also other participants mentioned the link between practicing presence and preventing dissociation: presence creates safety, seems to be the shared perspective of the interviewees.

Henrik talked about how we can use the physical senses to ground ourselves and prevent the mind from getting lost in doubts and worry spirals. Robert and several other interviewees mentioned doing breath work to help clients stay present. Kay specified: *Breathing is important, because it tells the brain that you're calm, you're safe.* The data suggests that the interviewees consider psychodrama to be a helpful method for practicing presence with the client, and helping trauma survivors integrate their past. The accounts also indicate that integrating the past can only happen by practicing presence.

4.5.4 Summary of Theme Four

Theme Four demonstrated participants' views on how integration is a physical act involving the body. The central message of this theme is that because the effects of trauma are partly physiological, the body needs to be involved in the healing process: With time, dissociation can be transformed into a capacity to stay present in the body, and

psychodrama - an action method - offers countless ways of practicing presence; rather than merely talking and thinking about healing, psychodrama allows clients to actually *embody* roles of healing.

4.6 Theme Five: Integration is a Spiritual Act

Several of the interviewees talked about the spiritual aspect of integration. This theme displays participant's views regarding why and how spirituality can or should be a part of the integration process, especially with clients healing from interpersonal trauma.

For example, Steven shared his view: *Trauma often happened by the hands of humans; many trauma survivors have mixed feelings in their relationship with other humans*. When clients find it difficult to trust humans, spirituality can become a source of safety. Steven, Kay and Rachel talked about using transpersonal strength-roles in their work. These roles present a type of strength such as God or a Higher Power. Several of the interviewees shared experiences of doing role-reversals with such roles. Another role mentioned was the 'Higher Self', which can also be seen as a spiritual tool.

Steven talked about working with the Future Self-role. This type of role is versatile because it includes a spiritual element, yet it is not restricted to religious beliefs. Working with the Future Self-role has several benefits mentioned by Steven, such as: It helps clients to focus on positivity, and remember their treatment goal. It gives hope and activates inner strengths, it concretizes and externalizes the future self and brings hope to

a practical level; the next step towards the future self becomes more concrete once the role is embodied.

In Psychodrama the spiritual is not an abstract idea, but something that can be embodied and seen. Steven shared an example from his practice:

I had a client in the group who wasn't able to feel hope for himself in terms of a future without using heroin and being comfortable in his skin. After working with strength-roles, the client chose someone to represent himself in the future, after recovery from addiction and having healed from trauma. Then they role-reversed, and I asked him: 'You're this guy's future self and he really needs to know how to become you. He can't see you yet. Give him advice, tell him what to do, tell him how you got to where you are in the future.' This helped him to find answers within himself, so that he can heal himself. We call that the autonomous healing centre.

This example demonstrates how psychodrama can help clients to see potentials for themselves that they couldn't see before; it allows them to have an embodied experience of hope, to believe in something that hasn't manifested yet.

Also Rachel talked about the spiritual aspect:

At the core of every person, no matter what they have gone through, is what I call the 'child of grace'. Even if they are very splintered, there's at least a shred of grace that has remained intact, even if it has been hidden by other parts. Often they can't see it themselves, they believe that this part hasn't survived the bad experiences. But this part can be retrieved, brought back to life so the person can blossom from the inside. It's the

soul-core that the person came in with into this life. So there's a spiritual piece that goes with this, something that psychologists usually don't talk about. But it's part of the whole self, and if you don't include that you're going to neglect a very important part of self.

Rachel shared several interesting points in this account. What she calls the 'child of grace' sounds very similar to Kay's descriptions of the 'sleeping-awakening child role' from TSM. In TSM, this role is the transformed wounded child role, the part of the person that has been hidden or sleeping. Through the process of integration, which includes nurturing and re-parenting the wounded child, the inner child transforms. With this new role also the person's innate creativity and spontaneity awakens. The autonomous healing centre mentioned by Steven seems to bear a similar function: To awaken the person's natural, innate healing capacity. Rachel also pointed out that spirituality is neglected by some psychologists. Like Rachel, Steven has also noted that spirituality seems to be important to the clients, and therefore should be included in the healing process.

Henrik described how integration can transform trauma into post-traumatic growth. He shares his personal experience of recovering from addiction:

At best trauma can become just a life experience, even a richness within my sense of self. What I've experienced brings depth into my life. I wouldn't want to experience it again, but because of that experience I want to live a good life, and do good things in the world. Trauma in a way forces us to examine the dark aspects, the sad and hurtful parts

within us and within humanity. When we are familiar with those, we also start to value the light parts more.

Whether we call it spiritual growth or personal growth or post-traumatic growth, the process of healing from trauma can bring more depth and meaning to a person's life.

4.6.1 Summary of Theme Five

Theme Five demonstrated that interviewees regarded spirituality as an important element in the healing process, especially for clients whose trust in other humans was broken. The data shows that spirituality in psychodrama can take many forms, and doesn't have to be limited to religious ideologies. When social relationships seem impossible to a person recovering from abuse, doing psychodrama work with more transpersonal roles can be comforting and empowering; spirituality can act as a source of light and hope not otherwise accessible to the client. Sometimes, the spiritual element is what transforms trauma into post-traumatic growth, giving new self-awareness, richness and meaning to a client's life.

4.7 Theme Six: Integration means Autonomy and Choicefulness

This part of the chapter organizes the data from the perspective of answering the question: How can therapists and psychodrama practitioners tell that a client has reached a place of integration and healing? The following three themes present various definitions of integration suggested by the interviewees. Although these different perspectives

emphasize different aspects of integration, together they create a coherent and holistic definition.

The sixth theme defines integration as coming to a place of autonomy and choice. The theme is divided in two sub-themes: 1) Integration means being autonomous, and 2) Integration means being free to choose. Since these two topics are closely related, they are placed under the same overarching theme.

4.7.1 Integration means being autonomous

This sub-theme presents the definition that integration means being autonomous and responsible for oneself. This definition was given by Steven, who said: *You can tell that a person has reached a place of wholeness or integration when the person has autonomy in their life, when they have the internal resources to be autonomous in the world.* Using slightly different words, Laila presented a similar definition: *When the person can stand on their own feet and take care of their needs.*

When asked how she would define integration, Kay answered: *When the person becomes a responsible authority for themselves.* Using TSM vocabulary, she added: *The abandoning authority role transforms from internalized abandonment to good self-care, making better decisions in the present. They learn how to put boundaries between the inner child and the internalized perpetrator.* These accounts suggest that interviewees define integration as a state of autonomy and responsible inner authority. The trauma survivor who likely experienced deficient parenting has developed a new role that

replaces the dysfunctional authority of the parents; the integrated client takes responsibility of themselves, becomes autonomous and makes self-caring decisions.

4.7.2 Integration means being free to choose

When I'm present, I have the freedom to choose what to do with my life. That frees you, and gives you distance to the trauma. Integration is when the person realizes their freedom and responsibility to choose how they want to live. This Gestalt-toned perspective offered by Henrik defines integration as choicefulness: While trauma limits a person's capacity to choose potentials freely, integration means overcoming those limitations. This makes sense when we consider that victimhood is an experience of limitation and powerlessness, an experience that doesn't involve choice, as Steven pointed out. Consequently, integration means returning to a place of being free to choose.

Also Robert talked about the element of choice, suggesting that integration means being able to choose freely what roles to play in each situation: *When roles are not like pathological, automatic reactions to outer events, but they are intentionally chosen responses: 'Right now, I need this role'. When a person's roles act as support mechanisms in life.* This answer highlights an interesting point evident in the data: Roles can be dysfunctional coping mechanisms, but equally they can act as functional support mechanisms in life. Integration then means seeing the difference between the two and having the capacity to choose the functional roles. Here we see how awareness of inner parts leads to integration: Only by being aware of inner parts, can a person choose which

role to express in any given moment. Robert also explained how roles are used both to reveal or express emotions, and to hide emotions. According to him, healing means having the awareness and freedom to choose when to use roles that express emotions when to choose a role to hide emotions.

Along similar lines, Laila shared how she can tell if there's been integration by the choices a client has made in between sessions. When a person is fragmented, the ambivalent personality aspects make chaotic and often self-harming choices. Also Rachel talked about self-sabotaging parts that keep the person from making self-caring choices. From this perspective, integration could mean being aware of the ambivalent inner parts, but having the ability to step into the responsible adult role and make a choice from that place.

In addition, Laila talked about how the process of making choices changes as one becomes more integrated: *A person can't really find their purpose in life before the selfhood is born. Until they have a clear, integrated sense of self, all decisions are directed from the outside, rather than from within, spontaneously.* Her account presents the idea that integration is evident when the person is self-directed and spontaneous rather than making choices based on other people's expectations.

4.7.3 Summary of Theme Six

Theme Six presented a definition of integration arising from the data that revolves around autonomy and choicefulness. Just as trauma limits a person's existence and

freedom, integration means expansion and overcoming limitations. Integration means being flexible and free to play with different roles within the self, and yet having a solid base in the responsible adult role. Choices that were once led by fear and self-sabotaging patterns are transformed into spontaneous and responsible self-expression. As a person moves through integration, they learn to choose new potentials outside of just coping and just surviving.

4.8 Theme Seven: Integration means Self-love and Self-care

The seventh theme is more succinct in terms of quantity of data, yet qualitatively significant. When asked about participants' definition of integration, several participants mentioned self-love, self-care and compassion towards self: *Being intact is when you love yourself again. I think it's all about self-love and self-care. And compassion for yourself. Not in an egotistical way, but that I think of myself in a careful, caring way. Then I think the identity has come to a wholesome place* (Rachel).

Also Laila talked about self-care, offering a slightly different perspective: *When self-care - whether it's sleep, nutrition, sport, etc. - is not just an external directive or not done just for the sake of seeking approval, but it is led from within.* This suggests that while self-care in itself can be an indicator of integration, there is a difference between being self-caring to impress the therapist or someone else, and being self-caring because it's an inner drive. This theme is also connected to the previous theme: As the person

develops a more caring and loving relationship to himself/herself, it becomes more natural to make healthy, self-supportive choices.

Laila also gave the following definition of integration: *Integration is when the self-esteem is developed to such an extent that the relationship to self becomes the most important relationship, the basis on which to build healthy relationships with others.* This perspective places the relationship to self as central to the definition of integration. In this account Laila suggests that although integration leads to healthier relationships with others, the basis of integration is acknowledging the relationship to self as the primary relationship. According to Laila then, the intrapsychic level is not only the starting point of healing from trauma, but also the point of arrival.

Also others talked about a conscious and compassionate relationship with self: *I would say that a person is integrated when they can accept their own defenses and masks with compassion* (Henrik). Steven shared a similar perspective: *[Integration] is when I'm not dissociating and rejecting parts of myself.* Similarly Kay described that a person has come to a more integrated place when the voice of the inner perpetrator has transformed into caring self-talk. Rachel mentioned self-forgiveness: *When they have compassion for themselves, when they are much more tolerant toward themselves and can forgive themselves.*

4.8.1 Summary of Theme Seven

Theme Seven presented the perspective shared by participants that integration means having a loving, caring and compassionate relationship with oneself. Although participants didn't talk about this theme in length, they all seemed to emphasize its significance. It is evident that this theme overlaps with the previous theme of autonomy and choicefulness: Making responsible, spontaneous and self-caring choices requires a conscious and compassionate relationship with self. The findings suggest that the relationship with self is an important indicator of integration, especially on the intrapsychic level.

4.9 Theme Eight: Integration means Authenticity & Spontaneity

The last theme defines integration as being authentic and spontaneous, as described by the participants. This theme is not surprising given that all of the interviewees use psychodrama in their practice, and that spontaneity and creativity are considered to be the curative factor of psychodrama. Authenticity and spontaneity are grouped under the same theme since it is very difficult to be one without the other.

Henrik shared his perspective why spontaneity and authenticity are indicators of integration: *Trauma can shut you down. It can prevent a person from being spontaneous and authentic -it's difficult to be spontaneous with all that baggage in the backpack. Like when you meet another person, there are all these projections that limit the authentic connection.*

Kay presented her definition of spontaneity: *Spontaneity means that you're in the body, you're present, you know what you're thinking and feeling, you know what you need.* According to Kay, the client integrates a specific role in psychodrama by stepping into the role and staying in it long enough until the person gains some spontaneity and creativity. In other words, spontaneity and creativity during role-reversals are an indication of transformation.

Robert talked about authenticity:

Just like a director in theatre, the therapist's job is to invite the person to open up and reveal more of themselves. But I can't command a person to do that, I can only invite them and encourage them. Delicately. Sometimes that means just sitting with the client and breathing. Everyone has their particular way of expressing themselves and hiding themselves . . . It is beautiful to be authentic, you don't have to withdraw behind a role. But sometimes masks are needed and they serve you.

In this account, Robert discusses the complicated connection between authenticity and safety: Authenticity is especially important in healing trauma because clients recovering from trauma usually have parts that are particularly difficult to reveal, as they are associated with shame, pain, fear and other difficult feelings. The more a person reveals, the more they need internal safety and resources to not get overwhelmed or triggered; revealing and being authentic doesn't just mean becoming more intimate with another person, such as the therapist, but also more intimate with oneself. As Robert noted, revealing oneself and practicing authenticity can be either healing or harmful

depending on how safely it is practiced. An implication of this is that authenticity is an indicator of integration, because a client who feels comfortable being authentic is clearly someone who feels safe psychologically and socially.

4.9.1 Summary of Theme Eight

Theme Eight showed that several of the interviewees consider spontaneity and authenticity as indicators of integration. Through the process of (safely practiced) psychodrama, the frozenness of trauma transforms into fluidity and playfulness. Whereas before roles were used as coping mechanisms to hide parts of self, healing takes place through revealing suppressed parts in an authentic and spontaneous way. Participants also explained that integration cannot be forced, but is a natural - and spontaneous - effect of safely practiced psychodrama. As Steven pointed out, complete integration may be an ideal, however, relative integration is possible even after complex trauma.

4.10 Summary of Findings

This chapter has presented eight major themes that together portray the main elements of the process of integration after trauma, and a definition of integration from a psychodramatic perspective. One conclusion from this study is that psychological integration is practically synonymous with healing from trauma; however, psychological

integration is intricately linked with social integration, physiological integration and potentially spiritual integration.

Another important conclusion arising from the data is the central and necessary role of safety when using psychodrama to heal from trauma: Developing safety in psychodrama is like creating a safe stage for the process of integration; without this foundation, the whole process collapses. The data suggests that developing internal and external safety is not merely an ethical precaution to prevent re-traumatization, but a curative factor of psychodrama.

Throughout the accounts, there were no direct contradictions between participants' experiences and perspectives, although interviewees emphasized different aspects in their narratives. Overall, the interviewees' accounts compliment each other, and together they present a multifaceted picture of the process of integration in psychodrama – a process that takes place on the intrapsychic, interpersonal, somatic and possibly spiritual level.

The interviewees' accounts also provide several definitions of what it means to be integrated. A synthesis of these definitions reads as follows: *A person with an integrated sense of self is one who makes autonomous, conscious and self-caring choices, is compassionate and self-forgiving toward themselves, and feels safe enough to express herself/himself authentically and spontaneously.*

Several participants pointed out that there is never a final end point to integration; in this light, the definition of integration is always relative. The next chapter discusses the implications of the study and concludes this paper.

Chapter 5: Conclusion and Implications

This chapter presents a discussion on the implications of the findings, on recommendations for future research and considers the limitations of the study.

This study pursued the research question: *'How dramatic techniques and processes can be applied in therapy to facilitate clients in regaining an integrated sense-of-self after experiencing interpersonal trauma'*. For this purpose, psychodrama practitioners with expertise in the field of trauma were interviewed, and the data was interpreted using thematic analysis. The eight resulting themes present an analysis of the data from various perspectives: The themes depict the essential elements of the process of integration after trauma, as well as present a definition of integration, derived from clinical experience. The red thread running throughout the data is an emphasis on how important integration is when addressing trauma, and also that psychodrama – when practiced safely – is an excellent therapeutic method for this purpose.

The findings demonstrate that the process of integration after trauma is a holistic one, happening on many levels (specifically, the intrapsychic, interpersonal, somatic and spiritual level). The implied suggestion for future studies about identity integration is to be aware of these various levels and how they influence each other. Moreover, this study adds to the growing body of literature exploring the benefits of experiential methods in healing trauma, and suggests that psychodrama – when practiced safely – is ideal for healing interpersonal trauma. According the participants, one of the main reasons why

psychodrama can be so effective in healing trauma is because it operates on all four levels. Thus, this study also contributes to a deeper understanding of the curative factors of psychodrama when healing interpersonal trauma.

One of the contributions of this study is to provide a more accurate definition of integration after trauma. As discussed in the literature review, although trauma experts have extensively discussed, researched and defined the concepts of fragmentation and dissociation due to trauma, the concept of integration – though it is frequently referred to in literature – has not been clearly defined. Even the definition provided by the American Psychological Association is vague and quite abstract: "The integration of personality denotes the gradual bringing together of constituent traits, behavioral patterns, motives, and so forth to form an organized whole that functions effectively and with minimal effort or without conflict." Although this definition provides a general scope for the concept, this definition does not explain what integration means in practical terms.

This study provides a qualitative answer to that question, from within a psychodramatic framework. Through a thematic analysis of in-depth interviews, this complex phenomenon was given an alternative definition. One of the implications is that by providing a more functional and specific definition, it will be easier to conduct quantitative research on the topic of identity integration. With studies such as the present one, the concept of integration can be more easily operationalized, leading to more valid quantitative research.

This paper has demonstrated why identity integration is basically synonymous with healing from trauma, and how psychodrama can be used (and has been used) for this purpose. The qualitative definition of integration presented in this study contributes to a deeper understanding of healing trauma. While extensive research has been conducted on understanding the causes and predictors of trauma and PTSD, this study shifts the focus to the process of healing. While the focus here is not on posttraumatic growth, it is clear that the topic of PTG overlaps with the topic of this study. In fact, it would be useful to study the exact relationship between integration and PTG: Does posttraumatic growth mean healing from trauma, or can PTG occur even while a person still suffers from fragmentation and dissociation? Does PTG lead to integration, or integration to PTG? These are some of the questions waiting for further exploration.

The topic of practicing psychodrama safely has gained more attention in the past two decades, in contrast to the early days of psychodrama when it was rarely emphasized. One, somewhat surprising, insight emerging from this study was that psychodrama can be particularly effective in integrating fragmented personality parts when it is practiced safely, but also *because* it creates safety. This is surprising because until now, safety in the context of psychodrama has mostly been discussed as an ethical precaution. While the ethical consideration is important, this study brings awareness to another point regarding safety: Developing safety in psychodrama is not only important because it lowers the risk of re-traumatization, but also because it is fundamental to the whole process of

integration; the data suggests that without safety, psychodrama simply cannot be effective in healing fragmentation.

Thus, in accordance with many trauma experts (like Dayton, 2015; Fisher, 2017; and Levine, 1997) this study highlights the connection between healing trauma and feeling safe. The exact relationship between safety and integration would be an excellent topic for a quantitative research, since the practitioners interviewed for this study all noted a close connection between the two factors. The findings of this study reflect the new wave of psychodrama used for healing trauma, showing a more trauma-informed approach. In contrast with the formative years of psychodrama, currently there seems to be considerably more synthesis between the field of psychodrama and the clinical understanding of trauma treatment. This synthesis was clearly observable in the interviews.

The limitations of the study included that the data comprised a wide scope of topics, which was reflected in the many themes presented in the data analysis. Possibly a more narrow focus of the research topic would have been preferable. For example, it might have been useful to focus on either the process of integration or on the definition of integration. However, this fact was evident to the researcher only after the data collection process. Another limitation is that this study does not lead to any representative findings, as it was a small-scale qualitative study. The findings are still considered to be valuable, especially considering that most of the interviewees were experts in the fields of

psychodrama and trauma treatment. This study has not presented any new insights as such, although it has raised awareness on issues that have not been prominent.

This study has examined integration from a psychodramatic perspective. However, the definition presented is accessible also to non-psychodrama practitioners; although some of the words used in the definition have a psychodramatic tone, the definition is nonetheless practical, comprehensible and easily applicable regardless of the therapeutic modality. Hopefully this study will inspire further exploration into the topic of identity integration after trauma, as well as raise awareness about the effectiveness of using psychodrama to help clients heal fragmentation.

References

- Addelson, K. P. (2002). *Gender struggles: practical approaches to contemporary feminism*. Rowman & Littlefield.
- Ali, A., & Wolfert, S. (2016). Theatre as a treatment for posttraumatic stress in military veterans: Exploring the psychotherapeutic potential of mimetic induction. *The Arts in Psychotherapy, 50*, 58-65.
- Alvesson, M., & Willmott, H. (2002). Identity regulation as organizational control: Producing the appropriate individual. *Journal of management studies, 39*(5), 619-644.
- Appleton, V. (2001). Avenues of hope: Art therapy and the resolution of trauma. *Art therapy, 18*(1), 6-13.
- Attigui, P. (2012). *Jeu, transfert et psychose.: De l'illusion théâtrale à l'espace thérapeutique*. Dunod.
- Baker, B. A. (2006). Art speaks in healing survivors of war: The use of art therapy in treating trauma survivors. *Journal of Aggression, Maltreatment & Trauma, 12*(1-2), 183-198.
- Barker, C., & Pistrang, N. (2015). *Research methods in clinical psychology: An introduction for students and practitioners*. John Wiley & Sons.
- Blatner, A. (2000). *Foundations of psychodrama: History, theory, and practice* (4th ed.). New York, NY, US: Springer Publishing Co.
- Boal, A. (1995). *The rainbow of desire: The Boal method of theatre and therapy*. Routledge.
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. sage.

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57-71). Washington, DC, US: American Psychological Association.

<http://dx.doi.org/10.1037/13620-004>

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.

Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davis, G. C., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: the 1996 Detroit Area Survey of Trauma. *Archives of general psychiatry*, 55(7), 626-632.

Brewer, J. S. (1976). Integration as a process in Gestalt-oriented psychotherapy: a proposed conceptualization.

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: mindfulness and its role in psychological well-being. *Journal of personality and social psychology*, 84(4), 822.

Cadell, S., Regehr, C., & Hemsworth, D. (2003). Factors contributing to posttraumatic growth: A proposed structural equation model. *American Journal of Orthopsychiatry*, 73(3), 279-287.

Callaghan, K. (1993). Movement psychotherapy with adult survivors of political torture and organized violence. *The Arts in Psychotherapy*.

Carey, L. (2006). *Expressive and creative arts methods for trauma survivors*. Jessica Kingsley Publishers.

Carnabucci, K. (2014). *Show and tell psychodrama: Skills for therapists, coaches, teachers, leaders*. Nusanto Publishing.

Casson, J. (2016). Shamanism, theatre and dramatherapy. In Jennings & Holmwood (Eds.), *Routledge International Handbook of Dramatherapy*, pp. 125-134.

Chu, J. (1998). *Rebuilding shattered lives: the responsible treatment of complex posttraumatic stress and dissociative disorders*. New York: Guilford Press.

Cohen, B. M., Barnes, M. M., & Rankin, A. B. (1995). *Managing traumatic stress through art: Drawing from the center*. Sidran Traumatic Stress Ins.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. Guilford Publications.

Cozolino, L. J. (2016). *Why therapy works: Using our minds to change our brains*. New York: W.W. Norton & Company.

Cozolino, L. (2014). *The neuroscience of human relationships: Attachment and the developing social brain*. WW Norton & Company.

Creeden, K. (2009). How trauma and attachment can impact neurodevelopment: Informing our understanding and treatment of sexual behaviour problems. *Journal of Sexual Aggression, 15*(3), 261-273.

Creswell, J. D., Way, B. M., Eisenberger, N. I., & Lieberman, M. D. (2007). Neural correlates of dispositional mindfulness during affect labeling. *Psychosomatic medicine, 69*(6), 560-565.

Crossley, M. L. (2000). Narrative psychology, trauma and the study of self/identity. *Theory & Psychology, 10*(4), 527-546.

Damasio, A. R. (1999). *The feeling of what happens: Body and emotion in the making of consciousness*. Houghton Mifflin Harcourt.

Damasio, A., & Meyer, K. (2009). Consciousness: An overview of the phenomenon and of its possible neural basis. *The neurology of consciousness: Cognitive neuroscience and neuropathology, 3-14*.

Daniels, L. R., & McGuire, T. (1998). Dreamcatchers: Healing traumatic nightmares using group dreamwork, sandplay and other techniques of intervention. *Group, 22*(4), 205-226.

Dayton, T. (2015). *Neuropsychodrama in the treatment of relational trauma*. Health Communications, Inc..

Dintino, C., & Johnson, D. R. (1997). Playing with the perpetrator. In Jennings, S. (ed.) *Dramatherapy: Theory and Practice, Volume 3*, Chapter 14. Routledge

Dissociation. (2018). In *APA Dictionary of Psychology*. Retrieved from <https://dictionary.apa.org/dissociation>

Dokter, D. (1996). 'Dramatherapy and clients with eating disorders: fragile board', in S. Mitchell (ed.) *Dramatherapy: Clinical Studies*, London, Jessica Kingsley Publishers.

Dokter, D., Jennings, S., & Holmwood, C. (2016). Embodiment in Dramatherapy. S. Jennings & C. Holmwood, *Routledge International Handbook of Dramatherapy*, 115-124.

Duey, C. J. (1991). Group music therapy for women with multiple personalities. *Case studies in music therapy*, 513-526.

Dunne, P. (2010). Narradrama with marginalized groups: Uncovering strengths, knowledges, and possibilities. *Healing collective trauma using sociodrama and drama therapy*, 25-53.

Elliott, R. K., Greenberg, L.S. & Lietaer, G. (2004) Research on experiential psychotherapies. In: *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (pp. 493-539). New York : John Wiley & Sons Inc.

Elmes, D. G., Kantowitz, Z. H. and Roediger, H. L. (1995) *Research Methods in Psychology, 5th ed.* St Paul: West Publications Company.

Eyerman, R. (2001). *Cultural trauma: Slavery and the formation of African American identity*. Cambridge University Press.

Fisher, J. (2017). *Healing the fragmented selves of trauma survivors: Overcoming internal self-alienation*. Routledge.

Fisher, J. (2001). Dissociative phenomena in the everyday lives of trauma survivors. *Annals of the Boston University Medical School: Psychological Trauma*, 1-22.

Follette, V., Palm, K. M., & Pearson, A. N. (2006). Mindfulness and trauma: Implications for treatment. *Journal of rational-emotive and cognitive-behavior therapy*, 24(1), 45-61.

Frey, D. (2006). Puppetry interventions for traumatized clients. In Carey, L. *Expressive and creative arts methods for trauma survivors*. Jessica Kingsley Publishers.

Fragmentation. (2018). In *APA Dictionary of Psychology*. Retrieved from <https://dictionary.apa.org/fragmentation>

Gembus, M. P. (2018). The safe spaces ‘in-between’—plays, performance and identity among young ‘second generation’ Somalis in London. *Children's Geographies*, 16(4), 432-443.

Germer, C., Siegel, R. D., & Fulton, P. R. (Eds.). (2016). *Mindfulness and psychotherapy*. Guilford Publications.

Gersie, A. (1996). *Dramatic approaches to brief therapy*. Jessica Kingsley Publishers.

Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age*. Stanford university press.

Glass, J. (2006). Working toward aesthetic distance : drama therapy for adult victims of trauma. In Carey, L. *Expressive and creative arts methods for trauma survivors*. Jessica Kingsley Publishers.

Gluck, J. (2013). Mindfulness and Drama Therapy. In L. Rappaport (Ed.), *Mindfulness and the arts therapies: Theory and practice* (pp.107.116). Jessica Kingsley Publishers.

Goffman, E. (1959). *The Presentation of Self in Everyday Life*, New York, Doubleday.

Goldfried, M. R., & Castonguay, L. G. (1993). Behavior therapy: Redefining strengths and limitations. *Behavior Therapy*, 24(4), 505-526.

Gray, A. E. L. (2001). The body remembers: Dance/movement therapy with an adult survivor of torture. *American Journal of Dance Therapy*, 23(1), 29-43.

Gray, A. E. (2002). The body as voice: Somatic psychology and dance/movement therapy with survivors of war and torture. *Connections*, 3(2), 2-4.

Greenberg, L. S., Watson, J. C., & Lietaer, G. (1998). *Handbook of experiential psychotherapy*. New York: Guilford Press.

Greenberg, M., & van der Kolk, B. (1989). Retrieval and integration with the "painting cure." *Psychological trauma*, 191-216.

Grehan, H. (2001). *Mapping cultural identity in contemporary Australian performance*. Peter Lang Publishing.

Haddock, S. A., Weiler, L. M., Trump, L. J., & Henry, K. L. (2017). The efficacy of internal family systems therapy in the treatment of depression among female college students: A pilot study. *Journal of marital and family therapy*, 43(1), 131-144.

Hall, S. (1996). The formation of a diasporic intellectual: an interview with Kuan-Hsing Chen', in D. Morley and K-H. Chen (eds) *Stuart Hall: Critical Dialogues*, London, Routledge.

Hardi, L., & Erdos, E. (1998). Nonverbal therapy of traumatized war victims. *Torture*, 8, 82-85.

Harnden, B. (2014). You arrive: Trauma performed and transformed. In Sajnani, & Johnson (Eds.), *Trauma Informed Drama Therapy: Transforming Clinics, Classrooms, and Communities*, Springfield, IL: Charles C. Thomas Publisher, pp. 122-51.

Haug, F. (ed.) (1987) *Female Sexualisation*. London: Verso.

Heiderscheid, A. (2016). *Creative arts therapies and clients with eating disorders*. London: Jessica Kingsley.

Heller, M. A. (2015). *Becoming incredible: Healing trauma through performance*. The University of Utah.

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence - from domestic abuse to political terror*. Hachette UK.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress*, 5(3), 377-391.

Hernández-Ruiz, E. (2005). Effect of music therapy on the anxiety levels and sleep patterns of abused women in shelters. *Journal of Music therapy*, 42(2), 140-158.

Hirakata, P., & Buchanan-Arvay, M. J. (2005). Into the fire: Using therapeutic enactments to bridge early traumatic memories of childhood sexual abuse. *International Journal for the Advancement of Counselling*, 27(3), 445-455.

Holmes, T., & Holmes, L. (2007). *Parts work: An illustrated guide to your inner life*. Winged Heart Press.

Hudgins, K. (2019). Psychodrama Revisited: Through the Lens of the Internal Role Map of the Therapeutic Spiral Model to Promote Post-traumatic Growth. *Zeitschrift für Psychodrama und Soziometrie*, 18(1), 59-74.

Hudgins, K. (2017). PTSD unites the world: Prevention, intervention, and training in the Therapeutic Spiral Model. *Why global health matters: Guidebook for innovation and inspiration*, 294-325.

Hudgins, M. K. (2002). *Experiential treatment for PTSD: The therapeutic spiral model*. Springer Publishing Company.

Hudgins, M.K., Culbertson, R., & Hug, E. (2009). *Action against trauma: A trainer's manual for community leaders following traumatic stress*. Charlottesville, VA.

Hudgins, M.K. & Drucker, K. (1998). The containing double as part of the therapeutic spiral model for treating trauma survivors. *The International Journal of Action Methods*, 51, 2, 63-74.

Hudgins, M.K., Drucker, K., & Metcalf, K. (2000). The containing double: A clinically effective psychodrama intervention for PTSD. *The British Journal of Psychodrama and Sociodrama*, 15, 1, 58-77.

http://drkatehudgins.com/yahoo_site_admin1/assets/docs/Containing_DoubleBPA_Article.173173224.pdf

Hudgins, M.K., and Kiesler, D.J. (1987). Individual experiential psychotherapy: An initial validation study of the intervention module of psychodramatic doubling. *Psychotherapy*, 24, 245-255.

<http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=1988-02002-001>

Hudgins, M. K., & Kipper, D. A. (1998). Action methods in the treatment of trauma survivors. *Journal of Group Psychotherapy, Psychodrama and Sociometry*, 51(2), 43.

Hudgins, K. & Toscani, F. (Eds.) (2013). *Healing world trauma with the therapeutic spiral model: Stories from the front-lines*. London: Jessica Kingsley Publishers.

Högberg, G., Nardo, D., Hällström, T., & Pagani, M. (2011). Affective psychotherapy in post-traumatic reactions guided by affective neuroscience: memory reconsolidation and play. *Psychology research and behavior management*, 4, 87.

Jackson, S. W. (1992). The listening healer in the history of psychological healing. *American Journal of Psychiatry*, 149, 1623-1623.

Jacobson, M. (1994). Abreacting and assimilating traumatic, dissociated memories of MPD patients through art therapy. *Art therapy*, 11(1), 48-52.

Jaffe, D. T. (1985). Self-renewal: Personal transformation following extreme trauma. *Journal of Humanistic Psychology*, 25(4), 99-124.

Jakovina, I. Ž., & Jakovina, T. (2017). Role Theory and Role Analysis in Psychodrama: A Contribution to Sociology. *Socijalna Ekologija*, 26(3), 151-169.

James, M., & Johnson, D. R. (1996). Drama therapy for the treatment of affective expression in posttraumatic stress disorder. In D. L. Nathanson (Ed.), *Knowing feeling: Affect, script, and psychotherapy* (pp. 303-326). New York, NY, US: W. W. Norton & Company.

Jennings, S. (ed.) (2013). *Dramatherapy: Theory and Practice, Volume 3*. Routledge.

Johnson, D. R., & Emunah, R. (Eds.). (2009). *Current approaches in drama therapy*. Charles C Thomas Publisher.

Johnson, D. R., Lahad, M., & Gray, A. (2009). Creative therapies for adults. In Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (Eds.). *Effective treatments for PTSD: practice guidelines from the International Society for Traumatic Stress Studies*. Guilford Press, 479-490.

Johnstone, K. (2012). *Impro: Improvisation and the theatre*. Routledge.

Jones, P. (2005). *The Arts Therapies: A Revolution in Healthcare*, London, Routledge.

Jones, P. (2007). *Drama as Therapy: Theory, Practice and Research* (2nd. Edition). London, Routledge

Karpman, S. (1968). Drama Triangle Script Drama Analysis. *Transactional Analysis Bulletin*, 7(26), 39-43.

Kazdin, A. E., & Mascitelli, S. (1982). Covert and overt rehearsal and homework practice in developing assertiveness. *Journal of Consulting and Clinical Psychology*, 50(2), 250-258.

Keane, T. M., Fairbank, J. A., Caddell, J. M., & Zimering, R. T. (1989). Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. *Behavior therapy*, 20(2), 245-260.

Kellermann, P. F. (2007). *Sociodrama and collective trauma*. Jessica Kingsley Publishers.

Kellermann, P. F., & Hudgins, K. (Eds.). (2000). *Psychodrama with trauma survivors: Acting out your pain*. Jessica Kingsley Publishers.

Kidron, C. A. (2003). Surviving a distant past: A case study of the cultural construction of trauma descendant identity. *Ethos*, 31(4), 513-544.

Krakow, B., Hollifield, M., Johnston, L., Koss, M., Schrader, R., Warner, T. D., ... & Cheng, D. (2001). Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: a randomized controlled trial. *Jama*, 286(5), 537-545.

Krystal, J. H., Giller, E. L., & Cicchetti, D. V. (1986). Assessment of alexithymia in posttraumatic stress disorder and somatic illness: introduction of a reliable measure. *Psychosomatic medicine*.

Lahad, M. (1992). Storymaking in assessment method for coping with stress. In S. Jennings (Ed.), *Dramatherapy theory and practice II* (pp. 150-163). London: Routledge.

Lahad, M., Farhi, M., Leykin, D., & Kaplansky, N. (2010). Preliminary study of a new integrative approach in treating post-traumatic stress disorder: SEE FAR CBT. *The Arts in Psychotherapy*, 37(5), 391-399.

Lahad, M., Leykin, D., Farchi, M., Doron, M., Gidron, Y., Rozenblat, O., & Fajerman, Z. (2016). SEE FAR CBT therapy for children with Post-Traumatic Stress Disorder under prolonged political conflict. *Journal of Psychology and Psychotherapy Research*, 3, 1-12.

Lamagna, J. (2011). Of the self, by the self, and for the self: An intra-relational perspective on intra-psychic attunement and psychological change. *Journal of Psychotherapy Integration*, 21(3), 280-307.

<http://dx.doi.org/10.1037/a0025493>

Landers, F. (2002). Dismantling violent forms of masculinity through developmental transformations. *The Arts in Psychotherapy*, 1(29), 19-29.

- Landy, R. J. (1994). *Persona and Performance*, London, Jessica Kingsley Publishers
- Landy, R. J. (2003). Drama therapy with adults. In Schaefer, C. E., *Play therapy with adults*. Hoboken, NJ: John Wiley & Sons.
- Landy, R. J. (2010). Drama as a means of preventing post-traumatic stress following trauma within a community. *Journal of Applied Arts & Health*, 1(1), 7-18.
- Lavergne, M. (2004). Art therapy and internal family systems therapy: An integrative model to treat trauma among adjudicated teenage girls. *Canadian Art Therapy Association Journal*, 17(1), 17-36.
- Layton, L. (1995). Trauma, gender identity and sexuality: Discourses of fragmentation. *American Imago*, 52(1), 107-125.
- Leskela, J., Dieperink, M., & Thuras, P. (2002). Shame and posttraumatic stress disorder. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, 15(3), 223-226.
- Lester, D. (2010). *A multiple self theory of personality*. Nova Science Publishers.
- Leveton, E. (2010). *Healing collective trauma using sociodrama and drama therapy*. Springer Publishing Company.
- Levine, P. A. (1997). *Waking the tiger: Healing trauma: The innate capacity to transform overwhelming experiences*. North Atlantic Books.
- Lev-Wiesel, R. (1998). Use of drawing technique to encourage verbalization in adult survivor of sexual abuse. *The Arts in psychotherapy*, 25(4), 257-262.
- Linden, S. B. (2013). *The Heart and Soul of Psychotherapy: A Transpersonal Approach Through Theater Arts*. Trafford Publishing.

Linstead, A., & Thomas, R. (2002). "What Do You Want from Me?" A Poststructuralist Feminist Reading of Middle Managers' Identities. *Culture and organization*, 8(1), 1-20.

Liotti, G. (1999). Disorganization of attachment as a model for understanding dissociative psychopathology. In J. Solomon and C. George (Eds.). Attachment disorganization. New York: Guilford Press.

Liotti, G. (2004). Trauma, dissociation and disorganized attachment: Three strands of a single braid. *Psychotherapy: Theory, Research, Practice, Training*, 41(4), 472-486. doi:10.1037/0033-3204.41.4.472

Llewellyn-Jones, M. (2002). *Contemporary Irish drama & cultural identity*. Intellect Books.

Lutgen-Sandvik, P. (2008). Intensive remedial identity work: Responses to workplace bullying trauma and stigmatization. *Organization*, 15(1), 97-119.

Lyons-Ruth, K. et al (2006). *From infant attachment disorganization to adult dissociation: relational adaptations or traumatic experiences?* *Psychiatric Clinics of North America*, 29:1.

MacNeilage, L. A., & Adams, K. A. (1979). The method of contrasted role-plays: An insight-oriented model for role-playing in assertiveness training groups. *Psychotherapy: Theory, Research & Practice*, 16(2), 158-170.

Madill, A., Jordan, A. and Shirley, C. (2000) Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies, *British Journal of Psychology*, 91: 1–20.

Matheson, F. I., Daoud, N., Hamilton-Wright, S., Borenstein, H., Pedersen, C., & O'Campo, P. (2015). Where did she go? The transformation of self-esteem, self-identity, and mental well-being among women who have experienced intimate partner violence. *Women's health issues*, 25(5), 561-569.

McMullian, S., & Burch, D. (2017). 'I am more than my disease': An embodied approach to understanding clinical populations using Landy's Taxonomy of Roles in concert with the DSM-5. *Drama Therapy Review*, 3(1), 29-44.

Merlin, B. (2017). *Acting: the basics*. Routledge.

Miller, B. J., Cardona, J. R. P., & Hardin, M. (2007). The use of narrative therapy and internal family systems with survivors of childhood sexual abuse: Examining issues related to loss and oppression. *Journal of Feminist Family Therapy*, 18(4), 1-27.

Minet, S. J. (2006). *Du divan à la scène: " Dans quelle pièce je joue?" (Vol. 258)*. Editions Mardaga.

Mitchell, S. (1992). Therapeutic theatre. In S. Jennings (ed.), *Dramatherapy: Theory and Practice, Volume 2* (Chapter four), London: Routledge.

Mobasher, M. (2006). Cultural trauma and ethnic identity formation among Iranian immigrants in the United States. *American behavioral scientist*, 50(1), 100-117.

Moran, G. S., & Alon, U. (2011). Playback theatre and recovery in mental health: Preliminary evidence. *The Arts in Psychotherapy*, 38(5), 318-324.

Moreno, Z. T. (1987). Psychodrama, role theory and the concept of the social atom. In J. Zeig, *The Evolution Of Psychotherapy.....The 1st Conference* (pp. 341-368). New York: Routledge

Morgan, C. A., & Johnson, D. R. (1995). Use of a drawing task in the treatment of nightmares in combat-related post-traumatic stress disorder. *Art Therapy*, 12(4), 244-247.

Naisen Väkivalta. (2019). *Ammattilaiselle*. Retrieved from: <https://www.naisenvakivalta.fi/ammattilaiselle/>

Newman, T. (2017). Creating the Role: How Dramatherapy Can Assist in Re/Creating an Identity with Recovering Addicts. *Dramatherapy*, 38(2-3), 106-123. <https://doi.org/10.1080/02630672.2017.1340492>

Nijenhuis, E. R. (2014). Dissociation in the DSM–5: Your View S’Il Vous Plaît, Docteur Janet?.

Ogden, P., Minton, K., Pain, C., & van der Kolk, B. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy (norton series on interpersonal neurobiology)*. WW Norton & Company.

Ørjasæter, K. B., Stickley, T., Hedlund, M., & Ness, O. (2017). Transforming identity through participation in music and theatre: exploring narratives of people with mental health problems. *International journal of qualitative studies on health and well-being*, 12(1), 1379339.

Ouimette, P. E., & Brown, P. J. (2003). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. American Psychological Association.

Paivio, S. C., & Greenberg, L. S. (1995). Resolving" unfinished business": Efficacy of experiential therapy using empty-chair dialogue. *Journal of Consulting and Clinical Psychology*, 63(3), 419.

Parnell, L. (1999). *EMDR in the treatment of adults abused as children*. New York, NY, US: W W Norton & Co.

Perry, R., Saby, K., Wenos, R., Hudgins, K., & Baller, M. (2016). Psychodrama intervention for female service members using the therapeutic spiral model. *The Journal of Psychodrama, Sociometry, and Group Psychotherapy*, 64, 1, 11-23.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.

Putnam, F.W. (1997). *Dissociation in children and adolescents: a developmental perspective*. New York: Guilford Press.

Rauch, S. L., van Der Kolk, B. A., Fisler, R. E., Alpert, N. M., Orr, S. P., Savage, C. R., ... & Pitman, R. K. (1996). A symptom provocation study of posttraumatic stress disorder using positron emission tomography and script-driven imagery. *Archives of General Psychiatry*, 53(5), 380-387.

- Riskin, L. L. (2013). Managing inner and outer conflict: Selves, subpersonalities, and internal family systems. *Harv. Negot. L. Rev.*, 18, 1.
- Ross, M. H. (2001). Psychocultural interpretations and dramas: Identity dynamics in ethnic conflict. *Political psychology*, 22(1), 157-178.
- Roth, S., & Friedman, M. J. (1998). Childhood trauma remembered: A report on the current scientific knowledge base and its applications. *Journal of Child Sexual Abuse*, 7(1), 83-109.
- Rowan, J. (2009). *Personification: Using the dialogical self in psychotherapy and counselling*. Routledge.
- Roy, D., & Ladwig, J. (2015). Identity and the arts: using drama and masks as a pedagogical tool to support identity development in adolescence. *Creative education*, 6(10), 907.
- Sajnani, N., & Johnson, D. R. (2014). *Trauma-informed drama therapy: Transforming clinics, classrooms, and communities*. Charles C Thomas Publisher.
- Sawyer, R. K. (2000). Improvisation and the creative process: Dewey, Collingwood, and the aesthetics of spontaneity. *The journal of aesthetics and art criticism*, 58(2), 149-161.
- Schechner, R. (1988). *Performance Theory*, New York, Routledge.
- Scheff, T. J. (1981). The distancing of emotion in psychotherapy. *Psychotherapy: Theory, Research & Practice*, 18(1), 46.
- Schouten, K. A., de Niet, G. J., Knipscheer, J. W., Kleber, R. J., & Hutschemaekers, G. J. (2015). The effectiveness of art therapy in the treatment of traumatized adults: a systematic review on art therapy and trauma. *Trauma, violence, & abuse*, 16(2), 220-228.
- Schrader, C. (2012). *Ritual theatre: The power of dramatic ritual in personal development groups and clinical practice*. Jessica Kingsley Publishers.

Schwartz, R. C. (1995). *Internal family systems*. New York: Guilford.

Schwartz, R. C. (2001). *Introduction to the internal family systems model*. Trailheads Publications.

Shadick, N. A., Sowell, N. F., Frits, M. L., Hoffman, S. M., Hartz, S. A., Booth, F. D., ... & Friedman, A. L. (2013). A randomized controlled trial of an internal family systems-based psychotherapeutic intervention on outcomes in rheumatoid arthritis: a proof-of-concept study. *The Journal of rheumatology*, 40(11), 1831-1841.

Shapiro, S. L., & Carlson, L. E. (2009). *The art and science of mindfulness: Integrating mindfulness into psychology and the helping professions*. American Psychological Association.

Shaw, A., Joseph, S., & Linley, P. A. (2005). Religion, spirituality, and posttraumatic growth: A systematic review. *Mental Health, Religion & Culture*, 8(1), 1-11.

Siegel, D. (2012). *Developing mind: How relationships and the brain interact to shape who we are*. New York: Guilford Press.

Slotoroff, C. (1994). Drumming technique for assertiveness and anger management in the short-term psychiatric setting for adult and adolescent survivors of trauma. *Music Therapy Perspectives*, 12(2), 111-116.

Solomon, M.F. & Siegel, D.J., Eds. (2003). Healing trauma: attachment, mind, body and brain. New York: W.W. Norton.

Solomon, J. & George, C. (1999). Attachment disorganization. New York: Guilford Press.

Stone, H., & Stone, S. L. (1989). *Embracing our selves: The Voice Dialogue manual*. Novato, CA: New World Library.

Stone, S. L., & Stone, H. (2007). The basic elements of Voice Dialogue, relationship and the Psychology of Selves: Their origins and development. Retrieved from: http://delos-inc.com/Reading_Room/reading_room.html

Sweezy, M. (2011). The teenager's confession: regulating shame in internal family systems therapy. *American journal of psychotherapy*, 65(2), 179-188.

Taipale, J. (2016). Social mirrors. Tove Jansson's Invisible Child and the importance of being seen. *The Scandinavian Psychoanalytic Review*, 39(1), 13-25.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of traumatic stress*, 9(3), 455-471.

Turner, V. W. (1982). *From ritual to theatre: The human seriousness of play*. Paj Publications.

UK Psychological Trauma Society. (2017). *Guideline for the treatment and planning of services for complex post-traumatic stress disorder in adults*. Retrieved from http://www.ukpts.co.uk/links_6_2920929231.pdf

van der Hart, O., van der Kolk, B. A., & Boon, S. (1998). Treatment of dissociative disorders. In J. D. Bremner & C. R. Marmar (Eds.), *Progress in psychiatry, No. 54. Trauma, memory, and dissociation* (pp. 253-283). Arlington, VA, US: American Psychiatric Association.

Van der Hart, O., Nijenhuis, E.R.S., Steele, K., & Brown, D. (2004). Trauma-related dissociation: conceptual clarity lost and found. *Australian and New Zealand Journal of Psychiatry* 2004; 38:906–914.

Van der Hart, O., Nijenhuis, E. R., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. WW Norton & Company.

Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma*. Penguin UK.

van der Kolk, B. A., Burbridge, J. A., & Suzuki, J. (1997). The psychobiology of traumatic memory: Clinical implications of neuroimaging studies. *Annals of the New York Academy of Sciences*, 821(1), 99-113.

Van der Kolk, B. A., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of traumatic stress*, 8(4), 505-525.

van der Kolk, B. A., van der Hart, O., & Marmar, C. R. (1996). Dissociation and information processing in posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 303-327). New York, NY, US: Guilford Press.

van Schalkwyk, S., Boonzaier, F., & Gobodo-Madikizela, P. (2014). 'Selves' in contradiction: Power and powerlessness in South African shelter residents' narratives of leaving abusive heterosexual relationships. *Feminism & Psychology*, 24(3), 314-331.

van der Velden, I., & Koops, M. (2005). Structure in word and image: Combining narrative therapy and art therapy in groups of survivors of war. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict*, 3(1), 57-64.

Villareal, G., Hamilton, D. A., Graham, D. P., Driscoll, I., Qualls, C., Petropoulos, H., & Brooks, W. M. (2004). Reduced area of the corpus callosum in posttraumatic stress disorder. *Psychiatry Research: Neuroimaging*, 131(3), 227-235.

Watkins, H. H., & Watkins, J. G. (1993). Ego-state therapy in the treatment of dissociative disorders. *Clinical perspectives on multiple personality disorder*, 277-300.

Werner, Riah, "Drama for Social Justice: Embodying Identity and Emotion in ELT" (2017). *MA TESOL Collection*. 719. Retrieved from: https://digitalcollections.sit.edu/ipp_collection/719

White, C., & Denborough, D. (1998). *Introducing Narrative Therapy: A Collection of Practice-Based Writings*. Adelaide: Dulwich Centre Publications.

Wiener, D. J. (1999). *Beyond talk therapy: Using movement and expressive techniques in clinical practice*. American Psychological Association.

Willig, C. (2012) Perspectives on the epistemological bases for qualitative research, in H. Cooper (ed.) *The Handbook of Research Methods in Psychology*. Washington, DC: American Psychological Association.

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-hill education (UK).

Wistrich, R., & Ohana, D. (Eds.). (2014). *The shaping of Israeli identity: Myth, memory and trauma*. Routledge.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy*. New York: Guilford, 254.

Appendix A: Contact Letter

Dear [name of clinic or center],

I am a student reading for an MSc in Clinical and Health Psychology at *Universidade Fernando Pessoa* in Portugal.

I am contacting the [name of clinic or center] to ask if there are psychodrama or drama therapy practitioners who would be interested in participating in a qualitative research I am doing as part of my Masters degree.

The topic I chose for my dissertation is identity integration of clients with fragmentation due to traumatic interpersonal experiences, and how dramatic techniques can be applied in psychotherapy to transform self-perception in these clients.

My aim is to interview professional psychodrama and drama therapy practitioners with experience in the field of trauma healing to find out if/how/when dramatic processes and techniques help clients to adopt a more empowered and integrated perception of self.

Participation in the study consists of one Skype or phone interview of 45-75 minutes in length (per participant). The interviews will be held during June and August 2019, at a time most convenient for the participant.

I kindly ask the administration of the [name of clinic or center] to let the members know about this opportunity. Thank you!

If there are interested practitioners who would like to participate in this research, please ask the interested participants to email me in order to arrange a time for the interview.

The interviews will be audio-recorded with the interviewee's consent, and names will be changed to ensure maximum anonymity.

Participation criteria is: 1) participants must have three or more years of professional experience in the field of trauma therapy, 2) participants must speak English or Finnish; 3) participants must have expertise in Psychodrama or Drama Therapy.

Once this dissertation is completed, it shall be presented at *Universidade Fernando Pessoa*. Dr. Pedro Cunha, professor at UFP, has agreed to help me as my tutor in this research.

(This study is not funded, so the only reward for participation in the study will be the contribution to psychotherapy research.)

All participation will be greatly appreciated. Should you or any of the prospective participants have any questions about the study, please do not hesitate to contact me via e-mail on

kim.seppala@gmx.com or 36580@upt.edu.pt

Yours sincerely,

Kim Seppälä

Appendix B: Information Sheet and Consent Form

(English version)

Dear Madam/Sir,

I am a student reading for an MSc in Clinical and Health Psychology at *Universidade Fernando Pessoa* in Portugal.

The topic I chose for my dissertation is identity integration of clients with fragmentation due to traumatic interpersonal experiences, and how dramatic techniques can be applied in psychotherapy to transform self-perception in these clients.

Your participation in this study is entirely voluntary and you have the right to withdraw from the study at any time.

The study involves conducting in-depth interviews with psychodrama practitioners working with trauma clients. The interview will last 45-75 minutes in length, and will be conducted as a video- or audio-call (with Skype). The interview consists of questions regarding the professional's experience with trauma clients, and specifically about his/her experiences with applying dramatic techniques (such as the empty chair, storytelling techniques, role taking, soliloquy, etc.) to help clients adopt an empowered sense of identity.

The interviews will be audio-recorded (with the interviewee's consent) and be transcribed by myself. Names shall be changed to ensure maximum anonymity. All audio-recordings and transcripts will be securely stored on my personal password-protected computer, and the data will be eradicated within 6 months after the research is completed.

Once this dissertation is completed, it shall be presented at *Universidade Fernando Pessoa*. Mr. Pedro Cunha, professor at UFP, has agreed to help me as my tutor in this research.

If you take part in the study, you have the right to:

- Refuse to answer any particular question, and to withdraw from the study at any time
- Ask any further questions about the study that occur to you during your participation

- Provide information on the understanding that it is completely confidential to the researcher. All information is collected anonymously and it will not be possible to identify you in any reports that are prepared from the study
- Be given access to a summary of the findings from the study when it is concluded.

Thank you in advance for participating in this study. Should you need any further clarifications in any part of the study, please do not hesitate to contact me via e-mail on kim.seppala@gmx.com.

Yours sincerely,

Kim Seppälä

CONSENT FORM

I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I have the right to withdraw from the study at any time and to decline to answer any particular questions

I agree to provide information to the researcher on the understanding that my name will not be used without permission

I understand that the interview shall be audio-recorded and that I have the right for the recording to be switched off at any time during the interview.

I agree to participate in this study under the conditions set out in the information sheet.

Signed _____
 Name _____
 Date _____

Appendix C: Information Sheet and Consent Form

(Finnish version)

TIETOA TUTKIMUKSESTA

Hei [nimi],

olen kliinisen psykologian maisteriopiskelija, Portugalin yliopistosta Universidade Fernando Pessoa:sta (MSc).

Tutkimukseni aihe on miten draamaa ja eri teatteriprosesseja voidaan soveltaa terapiassa auttaakseen traumatisoituneen henkilön identiteetin eheyttämisessä. Monet asiakkaat jotka ovat kokeneet ihmistenvälisiä traumaattisia kokemuksia, kärsivät identiteetin fragmentoitumisesta/ pirstoutumisesta. Voiko draamaprosessien, kuten psykodraaman, avulla auttaa traumatisoituneen henkilön minäkuvan eheyttämisessä?

Tutkimusta varten haastattelen psykodraamaohjaajia ja draamaterapeutteja, joilla on kokemusta traumaaja käsittelevien asiakkaiden kanssa. Haastattelu minun ja terapeutin välillä käydään Skypen välityksellä, ja se kestää 45-60 minuuttia. Haastattelu voidaan pitää joko video-muodossa tai pelkästään puhelinsoittona. Haastattelu ääni-tallennetaan haastateltavan luvalla. Haastateltavien nimet muutetaan, joten sisältö on anonymia. Tutkimusmateriaali käytetään ainoastaan tutkimusta varten, ja materiaali säilytetään tutkijan tietokoneessa ja hävitetään tutkimuksen päättymisen jälkeen.

Kun tutkimus on valmis, se esitetään syksyllä 2019 Universidade Fernando Pessoa:ssa. Tuutorina toimii Prof. Pedro Cunha.

Ennen haastattelua pyydän sinua allekirjoittamaan alla olevan lomakkeen, mikäli suostut osallistumaan tutkimukseen.

Jos suostut osallistumaan, sinulla on oikeus:

- Olla vastaamatta sinulle esitettyihin kysymyksiin,
- Keskeyttää osallistumisesi,
- Kysyä lisää tietoa tutkimuksesta,

- Jakaa tietoa ja kokemuksiasi sillä ymmärryksellä, että kaikki materiaali on luottamuksellista; mikäli materiaalia siteerataan tutkimuksessa, se tehdään anonyymissä muodossa,
- Nähdä yhteenveto tutkimuksesta sen valmistuttua.

Kiitän etukäteen tutkimukseen osallistumisesta! Tämä tutkimus ei ole rahoitettu, joten osallistumisesta ei saa mitään materiaalista palkkiota. Osallistumalla kuitenkin tuet tärkeän aiheen tutkimusta.

Mikäli sinulle herää kysymyksiä liittyen tutkimusprosessiin tai -tavoitteisiin, vastaan mielelläni sähköpostitse: kim.seppala@gmx.com

Kiittäen,

Kim Seppälä

LOMAKE TIETOISEN SUOSTUMUKSEN ANTAMISEEN

Olen lukenut yllä olevan tiedotteen ja ymmärrän tutkimuksen tavoitteen. Olen saanut vastauksen minua askarruttaviin kysymyksiin tutkimukseen liittyen ja ymmärrän, että voin esittää lisää kysymyksiä tutkimuksen edetessä.

Ymmärrän, että voin keskeyttää osallistumiseni kesken tutkimusta, ja voin jättää kysymyksiä vastaamatta.

Ymmärrän, että jaan tietoa luottamuksellisesti, ja että nimeäni ei paljasteta kysymättä lupaa minulta.

Ymmärrän, että haastattelu ääni-tallennetaan, ja että minulla on oikeus vaatia tallennuksen keskeyttämistä haastattelun aikana.

Suostun osallistumaan tutkimukseen yllä olevien ehtojen mukaisesti.

Allekirjoitus _____

Nimi _____

Päivämäärä _____

Appendix D: Interview Schedule

(English version)

Thank you for participating in the study. I will now ask you questions related to your work with trauma clients:

1) In what kind of setting(s) do you apply dramatic techniques (in therapy) with trauma clients?

2) What is important to take into consideration when using dramatic techniques in psychotherapy with trauma survivors?

BASED ON YOUR EXPERIENCE:

3 a) In what ways can dramatic techniques in psychotherapy help to release the victimized or wounded identity?

3 b) Can you share examples from your own practice?

3 c) How can dramatic techniques in psychotherapy help to establish a whole or empowered sense of self? Examples?

4) How can dramatic processes help the client to gain awareness about the different parts of the internal system?

5) How can dramatic processes help the client to transform conflict between internal parts?

6) How can dramatic processes help the client to be in the present moment and to differentiate past from present?

7) When are dramatic techniques in psychotherapy with trauma clients *not* useful in your experience?

8) How would you define 'identity integration' in clients recovering from trauma?
What is a "healed" or "integrated" identity from your perspective?

9) Is there anything else you feel is important to mention about this topic?

Appendix E: Interview Schedule

(Finnish version)

Kiitos haastatteluun osallistumisesta! Kysyn seuraavaksi kysymyksiä liittyen työkokemukseesi trauma-asiakkaiden kanssa.

1) Kertoisitko työpaikastasi: Missä käytät psykodraamaa trauma-asiakkaiden kanssa; yksintyöskentelyssä vai ryhmissä?

2) Mitä on erityisen tärkeää ottaa huomioon kun käyttää psykodraamaa ihmisten kanssa jotka toipuvat traumasta?

POHJAUTUEN KOKEMUKSEESI:

3 a) Miten dramaattiset menetelmät voivat auttaa asiakasta luopumaan uhrin identiteetistä tai haavoitetun identiteetistä?

3 b) Voitko jakaa tiettyjä esimerkkejä omasta työstäsi?

3 c) Entä miten dramaattiset menetelmät voivat auttaa asiakasta kehittämään uutta eheytyntyä ja voimaantunutta identiteettiä?

4) Millä tavoin dramaattiset menetelmät voivat auttaa asiakasta tulemaan tietoisemmaksi sisäisistä persoonallisuus-osista?

5) Millä tavoin dramaattiset menetelmät voivat auttaa asiakasta muuttamaan sisäisiä konflikteja?

6) Millä tavoin dramaattiset menetelmät voivat auttaa asiakasta olemaan läsnä tässä hetkessä ja erottamaan nykyhetki menneisyyden kokemuksista?

7) Missä tilanteissa psykodramaattiset menetelmät eivät ole sopivia trauma-asiakkaiden kanssa?

8) Miten sinä määrittelisit käsitteen 'identiteetin eheytyminen tai integraatio' kun puhutaan trauma-asiakkaista? Mitä 'eheytynyt minä-kuva' tarkoittaa sinun näkökulmasta?

9) Onko jotain muuta mitä haluaisit kertoa tästä aiheesta?

Appendix F: Example of initial coding

Codes	Data extract to which the code was applied
<p>Psychodrama in 1:1 therapy: why it's useful, how it can be done</p>	<p>1:1 work allows people to move at their own pace more easily. 1:205</p> <p>Body double and containing double are useful tools that can be applied to individual therapy. 1:110</p> <p>Can use objects, scarves or empty chairs to represent roles, if you don't have group members. 7:222</p>
<p>Secure attachment: why trust is important in the process of healing</p>	<p>Trust in the therapeutic relationship is really the basis of therapy. Because with most clients, especially trauma clients, there's deficiency in the primary attachment. And that leads to a lack of trust. There's no secure inner attachment. So the therapist often becomes the first secure attachment. That's why trust is such an important aspect in therapy. And then little by little, the client becomes more autonomous, as they become more secure internally. 5:225</p>
<p>Spiritual component is important for clients: it offers a non-human support</p> <p>A holistic approach includes acknowledging the spiritual</p>	<p>Trauma often happened by the hands of humans; many clients have mixed feelings in their relationship with other humans. Spiritual roles offer a type of strength that is not human. 7:214;</p> <p>At the core of every person, no matter what they have gone through, is what I call the 'child of grace'. At least a shred of grace that has remained intact, even if it has been hidden by other parts. And this part can be retrieved, brought back to life so the person can blossom from the inside. That soul-core that the person came in with into this life. So there's a spiritual piece that goes with this, something that psychologists usually don't talk about. But it's part of the whole self, and if you don't include that you're going to neglect a very important part of self. 4:544</p>

<p>Trauma can lead to post-traumatic growth, to valuing the good (the light) in the world.</p> <p>Transpersonal roles (TSM) add a spiritual dimension to psychodrama</p>	<p>At best trauma can become just a life experience, even a richness within my sense of self. What I've experienced brings depth into my life. I wouldn't want to experience it again, but because of that experience I want to live a good life, and do good things in the world. Trauma in a way forces us to examine the dark aspects, the sad and hurtful parts within us and within humanity. When we are familiar with those, we also start to value the light parts more. 3:160</p> <p>in TSM, we also use transpersonal strengths. 1:315.</p>
--	---

