CLINICIANS' CORNER I

TRAUMA DRAMA: HOW DO WE DEMONSTRATE THE IMPACT OF DRAMA ON HEALING

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Trauma Drama™ (Complex Trauma Institute, 2022)

For millennia, drama has been used to reintegrate traumatized people into society, yet theatre treatments are currently underutilized, perhaps because of barriers to quantification. As the complex trauma field coalesces around research agendas focused on the new CPTSD diagnosis in the ICD-11 (World Health Organization, 2018), it may make sense to examine traditional healing practices – like drama – since they naturally attract the injured, are well tolerated across cultures, and have been improved over generations. Throughout my life, when psychotherapeutic treatments have provided a partial remedy for personal traumas, I have found myself returning to drama as a reliable way to mop up residuals. In recent doctoral studies, I have heeded the charge to make a unique writer-specific contribution to the literature by conducting a dissertation study of Trauma Drama (TD; Spinazzola, 2019). TD is a manualized 18- to 24-session group intervention that synthesizes scenario-driven improvisational theatre with the expert-consensus treatment guidelines for complex trauma (Cloitre et al., 2012). TD is an evidence-informed intervention model adapted from Urban Improv, an improvisational theatre-based youth violence prevention program with some empirical support (Kisiel et al., 2006; Zucker et al., 2010). Although I studied TD in a complex-trauma-exposed residential-youth population, it is also offered through schools and community mental health agencies in the United States and Canada. TD utilizes a troupe composed of mental health providers and actors. It is a phased model. Phase I (weeks 1 to 5) utilizes improv games to cultivate emotional regulation skills and foster safe, trusting relationships among group members. Phase II (weeks 6 to 17) employs improvisational scene work based on pre-written scenarios that typify experiences of complex-trauma-exposed youth. Scenes are performed once through by troupe members and are rewound to pivotal decision points in the action. Participants are invited to brainstorm alternative decisions and act them out. Phase III (weeks 18 to 22) focuses on integrating lessons learned and application to everyday life.

> ***The thing about performance, even if it's only an illusion, is that it is a celebration of the fact that we do contain within ourselves infinite possibilities.***
>
> **—Daniel Day Lewis**

For the past 20 years, I have been a therapist, but for the 20 years prior (starting at age 5), I was an actor. Through the exploratory study of TD, I hoped that my "insider" actor/therapist knowledge might enable me to crack the tough nut of finding a way to study drama as a treatment for complex trauma. It seemed to me that if I could identify a simple matrix of relevant variables, with which to probe drama's characteristics, processes, and effects, that standardized variable matrix might be able to be used by researchers across cultures and settings. Data from smaller *(cont.)*

samples could then be combined into larger data sets. Those larger data sets might support statistical modeling capable of revealing how and for whom drama facilitates complex trauma healing. Consequently, my mixed-method study of TD (Sullivan, 2021) cross-compared three levels of data: physiological heart rate variability data, eight standardized psychological questionnaires, and phenomenological interviews.

TD appeared to be what I call a Smart Intervention, meaning that TD appeared to partner with the innate healing potentials of the participant's system to find hidden treatment targets and to dose challenges intuitively and in manageable chunks (Wickelgren, 1979). The conditions of TD's group milieu activated a subliminal Seek and Find mechanism within participants, which was able to locate the diffuse, non-verbally encoded, preverbal somatic and emotional treatment targets that were most relevant to the particular individual. TD then appeared to find successive treatment targets in a sequence up the developmental ladder. Automatic personalization via the Seek and Find mechanism appeared to be TD's potentially generalizable characteristic -- a developmental process (rather than a symptom outcome), which seemed to render TD capable of delivering differentially targeted personalized medicine in the group milieu. The International Trauma Questionnaire (ITQ [Cloitre, Bisson, et al., 2018; Cloitre, Shevlin, et al., 2018]), developed to evaluate the new CPTSD criteria and not available in time for the TD study, might provide evidence of change via the Seek and Find process. In addition, longitudinal brain imaging of the default mode network (DMN) at rest may show physical evidence that the Seek and Find has done its work. The DMN is a cortical network along the brain's midline that is involved in self-referential and autobiographical memory and which, when people are at rest, is responsible for providing a stable and continuous sense of self. A recent series of papers has described lack of activation in the DMN of the brain, as revealed through fMRI that exists in conjunction with a lack of sense of self when at rest in survivors of childhood trauma (as opposed to healthy controls who exhibit the opposite patterns [Lanius et al., 2020; Terpou et al., 2019, 2020; Thome et al., 2019]). TD findings taken together with the findings of those papers suggest that participants impacted by TD might show progressively greater activation of the DMN at rest as they started to develop a greater sense of self through TD's processes.

TD leveraged the handed-down *folkways* of theatre (egalitarian culture, skills, and beginning-middle-ending structure), along with theatre games and improvisations, to provide a predictably safe environment. Actors/facilitators and participants formed critical bonds that were trusting, behaviorally self-disclosing, and intimate, yet well contained within the special conditions of group time in the theatre space (apparently avoiding some of the relational confusion that might occur when working with complex-trauma-exposed populations [Courtois, 2021]). TD interspersed fun and play with serious topics. Troupe members and participants alike considered TD to be emotionally challenging work; they looked *(cont.)*

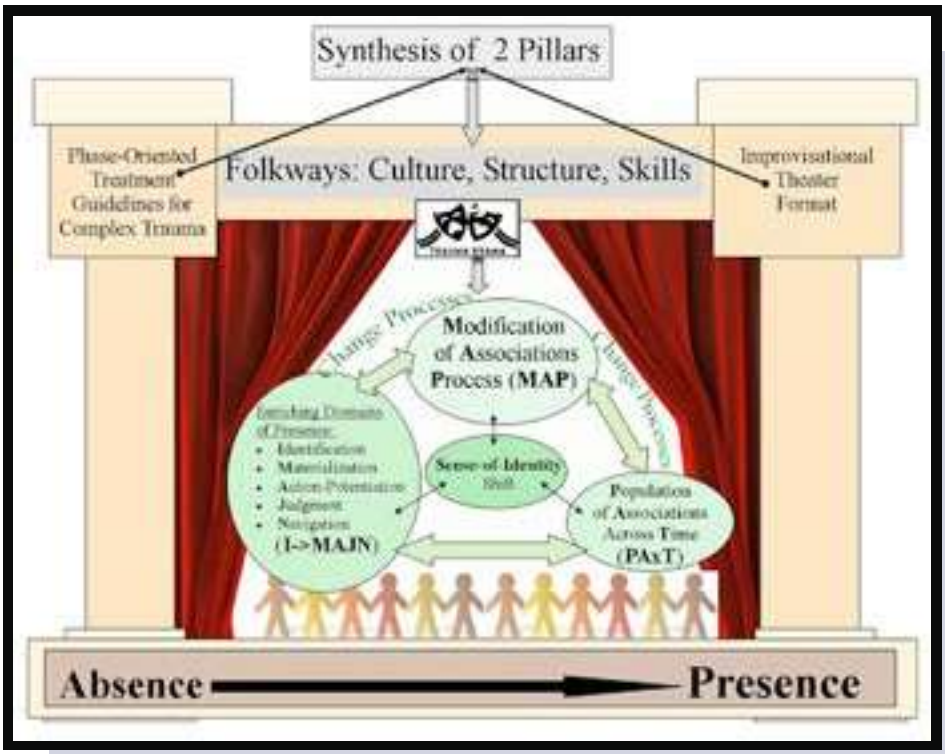

FIGURE 1 QUALITATIVE CONSTITUENTS & PROCESSES OF THE TRAUMA DRAMA EXPERIENCE

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forward to TD sessions as rewarding and empowering "Fun Mondays." For instance, Bond, one of the TD study participants, reported that following TD group sessions, he had felt unburdened and connected:

> It's not like a paperwork thing. It's not something like, 'I'm going to sit in an office for an hour and just talk about myself.' No. You learn from current things, old things, things that are day-to-day, things that you might walk down the street and find. But no one gets hurt. No one's in trouble. It might feel awkward and uncomfortable, but you're learning and you're growing. And that's the therapy. You deal with it because you know you're going to learn from it, and no one's getting hurt. It's dramatizing…not traumatizing. You just go there, and you have fun, and you come home. You don't really think on it too much, but you know in the back of your head, okay, people are in the same shoes and we feed off each other and are able to learn together and teach each other. That's kind of what this group is.

Another of TD's processes that facilitated change was the Modification of Associations Process (MAP). The MAP appeared to modify, update, and diversify associations that had been previously fixated by trauma. Through repeated occurrences of the MAP – and the consequent updating and expansion of previously fixated associations – participants pivoted away from Absence to a greater sense of Presence to self, others, and the world. Trauma-bound associations that had anchored a pervasively negative sense of self and isolation from self, others, and the world loosened and changed. The MAP may be thought of as leading people through the following seven steps: 1) grounding into the safe routine and ritual of the session; 2) up-regulating arousal during games or scenes; 3) being surprised by an activity or idea that challenged trauma-related associations to self, others, and the world; 4) risking thinking and/or acting differently because of the surprise; 5) discovering a new way of thinking/behaving as a result of having taken a risk; 6) down-regulating arousal in the wake of discoveries; 7) integrating new discoveries into everyday life (see Figure 2). I will apply the surprise, risk, and discovery steps to Taisha's quote below.

> I would feel very isolated. …I was actually very embarrassed and ashamed. I thought I was the only one that would go through really difficult things, and I would get my anger out on them. …I tried helping myself out, and I just got stuck. …But then I realized they've been through many situations that were similar to mine. Like I said earlier, I'm comfortable talking about situations like that [now] because I know that I'm not alone with it. You take the thing that's still really sad . . . like I said; you still have people that help you through it. …You can actually help each other. …It's really helpful because you might need that in life.

Taisha was surprised that she was not the only one to be embarrassed and ashamed. She risked identifying with others, and via that risk, she discovered that she was not alone and could get support from and give support to others. This represented a change in self, other, and worldview. The MAP weakened Taisha's associations to negative self-perceptions. Connection and identification with helpful others became associated with the *(cont.)*

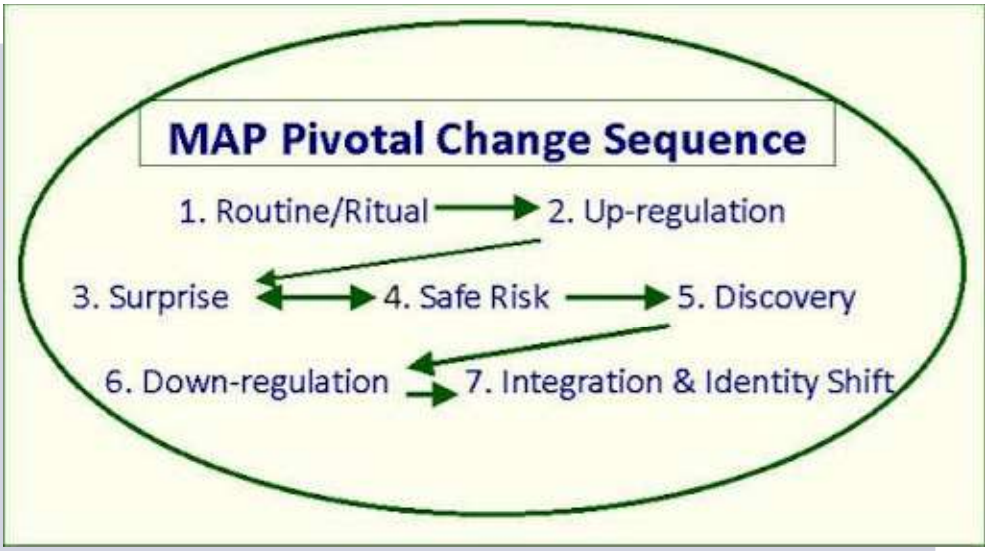

FIGURE 2 MODIFICATION OF ASSOCIATIONS PROCESS (MAP)

Note. Through the Modification of Associations Process (MAP), a primary mechanism-of-action/change process of TD, participants shifted from a state of Absence to a state of greater Presence. Multiple iterations of the MAP reorganized and expanded associations undergirding subjective experience of self, others, and the world. (Reprinted from Sullivan et al., 2019)

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possible affordance of relaxation, comfort, and protection as opposed to being primarily associated with inherent danger.

Another clear finding of the TD study was the critical importance of the Phase I stabilization component of TD's sequenced treatment in impacting Disturbances of Self Organization (DSO) and its factor clusters of emotion dysregulation, negative self-concept, and interpersonal problems as described by the new CPTSD diagnosis (Cloitre, 2020). TD's Phase I, with its focus on trusting, egalitarian relationships and reciprocity, reduced participants' negative sense of self, improved their perspectives on interpersonal relationships, and provided practice of emotional regulation skills via play. Participants named these gains as a prerequisite to their willingness to start TD's Phase II, which more directly addressed CPTSD factor clusters. A multi-time-point longitudinal study, using the ITQ might help validate and legitimize phased treatment for CPTSD and might also help to assess the contribution of each treatment phase to outcomes.

Although TD provided some potentially generalizable process outcomes across participants, it produced symptom outcomes that differed by particular physiological subtypes/phenotypes. I found three subtypes by examining shifts in nervous system balance over time as reflected through high frequency heart rate variability (HF HRV) electrophysiological data. The first subtype, Calming Down, showed arousal at pretest and nervous system balance at posttest. The second subtype, Waking Up, exhibited an immobilizing level of calm at pretest and an awakened level of arousal at posttest. The third subtype, Sowing Seeds, exhibited nervous system balance at pretest and an excessive calm at posttest. Each subtype showed unique and somewhat unanticipated patterns of symptom change over the course of the intervention. To illustrate, I will describe the symptom pattern of the Calming Down subtype – which, although carrying the highest cumulative trauma load – achieved the greatest nervous system balance of the three subtypes by the end of the TD treatment and was responsible for most of the statistically significant decrease in depression. Yet Calming Down showed a worsening in executive function symptoms. That mixed picture of recovery-in-progress makes sense. If, as my study suggests, TD diversified previously stuck patterns of neural connectivity, a messy period of more chaotic thinking might precede the settling down of the brain to a new order. It could be that patterns of improvement in certain symptoms, as well as an exacerbation (or transient exacerbation) in other symptoms, might be indicative of a growth/recovery trajectory and these patterns might differ by subtype/phenotype.

NATURALISTIC INTERVENTIONS LIKE DRAMA APPEAR TO HAVE THE POTENTIAL FOR TREATING COMPLEX TRAUMA

—SULLIVAN

Naturalistic interventions like drama appear to have the potential for treating complex trauma. They are simple yet complex in their capacity to interact differentially according to a person's specific needs. As such, drama as a treatment has previously defied systematic and methodical study. I have begun to identify a simplified matrix of variables and a method that may be used across cultures and treatment settings *(cont.)*

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in order to aggregate a larger data set on which statistical modeling can be used: a) to refine variables for the study of naturalistic treatments, b) to uncover different typological healing paths, and c) to identify helpful components of naturalistic treatments that might be added to existing therapies in order to increase effectiveness. In order for drama interventions to be broadly disseminated and funded, it is necessary to produce legitimate evidence of effect.

As I finish this article, Putin has invaded Ukraine, and refugees are streaming across borders. This reminds me that not only do we need adaptable, effective, and non-pathologizing CPTSD treatments for developmental trauma, but also for refugee populations affected by complex trauma. ∎

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Dr. Mimi Sullivan obtained the Doctor of Philosophy in Social Work from Widener University in 2021 and holds a Bachelor of Fine Arts in Theatre from The Catholic University of America in Washington, DC. Sullivan has co-authored a textbook chapter on the treatment of psychological trauma and has served as an Adjunct Assistant Professor at Widener University in the Center for Social Work Education (designing and teaching graduate-level coursework on trauma treatment, and co-writing a syllabus that has been used as a cross-institutional trauma-treatment course template disseminated by the Council on Social Work Education and the National Center for Trauma Education and Workforce Development). Sullivan's private psychotherapy practice in Haddonfield, NJ, is focused on addressing issues related to complex posttraumatic stress, in particular the neuro/bio/psycho/social impacts of interpersonal/intimate partner coercive control and other forms of psychological, emotional, and/or physical abuse/oppression. She has spoken widely on the cumulative impact of interpersonal trauma on the mind, body, and spirit, as well as on becoming free from abuse and its effects. Sullivan is working to create templates for practical field studies that accurately capture the effect of drama and other creative arts interventions on healing, when conducted by clinicians in the treatment setting. She was formerly a professional actor and member of the Actors' Equity Association (AEA) and the Screen Actors Guild-American Federation of Television and Radio Artists [SAG-AFTRA]). She has appeared in theatre, on television, and in film.

References

- Cloitre, M. (2020). ICD-11 complex post-traumatic stress disorder: Simplifying diagnosis in trauma populations. The British Journal of Psychiatry, 216(3), 129–131. https://doi.org/10.1192/bjp.2020.43
- Cloitre, M., Courtois, C., Ford, J., Green, B., Alexander, P., Briere, J., Herman, J., Lanius, R., Pealman, L. A., Stolbach, B., Spinazzola, J., van der Kolk, B. A., & van der Hart, O. (2012). The ISTSS expert consensus treatment guidelines for complex PTSD in adults. International Society of Traumatic Stress Studies. Retrieved from https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf
- Cloitre, M., Bisson, J. I., Brewin, C. R., Hyland, P., Karatzias, T., Lueger-Schuster, B., Shevlin, M. (2018). International Trauma Questionnaire - Child and Adolescent Version (ITQ-CA) [Measurement instrument].
- Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., Hyland, P. (2018). The international trauma questionnaire: Development of a self-report measure of ICD-11 PTSD and complex PTSD. Acta Psychiatrica Scandinavica, 138(6), 536–546.
- *Courtois, C. (2021). Clinician's corner: Best practices in relationship-based treatment of complex trauma. Complex Trauma Perspectives, 1(3), 3–6.*
- *Kisiel, C., Blaustein, M., Spinazzola, J., Schmidt, C. S., Zucker, M., & van der Kolk, B. (2006). Evaluation of a theater-based youth violence prevention program for elementary school children. Journal of School Violence, 5(2), 19–36. https://doi.org/10.1300/J202v05n02_03*
- *Lanius, R. A., Terpou, B. A., & McKinnon, M. C. (2020). The sense of self in the aftermath of trauma: Lessons from the default mode network in posttraumatic stress disorder. European Journal of Psychotraumatology. https://www.tandfonline.com/doi/abs/10.1080/20008198.2020.1807703*
- *Spinazzola, J. (2019). Trauma Drama: Twenty-two session intervention manual (3rd ed.). Complex Trauma Institute.*
- *Sullivan, M. (2021). Revising the Script: Mixed-Method Study of Trauma Drama for Complex-Trauma-Exposed Youth in Residential Treatment. Doctoral dissertation. Widener University. https://www.proquest.com/openview/157bc8d009545f4d46497efa3cb53ba4/1?pq-origsite=gscholar&cbl=18750&diss=y*
- Sullivan, M., Spinazzola, J., & Young, T. (2019, November). Rewriting the score: Trauma Drama with youth exposed to complex trauma [Poster presentation]. International Society of Traumatic Stress Studies, 34th Annual Meeting, Washington, D.D.
- Terpou, B. A., Densmore, M., Théberge, J., Frewen, P., McKinnon, M. C., Nicholson, A. A., & Lanius, R. A. (2020). The hijacked self: Disrupted functional connectivity between the periaqueductal gray and the default mode network in posttraumatic stress disorder using dynamic causal modeling. NeuroImage: Clinical, 27, 102345. https://doi.org/10/gj9pv7
- Terpou, B. A., Harricharan, S., McKinnon, M. C., Frewen, P., Jetly, R., & Lanius, R. A. (2019). The effects of trauma on brain and body: A unifying role for the midbrain periaqueductal gray. Journal of Neuroscience Research, 97(9), 1110–1140. https://doi.org/10/ggwh9g
- Thome, J., Densmore, M., Koppe, G., Terpou, B., Théberge, J., McKinnon, M. C., & Lanius, R. A. (2019). Back to the Basics: Resting State Functional Connectivity of the Reticular Activation System in PTSD and its Dissociative Subtype. Chronic Stress, 3, 247054701987366. https://doi.org/10/gkghs8
- Wickelgren, W. A. (1979). Chunking and consolidation: A theoretical synthesis of semantic networks, configuring in conditioning, S-R versus cognitive learning, normal forgetting, the amnesic syndrome, and the hippocampal arousal system. Psychological Review, 86(1), 44–60. https://doi.org/10/d9d6nt
- World Health Organization. (2018). ICD-11: International Classification of Diseases 11th Revision. https://icd.who.int/en/
- Zucker, M., Spinazzola, J., Pollack, A. A., Pepe, L., Barry, S., Zhang, L., & van der Kolk, B. (2010). Getting teachers in on the act: Evaluation of a theater- and classroom-based youth violence prevention program. Journal of School Violence, 9(2), 117–135. https://doi.org/10.1080/15388220903479628