Running Head: Teamwork and Trauma Recovery

TEAMWORK AND TRAUMA RECOVERY

Nancy Alexander, MSW, LCSW-C

5658 Thicket Lane

Columbia, MD 21044

nanwecan@comcast.net

Linda Ciotola, M.Ed., CHES (ret), TEP

4 Bateau Landing

Grasonville, MD 21638

linda.healingbridges@gmail.com

January 21, 2013

Trauma survivors are among the most challenging, frustrating and heart-wrenching populations in any treatment setting. Treating them has been associated with vicarious traumatization of the clinician (Neumann & Gamble, 1995). Diagnosed with everything from Borderline Personality Disorder to Dissociative Identity Disorder, their often intractable, unmanageable repertoires of 'acting out', self-destructive and demanding behaviors, causes many a well-intended clinician to refer these clients elsewhere. However we recognize they have developed a vast array of creative survival skills, making them well suited to psychodrama and the creative arts. As helpers, we feel overwhelmed (Figley, 1995) by their lack of insight, their regressions, chronic hopelessness, neediness, rage, their re-victimization and by their complicated, ambivalent transferences, which vacillate between love and hate, trust and paranoia, idealization and devaluation. Many of us wonder if we are 'cut out' to work with this emotionally demanding population. Should we do as many of our colleagues have done and refuse to treat them? Perhaps the better question here is "Am I cut out to work with this population alone?"

A team approach integrating psychotherapy and psychodrama brings an enhanced array of skills, knowledge and creativity to the treatment process (Lev-Wiesel, 2008). It provides the client with innumerable corrective emotional experiences, opportunities to concretize and integrate both horrendous life experiences and fractured ego-states in a safe consistent holding environment that is adaptive, pro-active and supportive. Our collaboration grew from a mutual interest in trauma work. One of us, rooted in psychodrama, using the Therapeutic Spiral Model (Hudgins, 2002), to help trauma survivors and the other, a psychotherapist specializing in trauma. Neurons fired and we embarked on our journey of collaboration. We are co-authoring this article in an effort to let creative dedicated clinicians know about this unique treatment approach, some of its fundamentals and its many benefits, for the client and for the clinician as well.

The Role of Trauma in the Trauma Spectrum Disorders

Trauma can be induced by many situations including war, crime, domestic violence, natural disasters and child abuse. It results from being personally exposed to terrifying experiences that involve actual or threatened death or serious injury, or witnessing an event that involves death, injury or threat to another person. The individual's response to the event involves intense fear, helplessness or horror. Most of the individuals in treatment with us are adult survivors of severe, complex and prolonged childhood trauma and carry diagnoses of Dissociative Identity Disorder and Posttraumatic Stress Disorder. Many have co-occurring diagnoses of Eating Disorders, Anxiety Disorders, Addictions and various personality disorders including Borderline Personality Disorder. All the clients we worked with have been in therapy for many years, many have had numerous psychiatric hospitalizations, many have had a history of suicide attempts and all of them present with high risk behaviors of some sort, whether by overt self-destructive actions like overdosing or cutting or slightly more subtle behaviors like gross violation of a diabetic diet or picking up strangers through internet sites.

The symptoms they report include recurrent, intrusive flashbacks, hallucinations, disorientation to time and place, inappropriate affect, memory loss, addictive behaviors, depression, anxiety, emotional detachment, misperception or distortion of reality, self-destructive behaviors and rituals, somatic disorders/body memories, distressing dreams, dissociative states, intense physiological distress and reactivity, feeling estranged from others, diminished ability to feel emotions, difficulty falling asleep or staying asleep, hyper-vigilance, exaggerated startle response, irritability or angry outbursts, difficulty concentrating or completing tasks, suicidal or homicidal ideation or behaviors. In short all of them have difficulty living their lives in a functional way and are distressed beyond what their current circumstances would warrant. As

Eugene O'Neill said in *A Moon for the Misbegotten,* "There is no present or future, only the past, happening over and over again, now." (O'Neill, 1970)

A central construct to consider when discussing trauma is the role of the brain. The brain is also central to understanding why psychodrama is so effective with trauma-induced disorders. When a person faces overwhelming trauma the brain absorbs information about the trauma and stores it in the limbic system (Van der Kolk, McFarlane, & Weisaeth, 1996). The limbic system is where sensations, emotions and non-verbal information are automatically stored. The body is then flooded with stress hormones, the fight, flight or freeze response takes over and when that happens cognition is blocked. The result is that the trauma experience stays stuck in the limbic system and because cognition is blocked the individual is unable to accurately process the traumatic events and make clear present-based sense of them. As long as the information is stuck in the limbic system body memories, flashbacks and dissociated affect, impulses and behaviors continue. Because psychodrama can address issues non-verbally if done properly it can provide a safe vehicle for accessing the trauma information stored in a non-verbal part of the brain and move it to the cognitive processing part of the brain where the information can be verbalized, accurately labeled and processed from a current day perspective.

The Fundamentals of Trauma-based Psychotherapy:

The core of reconstructive psychotherapy begins with the therapeutic relationship; it is the core of trauma recovery work (Greenberg, 1998). Without a strong positive psychotherapeutic bond nothing transformational can occur. Reparative work requires trust and empathy be established and maintained, it's a prerequisite before the client can internalize what body-psychotherapists call 'a body of trust' within the self (Ridge R. M., 1998). Cognitive-behavioral work and insight-

oriented work are both important components of trauma recovery but need to occur within a strong reparative relationship. The transference–counter-transference is that dynamic intersection that generates the energy for change. The client's emotional wounds occurred within some type of emotional bond that was violated and the individual cannot be fully restored unless healing occurs within the context of a reparative bond. J. L. Moreno asserted "we are wounded within relationship and we heal within relationship." (Moreno Z. T., 2010) Safety and consistency are essential and maintaining strong therapeutic boundaries is critical toward that end. Clients who have experienced abuse from an early age develop adaptive skills which disintegrate into dysfunction the result of which challenges the therapist's rules, boundaries and limitations. Clients may become preoccupied with ways to violate those boundaries and engage the therapist in non-therapeutic ways (Van der Kolk, Perry, & Herman, Childhood origins of self-destructive behavior, 1991). It is essential that the client recognize the repetitive emotional and behavioral patterns that regularly occur in their lives. By identifying their patterns and what triggers them the client takes a necessary first step toward symptom management. Guided imagery, music, relaxation or dissociative reduction techniques can be helpful in managing body memories or panic attacks (Blake & Bishop, 1994).

Beyond support and validation, beyond trust and understanding is the client's story. Every client has a unique story which has led to deeply ingrained patterns of behavior. Some patterns are overt and clearly identifiable but intra-psychic patterns are harder to identify. Because trauma memories are 'stuck' in the non-verbal part of the brain, psychotherapy alone may be inadequate because psychotherapy is word-based and trauma experiences are not (Van der Kolk, 1997). If the client cannot access the information or use words to describe what they are feeling, then what can be accomplished within the confines of that approach may be limited. The client may be

acting out but unable to explain why or produce enough information to describe their internal experience. It is in those swirling moments of instability that these clients become most difficult to manage and the therapist may begin to feel frustrated. At those times the therapist may resort to setting limits sometimes veiled threats, 'if you cut yourself I'll terminate with you' and the client's fear of abandonment rises along with their distrust; yet they have no better skills to manage their feelings or behavior than they did before. It is times like these that a creative team approach can move the stuck client and therapist to a higher level of competence (De Zulueta, 2006).

The Role of Psychodrama in Trauma Treatment:

Psychodrama is action based, expressive and creative. It allows the client to view past events from a here and now perspective and provides support while accurately labeling and processing trauma material. Because it is action based it is uniquely able, like other expressive therapies such as art and movement therapy, to access the non-verbal part of the brain and to transfer non-verbal material from that part of the brain to the cognitive processing part of the brain (Carey, 2006). It provides an opportunity for the client's inner world to be externalized and enacted, to be emotionally perceived, identified and understood, then to be remembered, repaired and re-internalized. When that happens the trauma memory can be stored in the cognitive part of the brain and sequentially organized along with other life events. This neutralizes its impact on the identity, perception and functioning of the trauma survivor.

One of the essential values of psychodrama is its emphasis on movement. In psychodrama it's not just tell me it's also show me, so the individual moves from sitting in a chair struggling for words to being able to communicate through often simple movements. Trauma memories are

contained in the brain and in the body. Through mindful breathing, (Springer & Rubin, 2009) movement and specific grounding techniques flashbacks can be controlled and the frozen dissociated client can find a way toward self-expression.

Psychotherapy and psychodrama are each rich and meaningful interventions but when used appropriately together they can provide a powerful forum for trauma recovery.

Essential Psychodrama Techniques Used in Collaboration:

The double is a special auxiliary role used in psychodrama. The double's function is to support the protagonist, client or the individual whose story is being enacted. While the double originated as a classical psychodramatic role, the art of doubling can enhance the therapeutic alliance to a greater degree than empathic, reflective or supportive listening (Hudgins, 2002). The clinician assuming the double role first explains the process and then asks permission to sit beside the client. The double always works towards establishing empathic attunement by doubling the client's breathing, posture, facial expression, gestures, verbalizations, and voice tone. The double forms a united front with the client to support the client in expressing unspoken inner feelings. The double speaks in the "I" as this inner voice of the client. Client is asked to repeat the statement if it is accurate or to correct it if it is not. So, even if doubling statement is inaccurate, it clarifies and furthers self-expression. This kind of doubling is called classical doubling. It is particularly helpful with clients who have *alexithymia* (Hudgins, 2002). There are two other types of doubling that are helpful in working with trauma survivors, the body double and the containing double. The body double, developed by the Therapeutic Spiral Model is used to decrease dissociation, and help people experience their bodies in a healthy state (Hudgins, 2002). The containing double also taken from the Therapeutic Spiral Model, balances cognition and

affect in an effort to help clients stay oriented to the present while working on trauma material (Hudgins, 2002). Types of doubling can be used by themselves, alternatingly or in combination with each other. Linda, co-author of this article, created the triple double, which interweaves all three types of doubling techniques from moment to moment depending on the client's needs. (Burden & Ciotola, 2002) (Ciotola & Hudgins, 2003)

Dr. Kate Hudgins who created Therapeutic Spiral Model tm defines the observing ego role as,"...a role in which people can neutrally observe and narratively label their behaviors." To make the term more user friendly for clients we call this the witness role, and teach the client its function, to allow them to give themselves neutral factual information about their thoughts, feelings, impulses and behaviors, without judgment. Once the witness role is internalized, it can be used at any time, enabling clients to step back from the trauma, view it a distance and then accurately label what occurred, something that did not happen at the time of the trauma. During a psychodrama the client can be role reversed into the witness role*,* as needed. role reversal occurs when participants exchange roles either interpersonally or intra-psychically.

De-roling occurs at the end of each drama to clear auxiliaries and props of any energy, feelings, projections or issues that were assumed during the drama. Each psychodrama ends with sharing*;* this unique event follows each drama wherein all participants share how the drama related to them. The personal information shared, relates to the work that just occurred and helps the client feel understood and empathically connected with the psychodrama team.

Following each drama the protagonist or client is asked to create a project of integration. These projects concretely express and record the drama's meaning. Linda describes it this way "…trauma has hard-wired the brain and body to hold on to a particular belief system, to ways of

reacting, to ways of being with self and others. ...like a mosaic whose pieces have been arranged in a particular pattern, psychodrama takes the old configuration apart and reorganizes traumatic experiences in a new way. But for a little while, those newly configured pieces are sort of up in the air and not glued together. The project of integration glues the transformed pieces together." A project of integration can be as simple as a one page collage or as complex as a power point presentation, it must include words and images in order to integrate right and left brain functions. Psychodrama integrates feelings and visual images contained in the limbic system with cognitive processing of the cerebral cortex; this allows the client to combine both types of memory and move forward. We encourage clients to complete their project of integration within 48 hours of the drama. This is because the brain tends to revert to old patterns before the new one gets glued in. The project is then shared with the therapist and psychodramatist the following week to further anchor in the crucial learning. Many of the projects we've seen reflect the depth, beauty and creativity of these trauma survivors as they make meaning of their psychodramatic experience.

We find follow up email is especially helpful. From shortly after the drama until it is clear that the client has successfully journeyed through the process, email messages are exchanged between the psychodramatist, the psychotherapist and the client. These may answer questions about the client's experience, provide specific suggestions or information. Most importantly they maintain emotional connection and safe containment.

Three Ways to Combine Psychodrama and Psychotherapy:

Out of our collaboration we formulated three different approaches that unite psychodrama and psychotherapy.

Collaborative approach –the psychodramatist and the psychotherapist are both in session with the client at the same time. These sessions are uniquely structured so that each clinician has a distinct role. When the psychodramatist assumes The doubling role during an individual therapy session it helps the client to remain grounded, express feelings, deal with dissociated aspects of self and work more effectively with the therapist while remaining within what Bessel van der Kolk calls, the window of tolerance. (Van der Kolk, 2003) This means that there is enough stimulation of the limbic system to access the trauma material, balanced with enough containment to keep the client from being re-traumatized.

During collaborative sessions, the therapist remains in her "therapist role", interacting with the client as she would normally do, while the psychodramatist assumes the doubling role. The therapist and psychodramatist do not talk directly with one another at that time and the therapist refers to the psychodramatist as the client's double. Both the therapist and the double focus attention on the client. The process takes some getting used to but once mastered it works perfectly. The psychodramatist sits next to client, in the double position, both face the therapist and a usual therapy session takes place while the psychodramatist uses what we call the triple double, a composite of classical doubling to help clients access and express feelings, the TSM containing double to help balance affect with cognition and the TSM body double to help the clients decrease dissociation and remain in their bodies in a more grounded state. The moment to moment flow of the three kinds of doubling takes place according to the client's needs.

When working collaboratively, clarity about role, boundary and function is essential. With a client population where boundaries have been violated and roles were confused, it is essential that the role of the psychotherapist as primary and the role of the psychodramatist as auxiliary be clearly and consistently maintained. Through the years of working together not one single client ever seemed unclear about which of us was doing what. We each played meaningful roles in the client's recovery process and emotional life, but they were distinctive roles, complimentary and valuable but distinct.

Clients with histories of severe trauma disorder need to demonstrate grounding and containment skills and have basic trust in the therapeutic relationship before being introduced to psychodrama. They have to be able to abstract well enough to grasp the concepts necessary to engage in psychodrama and demonstrate a commitment to the recovery process which includes preventing re-traumatization, controlling regression, learning to identify and avoid shifts in ego-states, being able to differentiate and utilize both psychotherapy and psychodrama.

Case Example:

Janice is a 55 year old married professional woman who was sexually abused by her father until the age of 13 and was emotionally abandoned by her mother. She had numerous therapists and a long history of depression, suicidal preoccupation and several inpatient psychiatric hospitalizations for treatment of DID and PTSD; in addition she had alcohol and nicotine dependence. Janice exemplified Tian Dayton's observation that 'trauma and addiction go hand in hand.' (Dayton T. , 2000, p. xvii) Trapped in the painful cycle of trauma and addictions, being

frozen and mute, she was unable to access her strengths, name the traumas and begin healing. As Tian states, “giving words to trauma begins to heal it.” (Dayton T. , 2000, p. xvi)

Janice was introduced to psychodrama because during therapy sessions she was mute for long periods of time and when she spoke it was in whispers; she displayed abrupt shifts in ego states, evidenced by changes in cognition, point of view, manner of speech, body movements and facial expression; these varied dramatically from alter to alter, also called personalities or parts.

After introducing the double role to the client, explaining its function, and how she could accept or change any doubling statement, and could request an end to doubling at any time, the psychodramatist assumed the double role and began tuning in to the client's breath, posture, facial expression, and what the client was communicating energetically if not verbally.

Double: ‘I feel frozen’

Janice: (no response)

Double: ‘I cannot move’

Janice: (blinks and gives small head nod, but says nothing)

Double: ‘I cannot speak’ (double is also 'leading' the client at this point with a *Body Double* technique of long slow audible breaths to help give the parasympathetic nervous system the 'ok' to calm down)

Janice: (presses lips together)

Double: ‘My lips are sealed. I cannot talk about what happened to me’

Janice: (begins to cry)

Double: (using her own body to 'lead ' the client,) says ‘I can feel all four corners of my feet on the floor and look at Nancy and just let my tears be.’

Janice: (still crying, looks at feet and places soles of feet firmly on ground, says nothing)

Double: Says, (while raising eyelids to look at Nancy), 'I can raise my eyelids and glance at Nancy and know I am ok here in this moment.'

Janice: (raises eyelids to look at Nancy, is breathing more deeply in sync with double)

Double: 'I know I am ok in this moment' (if that's right repeat it, if not correct it.)

Janice: nods head and says, 'Am ok'

Double: 'I can choose when to speak' (if that's right repeat, if not, correct it)

Janice: nodding (double nods with her), 'I can choose'

Double: 'I have choice here'

Janice: 'I have choice here'

The client then started to tell her story while remaining grounded and present. At times, vignettes, defined as short psychodramas that can be very brief or expand as indicated (Dayton, T 2005), evolve during these sessions so that specific therapeutic issues or trauma components can be addressed. The psychodramatist may also be in the director's role and can use the triple double from the director's role to help pace the work in a safe way. Collaborative sessions are scheduled between regular ongoing individual psychotherapy sessions. i.e., client and therapist meet 3x a week and one of those sessions is collaborative and involves the psychodramatist.

Alternating approach – full length psychodramas are scheduled as needed in order to work on more complicated emotional issues. Individual therapy sessions are ongoing and used to help prepare the client for and develop goals for the dramas. The psychotherapist attends the dramas taking either a strength role e.g. courage or the witness role. In a psychodrama all participants are fully engaged serving to validate and support the client, broadening and strengthening the emotional safety net to include the entire psychodrama team who see, hear and feel the client's

story. A psychodramatic experience "…allows clients to feel deeply seen, deeply felt by another, guided safely through feared internal landscape, and also fosters a sense of mastery and authenticity…. Having an emotional experience that is shared, safe, and when processed to completion, results in clients feeling open, at peace, having a sense of clarity, self-compassion and wisdom, further strengthens the bond to the therapist which allows emotional processing to proceed to a yet deeper level." (Schwartz, Galperin, & Gleiser, 2009, p. 19)

In our collaboration the psychodramatist adapted and modified her experience from the Therapeutic Spiral Model tm to guide the process. Our team consisted of the psychodramatist, the psychotherapist and two highly trained psychodrama auxiliaries. On average, the time frame of about 6 hours was scheduled in a private setting to do the work. Before the protagonist/client arrived the team set up the room and held a team meeting which addressed issues to be cleared so that team members could be fully present. Following the drama, de-roling and sharing occurred and the client was assigned a project of integration. Following the protagonist's departure the team remained to process, close and cleanup.

During dramas, the witness role held by the therapist, who had largely been holding this role psychologically for the client all along, and often took notes while in role that were useful in the project of integration and in follow up therapy sessions. Those sessions were more effective since the therapist learned first-hand about the client's psychodramatic experience.
The psychodramatist joins the therapy sessions before every drama to determine needs and goals and returns after the psychodrama to review the client's experience, see their project of integration and formulate further goals to be accomplished.

Clarissa – is a 50 year old unmarried professional woman with a history of child abuse. She is the youngest of 8 children abused and intimidated by her alcoholic father and neglected by her frightened mother. Cast in the role of family protector from an early age she was taught to stand up to her father and take care of her mother. A bright child she did well in school, left home and worked her way through college becoming an executive at an early age. She entered therapy with complaints of forgotten sexual encounters and worried that she hurt people in her sleep. Once diagnosed with DID, we found that she had a complex system of alters, she worked actively in therapy, journaling and following assignments perfectly. After three years she integrated her system. It turned out that she had sealed over many of her symptoms because she didn't want to admit she was still having difficulties. Once psychodrama became a part of her trauma treatment regimen, she found a place of freedom and self-expression. The approach we used with her was the alternating method. Individual therapy sessions were alternated with periodic full length psychodramas.

The contract for Clarissa's first private psychodrama was to eliminate the 'wall of pain.' This is something that occurred when one of her alters, 'Tom', felt the need to protect her by creating pain in the form of excruciating headaches and body pain. One auxiliary was asked to hold the role of the 'wall of pain' while the other held the role of 'Tom' with Nancy in the witness role and Linda using the triple double from her director's role. And as the drama unfolded Clarissa and her alter realized that the 'wall of pain' was no longer necessary in the present and the alter in fact was a child part suffering role fatigue and Clarissa was an adult who could choose to handle her feelings and situations differently. This freed her alter from that role and allowed Clarissa to access her spontaneity and creativity. As a result the physical pain created by this part

ended and a sense of safety within the system was established. "For over 40 years I have tried to break through the chains of the…'wall of pain' and now… it is gone"

<u>Combined approach</u> – an adequately trained clinician can assume both roles simultaneously during one session. Props concretize roles for both the therapist/director and the client and expand role options when no auxiliaries are present. Once the client is familiar with these processes role changes can occur seamlessly.

<u>Case Example:</u>

Suzie – a 46 year old single professional woman with a history of emotionally vacant relationships, presented with low self-esteem, anxiety, obsessive compulsive disorder and a sleep disorder. She sought therapy primarily because of a pronounced decrease in her ability to function at work and because she had become entangled in a dysfunctional romantic relationship and was unable to integrate her perception of it. She idealized 'Mike' and focused on every tiny exchange they had and yet had amassed a mountain of evidence that he was dishonest about his interest in her and activities with other women. Her internal battle about his truth and her hope was all consuming. Every incident intensified her focus and diminished her ability to think clearly and perceive accurately.

Therapy sessions had been reduced to yes buts and compulsive reiterations of each miniscule exchange. Though she could see and hear what the therapist reflected back to her she couldn't let go of him and her behavior was continuing to disintegrate.

Our first psychodrama à deux, psychodrama in which only the director and protagonist are present, began by asking Suzie to write her strengths on yellow sticky notes posted around the office. Strengths were integrated in action with the help of doubling done from the director's

role. Then Mike's positive and negative qualities were concretized in two scarf piles allowing the protagonist to identify each quality and its impact on her. When she chose a dark splotchy scarf to represent his lies and she wrapped that scarf around her head and over her face and said 'his lies are all around my head.' The doubling statement was 'his lies blur my vision and cloud my judgment. I just can't see through them." She repeated "yes, his lies are blinding me." Once his negative qualities were addressed, doubled and deepened, a photo was taken with her cell phone to help her remember what it was like to be wrapped up in 'Mike's' negative qualities. She was then directed to dispose of the scarves in whatever way seemed right to her, making a clear statement about the quality the scarf represented and how she planned to address that quality. Some were thrown in the trash, i.e. "I'm tossing your lies in the trash" and some were stomped on. Following the drama she experienced a shift in her feelings about him and was eventually able to disengage from the relationship.

Warming Up to Collaboration:

The first stage of the collaborative warm up is an interest in working differently and beyond one's usual scope starting with the therapist's willingness to expand into the world of psychodrama. The psychotherapist has to see the value in both approaches. Psychodramatists are more inclined toward thinking about collaboration since that modality is more group oriented by definition. Once the therapist learns about psychodrama and sees its value, there is a learning stage. Psychodrama is not just psychotherapy with movement, art or music. Psychodrama is an independently recognized field; created by J L Moreno during the 1920's (Moreno J. L., 1977), it

was designed to have many applications including recovery from trauma. It has a well-developed theory, techniques and credentialing process.

Once the therapist has become sufficiently familiar with psychodrama, the next step is the decision to share the client with another professional, to encourage the client to engage in psychodrama, to become familiar with those techniques and experiences. One of the most powerful side effects of working in tandem is that the client is provided with an opportunity to experience the relationship between the psychotherapist and the psychodramatist (De Zulueta, 2006). For individuals who have spent their lives in a world where people are in conflict, experiencing their treatment team demonstrate cooperation and good communication, show mutual support and have honest exchanges even if there are disagreements is often an amazing experience for clients. Often before or during a psychodrama ideas are openly brain stormed, even differences of opinion are valued and explored openly and without conflict.

Summary:

In summary, the collaborative work between psychotherapist and psychodramatist is beneficial because roles are mutually reinforced and clinicians feel supported in working with this complex and stressful population. We have received consistent feedback from protagonists about the safety and connection they have felt from having the exact same psychodrama team for each of their psychodramas. They felt that the team sharing and constancy of their dedication provided a unique opportunity to trust and be validated for the first time in their lives. These deeply personal experiences allow them to reformat their early attachment experiences (De Zulueta, 2006). One client affirms the process by saying "Now I am authentic…spending more time with people and less time alone and isolated… I am grateful and so very happy for being able to have these

experiences. I didn't even know people could feel like this." And another client says [through psychodrama]... "I found my voice and was honest in a way I have not been before. I can't express in words what a transformation it is. What you do is miraculous!"

References

Bien, T. (2006). *Mindful therapy: A guide for therapists and helping professionals.* Somerville, MA: Wisdom Publications, Inc.

Blake, R. L., & Bishop, S. R. (1994). The bonny method of guided imagery and music (gim) in the treatment of post-traumatic stress disorder (ptsd) with adults in a psychiatric setting. *Music Therapy Perspectives, 12*(2), 125-129.

Blatner, A. (2000). *Foundations of psychodrama: History, theory, and practice* (4 ed.). New York, NY: Springer Publishing Company, Inc.

Block, S. H., & Bryant Block, C. (2010). *Mind-Body workbook for ptsd: A 10-week program for healing after trauma.* Oakland, CA: New Harbinger Publications, Inc.

Burden, K., & Ciotola, L. (2002). The Body Double: An Advanced Clinical Action Intervention Module in the Therapeutic Spiral Model tm to Treat Trauma.

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

Ciotola, L., & Hudgins, K. (2003). The Body Double an Experiential Model for Eating Disorders.

Dayton, T. (2000). *Trauma and Addiction.* Deerfield Beach, Florida: Health Communications, Inc.

Dayton, T. (2005). *The Living Stage.* Deerfield Beech, Fla: Health Communications.

De Zulueta, F. (2006). The treatment of psychological trauma from the perspective of attachment research. *Journal of Family Therapy, 28*(4), 334-351. doi:10.1111/j.1467-6427.2006.00356.x

Greenberg, L. S. (1998). *Handbook of experiential psychotherapy.* New York, NY: The Guilford Press.

Hudgins, M. K. (2002). *Experimental treatment for ptsd: The therapeutic sprial model.* New York, NY: Springer Publishing Company, Inc.

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

Lev-Wiesel, R. (2008). Child sexual abuse: A critical review of intervention and treatment modalities. *Children and Youth Services Review, 30*(6), 665-673. doi:10.1016/j.childyouth.2008.01.008

Moreno, J. L. (1977). *Psychodrama.* Beacon, NY: Beacon House, Inc.

Moreno, Z. (2012, May 12). Wife of J L Moreno and co-developer of MOrenian Arts and Sciences. (L. Ciotola, Interviewer)

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy: Theory, Research, Practice, Training*, 341-347.

O'Neill, E. (1970). A Moon for the Misbegotten. In E. Rinehart and Winston, *A Treasury of Theater from Isben to Lowell* (p. 690). New York : Rinehart and Winston.

Ridge, R. M. (1998). Rebuilding the body of trust. *The Center for Experiential Learning (Charlottesville, VA), Newsletter*(Winter).

Schwartz, M., Galperin, L., & Gleiser, K. A. (2009, March 13). *Attachment as a mediator of eating disorder: Implications for treatment.* Retrieved from Castlewood Treatment Center for Eating Disorders: http://www.castlewoodtc.com/wp-content/uploads/2011/07/attachment_as_a_mediator.pdf

Springer, D. W., & Rubin, A. (2009). *Treatment of traumatized adults and children: Clinician's guide to evidence-based practice.* Hoboken, NJ: John Wiley & Sons, Inc.

Van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harford Review of Psychiatry, 1*(5), 253-265. doi:10.3109/10673229409017088

Van der Kolk, B. A. (1997). The psychobiology of post-traumatic stress disorder. *Journal of Clinical Psychiatry, 58*, Suppl. 9.

Van der Kolk, B. A. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics, 12*, 293-317.

Van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society.* New York, NY: The Guilford Press.

Van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991). Childhood origins of self-destructive behavior. *The American Journal of Psychiatry, 148*(12), 1665-1671.

ACKNOWLEDGMENTS

We would like to offer our profound thanks to our dedicated auxiliaries, Connie Newton and Lisa Miller, both TSM Certified Trained Auxiliary Egos for their tireless devotion to this work and for their brilliance, creativity, warmth and loving support of our protagonists and our psychodrama team. Without them this work could not have been accomplished.

We would also like to offer our admiration and appreciation to all of our protagonists for their courage and their trust. It is because of you that we do what we do.

Nancy Alexander can be reached at nanwecan@comcast.net or at 410-730-8780
Linda Ciotola can be reached at linda.healingbridges@gmail.com or at 410-827-8324 or you can visit at her website at www.healing-bridges.com