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The impact of childhood trauma on intimacy: A literature review exploring Drama Therapy techniques for intimacy recovery in adult relationships.

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The impact of childhood trauma on intimacy: A literature review exploring Drama Therapy techniques for intimacy recovery in adult relationships.

Key words: *Drama Therapy, Childhood Trauma, Intimacy, Relationships, Trauma Treatment.*

Chapter Outline

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Chapter I: General Introduction

Background

Defining Intimacy and Relationships

As human beings we are arguably one of the most social species on the planet and have a fundamental need to be appreciated, cared for, accepted, and loved (Fitness, Fletcher & Overall, 2007; Fletcher, Simpson, Campbell & Overall, 2019). For many people, across sociocultural environments and influences, this extends to the goal of forming a long-term and intimate connection with another person in life – an endeavour which requires a significant investment of energy and time (Fletcher et al., 2019). Intimate relationships refer to varying forms of interpersonal relations, such as the parent-child relationship; however modern Western European societies tend to associate intimacy with romantic or sexual connections (Moss & Schwebel, 1993). Intimate partnerships between adults, within conventional Western standards of monogamy, was the primary focus of this research.

The study of intimate relationships forms a major domain of interest in social psychology with research ranging across numerous disciplines, such as anthropology, biology, sociology, and various subcategories within psychology itself (Fitness, Fletcher, & Overall, 2007). Intimacy stems from the Latin words *intimus* (innermost) and *intimare* (making the innermost known), and can be used to refer to feelings, modes of communication, sexual activities, behaviours, or relationships (Reis, 2018). It is both a natural and unbounded concept characterised by a set of features in a constant state of flux (Prager, 1995). With this, intimacy tends to overlap with other multifaceted concepts such as love, trust, affection, and familiarity (Derlega, 2013; Durnová & Mohammadi, 2021). Considering the broad associations with a superordinate term such as intimacy, it is necessary to distinguish intimate interactions from intimate relationships (Prager, 1995).

Within a particular time-and-space paradigm intimate interaction is grounded in the exchange of personal, subjective, and innermost experiences and the experiential by-products of this exchange (Prager, 1995; Derlega, 2013). These experiences can occur without words and outside established relationships (i.e., between strangers) (Prager, 1995). This provides a framework for communication and connection, which can take shape on emotional, intellectual, physical, spiritual, and experiential levels (Loggins, 2022). Relational intimacy is

therefore identified by frequent intimate interactions between people in a relationship, which is framed by a broader historical time-and-space paradigm (Prager, 1995). However, it is pertinent to note that within the parameters of any relationship, only a portion of interactions are intimate in nature (Prager, 1995).

Intimacy typically takes place in spaces that offer a sense of safety, closeness, and trust wherein individuals are able to feel recognised for their feelings and experiences (Durnová & Mohammadi, 2021). As a process of sharing and a relational exercise, intimacy is inherently collaborative and helps deepen our understanding of ourselves and others (Derlega, 2013). The benefits of these intimate interactions foster the feelings of acceptance, trust, love, and belonging, which satisfy human psychological needs (Derlega, 2013; Fletcher et al., 2019). Additionally, intimate relationships have been shown to improve both mental and physical health as well as contribute to greater relationship fulfilment (Loggins, 2022). Neuroimaging studies have further demonstrated that intimate interactions with others can be experienced as equally rewarding as primary appetite stimuli (Park et al., 2021).

However, despite positive correlations associated with experiences of intimacy, relationships are frequently and naturally met with obstacles, which may challenge and impair intimate interactions (Khaleque, 2004; Loggins, 2022). These hurdles are varied in nature and can include conflict, communication difficulties, stress, fear of intimacy, difficulties with emotional closeness, poor relationship satisfaction, substance abuse, exposure to trauma, and other forms of psychopathology (Khaleque, 2004; Park et al., 2021; Loggins, 2022). While this is not an exhaustive list of the difficulties that may be faced within a relationship, empirical evidence supports that the presence and severity of these later-life challenges are exacerbated by past childhood trauma (Mandelli, Petrelli & Serretti, 2015; Danese & Baldwin, 2017).

Exploring the Role of Childhood Trauma

Childhood trauma denotes an event or series of events that creates intense experiences of helplessness during development, which culminates in terror and feelings of instability, distrust, and insecurity (de Thierry, 2016). As indicated by de Thierry (2016: 15), “children become traumatised in any environment where fear is a theme”. For example, children who grow up in emotionally tense, anxious, angry, or restricted atmospheres – even when

observable violence and anger does not occur – develop coping mechanisms in response to handle their own emotions (Jaworska-Andryszewska & Rybakowski, 2019; de Thierry, 2016). This typically happens when parents and/or caregivers are unavailable, for a multitude of reasons, and the child has no adult to help guide them in processing feelings that materialise in response to challenging events (de Thierry, 2016).

Trauma affects children differently at particular stages of development with the effects also dependent upon the types of traumas experienced, genetic and environmental factors, and whether these circumstances are ongoing or not (Jaworska-Andryszewska & Rybakowski, 2019). Traumatic events during this developmental period can include neglect; emotional, physical, or sexual abuse; abandonment; death; exposure to domestic and/or community violence; medical trauma; ethnic cleansing; and war (Cook et al., 2005; Kliethermes, Schacht, & Drewry, 2014). According to Mills & Turnbull (2004), natural disasters tend to elicit less post-traumatic psychopathology as opposed to interpersonal trauma. Within this research context, the types of traumas explored were of an interpersonal nature. This refers to trauma that occurs within relationships, which are contextualised by trust, power, and responsibility (Norman et al., 2012).

With these variations identified above, the immediate and long-term consequences of childhood trauma are multifaceted and can vary significantly (Cook et al., 2005). However, studies suggest that exposure to severe stress during childhood can produce an "enduring systemic inflammatory response not unlike the bodily response to physical injury" (Danese & Baldwin, 2017: 517), which may adversely impact brain development. This has the potential to undermine personality development in addition to an individual's capacity to form and maintain healthy relationships (Khaleque, 2004; Kliethermes, Schacht, & Drewry, 2014). This has direct implications on one's ability to engage in meaningful intimate interactions and relationships, which are significant to the fulfilment of human psychological needs (Derlega, 2013; Fletcher et al., 2019).

Later risks of psychopathology, poor reactivity to stressors, substance abuse, and re-victimisation also increase with trauma exposure – particularly in the absence of treatment and nurturing home environments during childhood (Khaleque, 2004; Mandelli, Petrelli & Serreti, 2015; Danese & Baldwin, 2017). Considering the potential impacts of childhood trauma,

various existing therapeutic interventions have been developed to enable individuals to confront these experiences in later life.

Trauma Treatment in Adulthood

Most empirically validated trauma treatments tend to target individual symptoms on biological and psychological levels. Pharmacological treatments are often used in trauma treatment to mitigate the physiological impacts of post-traumatic stress, depression, and anxiety (Briere & Scott, 2015). Psychological interventions, on the other hand, usually focus on processing traumatic memories and developing coping and regulation skills (Briere & Scott, 2015). Numerous established therapeutic models facilitate this and psychological treatment frequently incorporates Cognitive-Behavioural Therapy (CBT), affect-regulation training, Dialectical-Behaviour therapy (DBT), and/or psychodynamic approaches (Cook et al., 2005; Briere & Scott, 2015). Within these approaches, treatment can be conducted in individual or group settings (Briere & Scott, 2015).

Due to the complex nature of early traumatic experiences and how these events may have compounded with other difficulties over the lifespan, therapeutic approaches need to be multimodal, directed toward behaviour change, and client-specific (Courtois, 2008; Courtois & Ford, 2012). However, despite advancements in trauma-related research and management, treatments available are typically expensive, inaccessible, and long-term (Su & Stone, 2020). Reliving one's experiences of trauma in therapy can also be a daunting and triggering process, which may influence an individual's commitment and feelings of safety within the therapeutic space. For example, many people with traumatic histories tend to struggle expressing their difficulties through language with what may feel incommunicable through words (Steele, Boon, & van der Hart, 2016). Thus, the therapeutic relationship serves as both a critical and inherently fragile component of the healing process (Courtois, 2008; Su & Stone, 2020).

The need for client-specific and multimodal therapeutic approaches, as indicated by Courtois & Ford (2012), highlights the necessity of supporting research into trauma treatments and techniques that go beyond what is currently emphasised (e.g. CBT, DBT). Furthermore, this calls attention to the exploration of interventions that provide adaptability. It is for these

reasons that I believe that Drama Therapy, which is a client-centred and experiential mode of treatment, is an approach worthy of exploration in this regard.

Drama Therapy and Trauma Treatment

As a therapeutic modality, Drama Therapy has been increasingly involved in the treatment of both individual and collective trauma with a wide variety of populations since its formalisation in the 1980s (Sajnani & Johnson, 2014). It is a distinct and versatile style of psychotherapeutic intervention in which performance, improvisation, art, interaction, play, and dramatisation form the foundation of the healing process (Bourne, Selman, & Hackett, 2020). This is achieved through the facilitation of symbolic expression via creative structures (Landy, 1994). Embodiment, improvisation, role-play, and the distance afforded by projection and metaphor, can be applied interchangeably in an effort to meet client needs and enhance change on cognitive, behavioural, relational, and affective levels (Landy, 1994; Malchiodi, 2022).

Drama therapists can draw from various paradigms to support their work in trauma treatment (Miholić & Martinec, 2013; Sajnani & Johnson, 2014). For example, some approaches are largely expressive and work directly with elements of traumatic material, while other techniques address trauma from a more distanced perspective (Sajnani & Johnson, 2014; Landy, 1994). There are numerous processes, which facilitate the efficacy of Drama Therapy (Frydman & McLellan, 2014; Jones, 1996; Landy, 1994; Leather & Kewley, 2019). This can include but is not exclusive to: dramatic ritual (Emunah, 2013); Neuro-Dramatic Play (Jennings, 2011; Holmwood, 2021); the Sesame Approach established by Marian Lindkvist (Casson, 1997); the Role Method (Landy, 1994); Bibliotherapy (Lahad, 2009, 2012; Johnson, Pendzik & Snow, 2012); Narradrama (Dunne, 2009; Bezuidenhout, 2012); Psychodrama (Dayton, 2005; Moreno, 1941); the Five Phase Model and Self-Revelatory Performance (Emunah, 2013); Developmental Transformations (Johnson, 2009, 2014); and the Nine Core Principles of Drama Therapy as identified by Jones (1996).

With regard to trauma treatment, Drama Therapy has already made several unique contributions. These include: the collaborative nature of the relationship between client and therapist; identification of traumatic material through the use of theatrical techniques, which moderates distance from the event(s); emphasis on imaginal exposure (which is also

incorporated in CBT); engagement of the body; extensive trauma processing through role exploration; and the recovery of pleasurable activities through play (Sajnani & Johnson, 2014; Malchiodi, 2022). As a discipline that is grounded in its use of spontaneity, flexibility and co-creation, Drama Therapy utilises tools that stimulate connection (Malchiodi, 2022). This adaptability also makes Drama Therapy effective regardless of age, ability and background (Godfrey & Haythorne, 2013).

Considering that Drama Therapy is a flexible and client-centred intervention, it is my opinion that many of the techniques utilised within trauma treatment provide a distinct and supportive form of therapy, which can promote intimacy recovery in adult relationships. This is significant to the aforementioned notions regarding intimacy, which highlight the influence of intimate interactions and relationships on mental and physical well-being (Derlega, 2013; Loggins, 2022).

Rationale

This research report is pertinent across various domains. Throughout the human lifespan, people develop relationships as a means to receive and provide social support, contribute time, lend knowledge and skills, and impart encouragement – all of which help us attain our goals (Orehek, Forest, & Barbaro, 2018). As social creatures, having close interpersonal relationships with others provides us with the belonging, influence, integration and fulfilment of needs, and shared emotional connection that is fundamental to our mental, emotional, and physical health (McMillan & Chavis, 1986). This is demonstrated further by bodies of research, which indicate significant associations between adult intimate relationships, quality of life, longevity, and psychological adjustment (Khaleque, 2004). With this, the attainment of healthy relationships and partnerships is pertinent to our human welfare.

In the absence of these connections, people become more vulnerable to loneliness, depression, anxiety, substance abuse, and a variety of physical ailments, such as impaired immune capacities (Ditzen, Hahlweg, Fehm-Wolfsdorf, & Baucom, 2011). Unhappy relationships pose similar risks wherein the repeated activation of the psychophysiological stress systems compromises the individual health of both partners (Ditzen et al., 2011). Perpetual discord in intimate partnerships, whether a couple is married or not, inhibits personal and professional

functioning, disrupts mental and physical health, and fractures children's development (Karney, Bradbury, & Lavner, 2018). Thus, intimate partnerships have a direct impact on the parent-child relationship. To quote Karney, Bradbury & Lavner (2018: 33), "to the extent that stable, satisfying adult relationships provide a supportive environment for all family members to thrive, promoting such relationships is an enduring and worthwhile goal of social policy".

According to the World Health Organisation (WHO, 2023), it is estimated that approximately 1 billion children, between 2–17 years old, have experienced physical, sexual, or emotional violence or neglect in the past year. Similarly, child abuse is the third leading cause of death in children between 1 and 4 years of age, while 3 in 4 children regularly suffer physical or psychological abuse at the hands of parents and caregivers (Kodner & Wetherton, 2013; WHO, 2023). Child maltreatment is a serious global concern, posing severe lifelong consequences. However, despite recent national surveys in several developing countries the data is still lacking (WHO, 2023). Similarly, studies guiding the best means of prevention and management are insufficient (Kodner & Wetherton, 2013; WHO, 2023).

Although numerous factors may increase the risk of child maltreatment, certain features of the relationships within families or among intimate partners can put children in even more jeopardy of behavioural, physical, and mental health problems as adults themselves (Danese & Widom, 2020). Qualities and behaviour patterns of parents and caregivers that may increase the risk of childhood trauma include: depriving the child of a nurturing environment; not bonding with the child during infancy; poor or unrealistic awareness of development; abusing alcohol or drugs; low self-esteem; lack of impulse control; untreated mental or neurological disorders; involvement in criminal activity; financial strain; and experiences of maltreatment as children themselves (WHO, 2023). What this reinforces is the importance of identifying tools that will help adults improve their intimate relationships and establish better environments for children to grow up in where caregivers are cognisant of their own tendencies, behaviours, and triggers.

Considering that interpersonal trauma occurs in relationships, it has the potential to impact future relationships. Thus, adults who have suffered from their own childhood trauma are at an increased risk of transferring their own trauma to their infants (Isobel et al., 2019). This is a distinct form of trauma known as intergenerational or transgenerational trauma, which is transmitted relationally across generations (Pember, 2016; Isobel et al., 2019). Intergenerational trauma is the process through which parents with unresolved trauma, by

means of interactional patterns, circulate their trauma to their children (Isobel et al., 2019). The result is the effects of trauma being experienced without the initial traumatic exposure (Isobel et al., 2019). The science of epigenetics supports this premise and proposes that along with DNA, "our genes can carry memories of trauma experienced by our ancestors that influence how we react to trauma and stress" (Pember, 2016: 3). However, these assertions have been contested in some studies reporting limited reproducibility (Gladish, Merrill, & Kobor, 2022). Regardless of this debate, the replication of trauma-informed behavioural patterns raises broader public health concerns and emphasises the cyclical impact that trauma inflicts on individuals and society at large.

While the difficulties of maintaining healthy relationships affect all couples, low-income couples are especially vulnerable due to environmental influences and a lack of supportive resources (Karney, Bradbury, & Lavner, 2018). In South Africa for example, and on account of colonialism and Apartheid, wherein poverty is structurally integrated, a substantial portion of public capital went to the white minority (Mayekiso & Tshemese, 2007; Obuaku-Igwe, 2015). This left an inordinate number of people and groups – particularly within black communities – with substandard access to resources, which is still apparent today (Mayekiso & Tshemese, 2007; Moodley & Ross, 2015; Williamson et al., 2017). In addition to the social, health, and educational consequences of traumatisation in childhood, there is also an economic impact (Danese & Widom, 2020; WHO, 2023). Examples of this include the costs of hospitalisation, mental health treatment, child protection, long-term health expenditure, and legal action (Berkowitz, 2017; Danese & Widom, 2020).

Medical care, quality of education, and access to water and electricity are among many of the disparities that continue to be structured along racial lines in South Africa (Duncan et al., 2007; Obuaku-Igwe, 2015; Gordon, Booysen, & Mbonigaba, 2020). What this calls attention to is the fact that the most vulnerable couples struggle because socioeconomic challenges can limit their livelihood and exacerbate relationship strain (Karney, Bradbury, & Lavner, 2018). Due to this it is important that the therapeutic modalities dedicated toward the treatment of trauma are accessible and diversified in terms of the theoretical and practical knowledge from which the mediums draw upon. Furthermore, it points to the significance of contextual analysis in the ways in which psychosocial problems and mental illnesses are understood (Duncan et al., 2007). Gender-based and intimate-partner violence is another crucial concern with this research. Rife in South Africa. There is an interplay of this in intimacy, trauma, and therapy

support. Although this research is not specific to the South African environment, it is significant to address these concerns in that they inform best means of prevention and practice.

What is evident through this exploration is the ways in which these broader issues are interrelated. The benefits of intimacy and close relationships with regards to human health are clear. However, what is also apparent is how the cyclical nature of interpersonal trauma has the potential to impede on these benefits – in addition to other consequences. This is evident in how aspects of the relationships within families or among intimate partners jeopardise children's development. These are emphasised on societal levels where low-income couples may be at further risk. Similarly, gender-based violence reflects the interplay between intimacy and trauma dynamics.

With the intention of preventing the cyclical nature of childhood trauma and mitigating its widespread impact, it is of the utmost importance that individuals are enabled to self-regulate, understand their traumatic experiences, and examine how they manifest in their relationships and daily lives (Berceli & Napoli, 2006; Magruder et al., 2017; Bowen et al., 2019). There are existing and scientifically supported psychological approaches, which are utilised in the treatment of trauma (Cloitre, 2015; Corey, 2021) as well as techniques dedicated to resolving discord between intimate partners (Solomon, 2003; Corey, 2021). However, research pertaining to the treatment of trauma with the intention of fostering intimacy is limited, despite evident correlations between the two notions (Khaleque, 2004).

Similarly, in the Drama Therapy field, there is little evidence indicating how the discipline could be utilised with the specific intention of fostering intimacy in relationships. Considering that Drama Therapy techniques are a versatile and effective means of navigating trauma (Sajnani & Johnson, 2014), it is my opinion that the modality can be applied to bettering intimate partnerships as well. I believe that the question of how Drama Therapy could facilitate this was also significant in broadening the scope of the literature reviewed specific to Drama Therapy in this research, and illustrating how the Arts Therapies continue to contribute towards needs within the fields of psychological and social welfare.

Research Questions

Main Question:

How may Drama Therapy techniques facilitate the recovery of intimacy in adults confronting past childhood trauma?

Secondary Questions:

- What are the impacts of childhood trauma?
- How does childhood trauma influence intimate experiences in adulthood?
- What Drama Therapy approaches may be useful in addressing childhood trauma and intimacy recovery?

Aims

The aim of this research was to explore how Drama Therapy techniques may assist in the recovery of intimacy in adults navigating varied effects of childhood trauma. In order to facilitate this inquiry, literature specific to the ways in which childhood trauma may manifest in adulthood was assessed. This was followed by critical exploration of the impact of childhood trauma on intimacy as well as existing treatment modalities in this regard. From this discussion, features of intimacy and the therapeutic interventions that emerged as significant to the recovery of intimacy were identified. This informed an integrative method of collecting and analysing literature on particular Drama Therapy approaches that may support these features of both intimacy and the therapeutic interventions addressed.

Chapter II: Theoretical Framework

Theoretical frameworks are utilised to ground and support studies through logical and connected groups of concepts, which are developed from theories (Varpio et al., 2020). Theories refer to a systematic sequence of interrelated statements and notions, which specify the ways in which multiple variables or propositions relate (Green, 2014; Varpio et al., 2020). This research is underpinned by Attachment Theory, which was developed by psychiatrist and psychoanalyst, John Bowlby (1969). This choice of theoretical framework informed what I looked for in the literature engaged with throughout this report. This helped me identify what I found meaningful or generalisable in the findings of this research (Green, 2014). In order to

substantiate this decision, the following discussion pertains to the foundations of Attachment Theory and its applicability to this research context.

Attachment Theory emerged as a major revision of the dominant psychodynamic theories of its time and was established by drawing on ethological research, systems theories (Moreno, 1941; Bronfenbrenner, 1979), and other developmental literature (Allen, 2011). Bowlby (1969) asserted that, as an evolutionary mechanism for survival, infants are wired to maintain closeness with caregivers when distressed and in need of care (Allen, 2011; Counted, 2017). While multiple attachments may be formed during this developmental period, empirical evidence strongly supports that infants show consistent preferences for proximity to one caregiver, which is usually the maternal figure (Hazan & Shaver, 1994). Within this framework, it is the responses of the primary caregiver to proximity-seeking behaviours of the infant that serve as determinants of the child's future behaviours (Allen, 2011).

Attachment is a behavioural system, which is activated by perceived threats (Ein-Dor & Hirschberger, 2016). The behavioural outcomes of this, such as proximity-seeking, thus increase the likelihood of support, protection and survival (Ein-Dor & Hirschberger, 2016). In other words, attachment behaviour is behaviour through which a specific, active, and affectional relationship is established with a person or object (Ainsworth, 1964). This tends to evoke a response from the object or person, and thus initiates a chain of interaction which reaffirms the affectional relationship (Ainsworth, 1964). In optimal scenarios children experience responsive, comforting, and sensitive caregivers (Allen, 2011). This culminates in the development of a secure attachment relationship between a child and their caregivers, which promotes coregulation and emotional communication (Galbally et al., 2022; Kliethermes, Schacht, & Drewry, 2014).

These consistent attachment representations allow for the development of a "secure base", which guides behaviour in times of security and provides safety in moments of danger or stress (Waters, Weinfield, & Hamilton, 2000). This reassures children in their attempts to explore their developing skills (Allen, 2011). With this attachment fosters the sense of trust, autonomy and knowledge that is central to dealing with threats to self, which generally coincide with identity formation during development (Counted, 2017). It is important to note that working models of attachment are not static or confined to infancy alone but are established by experiences throughout infancy, childhood, and adolescence (Hazan & Shaver, 1994).

Throughout development and into adulthood, attachments may be established with other substitute caregivers that satisfy basic attachment needs and contribute to identity development (Counted, 2017).

Secure attachment provides the basis for the development of social bonds, brain development, and the progression of brain structures that are critical for the regulation of stress (Galbally et al., 2022; Bumbacco & Scharfe, 2023). Oxytocin links the attachment system to the reward system and, via the parental bonding process, attachment, love, and care start to become rewarding (Lahousen, Unterrainer, & Kapfhammer, 2019; Marganska, Gallagher, & Miranda, 2013). These experiences culminate in expectations about the self, the world, and relationships (Waters, Weinfield, & Hamilton, 2000). Secure attachment experiences can also function as a buffer against future unsupportive and discouraging relationships (Waters, Weinfield, & Hamilton, 2000).

Studies by Mary Ainsworth and her colleagues identified three distinct patterns of attachment behaviour: secure, insecure/avoidant, and insecure/ambivalent (Allen, 2011). Main & Solomon (1986) later proposed a fourth pattern, which is identified as disorganised/controlling. Secure attachment, as described above, includes basic trust in the caregiver and surety that the caregiver will be available, sensitive to the child's needs, and lovingly respond to the child's requests for comfort and security (Mayseless, 1996; Ein-Dor & Hirschberger, 2016). This affirms the child in their ability to rely on themselves and turn to others when in need of support. This culminates in both low attachment avoidance and low attachment anxiety (Ein-Dor & Hirschberger, 2016). Avoidant attachment occurs as a result of persistent rejection from the caregiver when the child reaches out for comfort or protection (Mayseless, 1996; Ein-Dor & Hirschberger, 2016). In the most severe circumstances this manifests in extreme emotional self-sufficiency and antisocial behaviour in adulthood that serves as a mechanism of self-protection (Mayseless, 1996). Avoidant individuals are thus typically quick to respond to potential threat (Ein-Dor & Hirschberger, 2016).

Ambivalent attachment patterns are characterised by uncertainty as to whether the caregiver will be responsive and available when approached (Mayseless, 1996; Pietromonaco, DeBuse, & Powers, 2013). As a consequence of this uncertainty, the child is more susceptible to separation anxiety and hostility towards the caregiver (Mayseless, 1996). Typically, this occurs in response to parenting styles that are highly unpredictable wherein threats of abandonment

may be used as a means of control (Mayseless, 1996). In adulthood, these individuals may be excessively preoccupied with past attachment experiences (Mayseless, 1996; Pietromonaco, DeBuse, & Powers, 2013). The disorganised attachment pattern is more recent compared to the other three attachment styles described and as such has variations particular to the research paradigms it has been investigated within.

Some researchers suggest that disorganised attachment involves oscillation between the avoidant and ambivalent patterns (Mayseless, 1996; Allen, 2011). These patterns of behaviour are often understood as a reversal of the parent-child role (Mayseless, 1996). For example, in some instances caregivers may harbour unresolved attachment needs (e.g. through their own traumatic experiences), which are then directed toward the child (Mayseless, 1996; Pietromonaco, DeBuse, & Powers, 2013). In these circumstances the child becomes responsible for providing care and comfort to the parent, rather than being parented themselves (Mayseless, 1996).

Thus, in order for the child to attain proximity to the parent, the child must cater to the parent's needs for reassurance and comfort (Mayseless, 1996). Since infants cannot understand the conditions under which they can achieve proximity to their caregivers, the tendency is to react in a disoriented and disorganised manner (Ainsworth, 1964; Mayseless, 1996). Parents may convey their own needs to be nurtured in frightening ways, however by about the age of three, the capacity for the child to understand and respond to these wishes emerges (Mayseless, 1996). Insecure or disorganised attachment patterns pose a significant interactional risk factor with other variables, such as poverty, violence in home environments, or negative life events, that predict behavioural and emotional difficulties (Allen, 2011). This reinforces the ways in which attachment patterns from childhood have the potential to impact later life and therefore intimate relationships.

Intimate relationships are influenced by social cognitions, emotions, attachment, and evolutionary notions, which are acknowledged as integrative rather than mutually exclusive ideas (Fitness, Fletcher, & Overall, 2007). Our attachment to other human beings serves as an important element of our experience "from the cradle to the grave" (Bowlby, 1994: 29). In order to facilitate exploration into how Drama Therapy may benefit traumatised individuals with the purpose of enhancing intimacy in relationships, further information was considered in the form of a Literature Review.

Chapter III: Literature Review

In order to explore how Drama Therapy may be useful in dealing with childhood trauma and building healthy intimate partnerships, various notions were examined. The purpose of this literature review was to evaluate the state of knowledge in terms of what prior research has addressed; main points and areas of contention where these are relevant; and potential gaps in the studies examined (Knopf, 2006). Information was structured thematically in order to comprehensively summarise collective conclusions most relevant to this research interest (Knopf, 2006). This included identification of the possible impacts of childhood trauma and how different forms of trauma may affect intimacy in adulthood, as well as literature specific to prominent and evidence-based psychological approaches to treatment. This informed an analysis of trauma treatment within Drama Therapy settings and the tools and techniques typically utilised. While not all individuals who are exposed to trauma experience lifelong challenges as a result; this research focused explicitly on those who have experienced childhood trauma and consequential difficulties in adulthood. Through an critical engagement with the impacts of childhood trauma, the ways in which these impacts influence intimate relationships became evident. Additionally, a review of scientifically supported therapeutic interventions in this regard was used to illustrate what may be key for the support of intimacy recovery. This demonstrated the potential of Drama Therapy techniques for posttraumatic intimacy support.

The Impact of Childhood Trauma

With the intention of evaluating how Drama Therapy may foster intimacy between partners in the context of childhood trauma, it was relevant to establish the typical areas of impairment pertinent to these childhood experiences. This was, and is, significant when considering which therapeutic practices may best benefit particular clients and/or client groups (Landy, 1994; Corey, 2021). With this in mind, areas of impairment, regardless of the manner of trauma experienced during childhood, have been identified as: dysregulation in behaviour and emotion, cognitive and attentional difficulties, biological changes, altered perceptions of self and the external world, and deficits in attachment and relationships (Watts-English, Fortson, Gibler, Hooper, & De Bellis, 2006; Briere & Scott, 2015; Kliethermes et al., 2014; Marganska et al., 2013). In an effort to explore how these impairments affect intimacy and might be mitigated, these challenges in behaviour, cognitions, physical health, and attachment were evaluated more critically.

Disturbances in behavioural and emotional regulation is regarded as one of the more marked symptom clusters associated with childhood trauma (Kliethermes et al., 2014; Janiri, Moccia, Dattoli, Pepe, Molinaro, De Martin, Chieffo, Di Nicola, Fiorillo, Janiri, & Sani, 2021). This can be attributed to the fact that there is little opportunity for children to develop adaptive coping skills when confronted by strong emotions in unsafe environments (Dvir, Ford, Hill, & Frazier, 2014; Su & Stone, 2020). Children often become overwhelmed by their feelings in stressful and invalidating circumstances, which can undermine their capacities to cope. This can hamper the development of necessary social skills as well as one's ability to be aware of, identify, and feel emotions (Watts-English et al., 2006; Kliethermes et al., 2014). Moreover, impulse control, healthy emotional expression, and capacities to handle later crises are commonly disrupted (Ford & Russo, 2006; Dvir et al., 2014). In situations where stress or powerlessness recur, these individuals find it more difficult to regulate their emotional experiences (Su & Stone, 2020; Marganska et al., 2013).

Behaviour patterns that form in response to emotional dysregulation tend to be inclined toward rigidity or disinhibition – tendencies which naturally develop in order to help the child survive the trauma (Ford & Russo, 2006; Kliethermes et al., 2014). Reckless conduct has been linked to challenges with impulse control and executive functioning whereas inflexible behaviours typically emerge from the desire to manage or control intolerable feelings (Kliethermes et al., 2014; Marganska et al., 2013). Whiteside & Lynam (2001) proposed that there are four central factors driving impulsive behaviours: lack of forethought, limited resolve, sensation seeking, and urgency. Thus, people who exhibit high levels of urgency in situations of emotional turmoil are more prone to impulsive decision-making (Marganska et al., 2013; Selby, Anestis, & Joiner, 2008). Childhood maltreatment has also been associated with heightened threat perception owing to the fact that individuals with a history of childhood trauma generally develop distorted perceptions of their emotions and signs of threat (Danese & Baldwin, 2017).

Other behavioural symptoms of emotional dysregulation may present as irascibility, persistent arousal, hypersensitivity, regular suicidal ideation, and maladaptive coping strategies (e.g., self-harm and addictions) (Marganska et al., 2013; Su & Stone, 2020; Ford & Russo, 2006). In accordance with a hypothesis proposed by Perez, Lorca, & Marco (2021), the purpose behind maladaptive coping mechanisms, such as self-mutilating behaviour, is to escape dissociation and negative affect. Emotional dysregulation is also a well-documented feature of many

psychological disorders such as Borderline Personality Disorder (BPD), anxiety disorders, eating disorders, and Post-Traumatic Stress Disorder (PTSD), which are also associated with cognitive and attentional difficulties in response to childhood trauma (Gill, Warburton, Sweller, Beath, & Humburg, 2021; Briere & Scott, 2015; Marganska et al., 2013).

Reduced cognitive functioning in areas such as intellectual performance and reward processing pose strong correlations with interpersonal trauma (Williams, Cole, Girdler, & Cromeens, 2020). However, there are numerous ways in which challenges with attention and cognitive processes may present following exposure. This can include dissociative tendencies, difficulty anticipating or planning ahead, disengagement, and a lack of prolonged curiosity to varying degrees of severity (Williams et al., 2020; Fan, Liu, Xia, Li, Gao, Zhu, Han, Zhou, Liao, Yi, & Tan, 2021; Kliethermes et al., 2014; Su, D'Arcy, Yuan, & Meng, 2019). Kliethermes et al. (2014) proposed that a way of conceptualising these reactions is through the excessive development of avoidance responses. Symptoms such as memory loss, impaired executive functioning, dissociation, depersonalisation, numbing, and derealisation are common presentations of avoidance-related trauma responses (Su et al., 2019; Kliethermes et al., 2014). Williams et al. (2020) posit that problems in cognitive functioning may also serve as a mechanism through which interpersonal trauma contributes to drug use. The risk for initiation of drug use is increased by general cognitive dysfunction, sensation-seeking, impulsivity, and recklessness (Williams et al., 2020). Consequently, prolonged substance abuse contributes to cognitive impairment and shortfalls in working memory, cognitive flexibility, and awareness (Ramey & Regier, 2019; Su & Stone, 2020; Williams et al., 2020).

Studies concerned with biological changes in adults exposed to childhood trauma illustrate that deficits in explicit memory and cognitive processes may be related to smaller hippocampal volume (Smith, Thomasson, Yang, Sibert, & Stocco, 2021; Danese & Baldwin, 2017). Similarly, deviations in the functional or structural aspects of the prefrontal cortex appear to be associated with reduced executive function (Danese & Baldwin, 2017). Impairments in reward processing have been substantiated through human studies, which have shown how childhood trauma may disrupt responses to reward-predicting cues by inhibiting activation within the basal ganglia (Dillon, Holmes, Birk, Brooks, Lyons-Ruth, & Pizzagalli, 2009; Danese & Baldwin, 2017). Findings in humans have also highlighted how the development and functionality of the amygdala are highly dependent on the early social environment (Zimmermann, Richardson, & Baker, 2019; Danese & Baldwin, 2017).

The hypothalamic-pituitary-adrenal (HPA) axis is central to brain function and serves as a neuroendocrine pathway involved in biological adjustments to strain (Hosseini-Kamkar, Lowe, & Morton, 2021; Danese & Baldwin, 2017). Experiences during early life play a crucial role in the development of the HPA axis as well as its functioning across one's life-span (Kliethermes et al., 2014). Human studies highlight that traumatised individuals regularly experience exacerbated cortisol reactivity when confronted with new stressors in addition to elevated baseline cortisol levels (Hosseini-Kamkar et al., 2021; Danese & Baldwin, 2017). Through these effects on the brain, increased glucocorticoids (which are involved in influencing mood, behaviour, and sleep) can have long-term impacts on cognitive and affective processes (Danese & Baldwin, 2017). These physical changes and manifestations of childhood trauma all have the capacity to thwart life potential and one's ability to develop secure and healthy interpersonal relations.

Different sensory information regulates the attachment and reward system in various species (Lahousen et al., 2019). Thus, the attachment relationship between a mother and her infant is highly predictive of future relationships wherein the likelihood of attachment security increases among children who grow up in supportive and socially positive environments (Marganska et al., 2013; Lahousen et al., 2019). Secure attachment connotes feelings of safety in being able to depend upon attachment figures in situations of emotional distress and promotes autonomy and curiosity – given that there is a known space of comfort when needed (Allen, 2013). From an evolutionary perspective, this is designed for the purposes of enhancing the child's survival (Allen, 2013). With regard to childhood maltreatment, deficits in attachment and relationships occur from poor modelling of relationships during developmentally vulnerable periods (Su & Stone, 2020). This hinders the development of feelings of security and trust, which are central to human health (Su & Stone, 2020).

Early life stressors have been the focus of countless studies (Carr et al., 2013). In the context of childhood trauma, attachment relationships are often disrupted. This results in the underdevelopment of cerebrum structures associated with self-regulation, which brings about chronic states of dysregulation characterised by both hyperarousal and hypoarousal (Zarse et al., 2019; Kliethermes, Schacht, & Drewry, 2014). Research posits that most chronically traumatised individuals display disorganised and dissociative attachment styles in later life where interpersonal interactions may further trigger trauma-related difficulties (Kliethermes,

Schacht, & Drewry, 2014; Karantzas, Younan, & Pilkington, 2022). These patterns have direct implications on relationships and consequent experiences of intimacy (Karantzas et al., 2022).

From a neurobiological perspective, the stress of traumatic early life experiences releases various neurotransmitters and mediators into specific areas of the brain, which interact with developing neuronal networks (Perry, 1994; Jaworska-Andryszewska & Rybakowski, 2019; Delima & Vimpani, 2011). This can create structural and functional abnormalities, which may adversely impact cognitive and emotional processes (Jaworska-Andryszewska & Rybakowski, 2019; Perry, 1994). Increasing evidence proves that exposure to high or sustained levels of psychosocial stress, maltreatment, and primary attachment deprivation during childhood poses severe consequences for adult behaviour (Zarse et al., 2019).

Traumatic events are developmentally neurotoxic – specifically to brain systems involved in stress responses and social interaction (Van der Kolk, 2003, 2014; Zarse et al., 2019). In the absence of resilience factors, adverse childhood experiences (ACEs) occurring at high levels, have the potential to damage later parental attachment, nurturing and protective behaviours, and produce intergenerational cycles of trauma and psychiatric illnesses (Pember, 2016; Isobel et al., 2019; Zarse et al., 2019; Van der Kolk, 2014). Another critical causal factor related to childhood trauma is through caregiver-child attachment (Kliethermes, Schacht, & Drewry, 2014). Childhood trauma experiences which have the potential to impede numerous aspects of development and disrupt the formulation of healthy attachment styles (de Thierry, 2016; Galbally et al., 2022; Bumbacco & Scharfe, 2023). In later life, this may hinder relationships and an individual's capacity to manage intimate interactions (Karantzas et al., 2022).

For children, the betrayal of trust represents a threat to their survival and causes distance from caregivers who cannot offer safety and protection (Kliethermes et al., 2014). In response to the distance, people may lose their capacity to detect unsafe behaviours into adulthood and are more likely to stay in unhealthy relationships (Erickson, Julian, & Muzik, 2019; Su & Stone, 2020) and engage in trauma re-enactment in their intimate partnerships – either by choosing abusive partners or becoming abusive themselves (Su & Stone, 2020; Erikson et al., 2019). Due to disruptions in attachment and stability, individuals may experience distortions in the ways in which they view themselves as well as the world around them (Whiteman, Kramer, Petri, & Weathers, 2019; Kliethermes et al., 2014). This correlates with the aforementioned impacts in cognitive, affective, and biological domains. Kliethermes et al (2014) highlighted that

childhood trauma may contribute to distorted beliefs through conditioning or as a means to cope with the trauma (Whiteman et al., 2019). These coping mechanisms may further impair social capacities and mental health through consistent ruptures to one's self-esteem (Kliethermes et al., 2014). With this, it is apparent that the early life adversities of childhood trauma have the potential to leave individuals with lifelong emotional and cognitive difficulties, which perpetuate emotional and physiological responses to difficult situations (Sguera, Bagozzi, Huy, Boss, & Boss, 2020).

These areas of impairment are also significant to diagnoses of PTSD (Briere & Scott, 2015; Kliethermes et al., 2014). PTSD is perhaps the most common response to severely traumatic events and can occur at any age from one's first year of life (American Psychiatric Association, 2013). Symptoms of PTSD typically ensue within 3 months of trauma exposure, however delayed expression can occur and may take years before the diagnostic criteria are met (American Psychiatric Association, 2013). For a significant number of people, emotional and behavioural symptoms are mostly present while others tend toward negative perceptions and dysphoria (Davey, 2014). Arousal, reactivity, dissociation, or a combination of symptoms dominate for different people with variations over time (Karatzias, Murphy, Cloitre, Bisson, Roberts, Shevlin, Hyland, Maercker, Ben-Ezra, Coventry, & Mason-Roberts, 2019; Davey, 2014). Central to the development and maintenance of PTSD are negative post-traumatic cognitions (Kooistra, Hoeboer, Oprel, Schoorl, van der Does, ter Heide, van Minnen, & de Kleine, 2023). Poor perceptions of the self and the world (i.e. beliefs that one is worthless, toxic, or broken) are reinforced by intense emotions, intrusive thoughts, and elevated arousal, which continue to produce a sense of imminent danger or threat (Brown, Belli, Asnaani, & Foa, 2019; Su & Stone, 2020; Kooistra et al., 2023).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013), symptom duration also varies widely, from recovery within 3 months, to more than 50 years. The intensity and recurrence of symptoms may also appear in the context of life stressors, reminders of the original trauma, or in response to new traumas (Davey, 2014; American Psychiatric Association, 2013). PTSD is perpetuated by the psychological role of fear and is accompanied by the presence of at least one symptom of intrusion, which pertains to recurring memories of the traumatic event; distressing dreams where the content or emotional experience is indicative of the traumatic event; dissociative reactions; and prolonged psychological distress (Davey, 2014; Karatzias et al., 2019).

According to Kooistra et al. (2023) poor adaptive coping mechanisms are positively correlated with PTSD symptom severity. Behaviours and strategies that are typically utilised to mitigate this threat perception offer short-term alleviation of symptoms but perpetuate negative cognitions in the long term (Kooistra et al., 2023; Brown et al., 2019). These distortions in cognitive and attentional capacities reflect the cyclical patterns produced by post-traumatic symptoms, while the challenge in alleviating these difficulties is supported by the aforementioned biological shifts that transpire in response to trauma exposure. However, not all manifestations of childhood trauma result in a PTSD diagnosis.

Through the categorical exploration of the varying potential impacts of childhood trauma, the areas of impairment which may require attention in therapeutic treatment were identified. The central domains of difficulty specific to childhood trauma refer to: challenges with emotional and behavioural regulation (Watts-English et al., 2006; Kliethermes et al., 2014; Su & Stone, 2020; Marganska et al., 2013), cognitive and attentional problems (Ramey & Regier, 2019; Williams et al., 2020; Fan et al., 2021), biological changes (Hosseini-Kamkar et al., 2021; Danese & Baldwin, 2017), deficits in attachment and relationships (Lahousen et al., 2019; Allen, 2013; Erickson et al., 2019), and poor perceptions of self and the world (Whiteman et al., 2019; Kooistra et al., 2023). Many of these manifestations are also central to symptoms present within PTSD, which is the most common response to severe trauma (Davey, 2014; Karatzias et al., 2019; American Psychiatric Association, 2013). Analysis of these symptom clusters was significant to the overarching aim of evaluating how Drama Therapy may foster intimacy between partners in the context of childhood trauma. In order to expand upon this further, literature pertaining to the ways in which adult experiences of intimacy may be affected by childhood trauma were examined.

Childhood Trauma and Intimacy in Adulthood

In order to evaluate how the experience of trauma and the symptoms described above could be reduced and/or eliminated within therapy and with the intention of fostering intimacy between relationship partners, literature specific to the impact of childhood trauma on intimacy in adulthood was explored. According to Descutner & Thelen (1991), difficulties with intimacy can be understood as the impaired ability to share personal thoughts and feelings with others. Problems establishing and maintaining intimacy are commonly associated with poorer mental well-being and general health as well as reduced relationship satisfaction across various forms

of relationships (Criddle et al., 2022; Wiffen & Oliver, 2013). These impacts can influence interactions with friends, family, colleagues, and partners – the most extensive of which tends toward intimate relationships (Mills & Turnbull, 2004).

PTSD has one of the highest correlations with distressed intimate relationships (Leifker, White, Blandon, & Marshall, 2015; Wiffen & Oliver, 2013). This is owing to the fact that interpersonal trauma often stimulates fears concerned with emotional and physical intimacy, relationship closeness and commitment, and difficulties in providing support to one's partner or responding to their attempts at initiating intimacy (Criddle et al., 2022; Khaleque, 2004; Leifker et al., 2015). In the aftermath of personal trauma, difficulties relating to others and recognising trustworthiness may contribute to prolonged intimacy avoidance (Criddle et al., 2022; Mills & Turnbull, 2004; Kliethermes et al., 2014). Maladaptive coping strategies surrounding interpersonal interactions may indicate attempts to avoid vulnerability – wherein one's experiences may be exposed to judgement or punishment by another person (Larsen, Sandberg, Harper, & Bean, 2011). When authentic expressions of vulnerability produce positive responses from listeners, the likelihood of those expressions occurring again within other environments increases (Larsen, et al., 2011). However, vulnerable behaviours that would typically promote intimacy may have a tendency of being punished or invalidated in the context of childhood trauma (Larsen et al., 2011).

Evidence illustrates that a lack of or unsupportive intimate relationships increases one's susceptibility to many psychological problems such as stress and anxiety, risky sexual behaviour (e.g., condomless sex, multiple sexual partners), lower relationship quality, substance abuse, suicide, and other forms of psychopathology (Khaleque, 2004). However, Khaleque (2004) highlighted that insufficient empirical evidence exists specifying the relationship between psychological adjustment, quality of life, and intimacy. Additionally, many moderating factors can mitigate and protect against these harms (Larsen et al., 2011). It has also been well established that different forms of trauma generate varying outcomes (Descutner & Thelen, 1991). Considering that different forms of adverse child experiences may culminate in distinct immediate and lifelong consequences (Malinosky-Rummell & Hansen, 1993), it was significant that the impacts of each were analysed. Forms of maltreatment that are most commonly recognised include: sexual abuse, physical abuse, psychological or emotional abuse, and neglect (Norman et al., 2012; Larsen et al., 2011).

Physical abuse in childhood denotes the infliction of bodily harm on a child through intentional actions (Talmon, Uysal, & Gross, 2021; Malinosky-Rummell & Hansen, 1993). This includes endeavours such as shaking, throwing, kicking, burning, mutilating, strangling, poisoning, and exposing a child to extreme temperatures (Malinosky-Rummell & Hansen, 1993; Talmon et al., 2021). Parental anger is often directed toward children when a child is unable to meet parental demands (Malinosky-Rummell & Hansen, 1993). When children are confronted with physical abuse, psychological difficulties such as depression and feelings of worthlessness commonly materialise as well (Larsen et al., 2011; Malinosky-Rummell & Hansen, 1993). These individuals tend to be more likely to blame themselves for circumstances out of their control and consequently distance themselves from perceived stressful situations (Larsen et al., 2011; Malinosky-Rummell & Hansen, 1993).

Childhood physical abuse is notorious for its toxic implications on people's long-term health (Talmon et al., 2021). The long-term impacts of physical abuse in childhood, without considering the physical injuries themselves, may incorporate reduced cognitive functioning and language abilities; hostility towards peers and adults; greater noncompliance; conduct disorders; psychosis; physical illnesses; depression; anger; paranoia; dissociation; and anxiety (Rasool, 2022; Malinosky-Rummell & Hansen, 1993; Talmon et al., 2021). Incontinence, sexual misconduct, antagonism, and social isolation may be indicative of the repercussions of physical abuse amongst child and adolescent populations as well (Sirotnak, Grigsby, & Krugman, 2004).

Rasool (2022) emphasises that caregivers and family members who utilise violence to mitigate life's challenges, educate their children to repeat the same behaviour patterns in their own lives. Empirical findings uphold the profound link between physical abuse and aggression (Rivara, Adhia, Lyons, Massey, Mills, Morgan, Simckes, & Rowhani-Rahbar, 2019; Malinosky-Rummell & Hansen, 1993). However, later perpetration of abuse may be moderated by the perpetrator's personal experiences of childhood trauma, their relationships, physical and psychological factors, as well as present strain (Malinosky-Rummell & Hansen, 1993). Lifetime prevalence studies carried out in South Africa have highlighted that at least 23% of adolescents reported exposure to family violence (Rasool, 2022). This presence of physical brutality is linked to later violent behaviour, which encourages the normalisation of violence and reinforces notions that it can be used to dominate others and intimate partners into

submission and compliance (Rasool, 2022). These notions are also strongly associated with the impacts of another form of physical trauma.

Sexual abuse is the highest predictor of suicide among different forms of trauma (Gawęda, Pionke, Krężołek, Frydecka, Nelson, & Cechnicki, 2020). Sexual trauma or abuse refers to a range of traumatic events in childhood that are of a sexual nature (Everstine & Everstine, 2019). This can include exposure to sex and/or bearing witness to inappropriate or sexual behaviour from an adult (Everstine & Everstine, 2019). More specific forms of sexual abuse, which constitute sexual assault, concern any manner of sexual contact between an adult and a child i.e., molestation, rape, sodomy, incest, and exhibitionism (Everstine & Everstine, 2019). These atrocities are typically committed by someone whom the child trusts, which can exacerbate negative outcomes (Loh, Gidycz, Lobo, & Luthra, 2005; Everstine & Everstine, 2019). There is an increased stigma attached to sexual trauma, especially amongst male populations, thus occurrences of sexual abuse are often underreported (Larsen et al., 2011).

Most studies concerned with the role of childhood trauma on intimacy have focused on the impact of sexual trauma – which, within this research context, refers to sexual conduct or contact between an adult and minor under the age of 18 (Vaillancourt-Morel, Rellini, Godbout, Sabourin, & Bergeron, 2019). The age of consent for engaging in sexual activity differs across countries owing to socio-political and cultural norms, however it tends to vary between 12 and 21 years old (Sharan, 2023; Vaillancourt-Morel et al., 2019). As a result of shifting perspectives regarding childhood and sexuality since the 19th century, the minimum age of consent currently averages between 14 and 18 years old around the world (Pitre & Lingam, 2022; Sharan, 2023). Regardless of the particulars specific to age and consent, general conceptions pertinent to the experience of sexual trauma remain the same.

A study conducted by Martinson, Sigmon, Craner, Rothstein, & McGillicuddy (2013) aimed at evaluating the function of intimacy in adults subjected to sexual trauma in childhood. Results of this research indicated that individuals with experiences of sexual trauma had greater delays in responding to intimacy and trauma-related stimuli in comparison with the control group, across genders (Martinson et al., 2013). The presence of PTSD symptoms and avoidance, wherein aversion plays a key role, were identified as significant to this inactivity (Martinson et al., 2013; O'Loughlin & Brotto, 2020). However, Martinson et al. (2013) indicated that more

research, which is dedicated toward understanding the mechanisms through which intimacy issues are experienced by individuals with a history of sexual trauma and PTSD, is needed.

Survivors of sexual trauma frequently face many long-term impacts on their interpersonal functioning (Davis, Petretic-Jackson, & Ting, 2001). Some investigations into the effects of sexual abuse in childhood have reported that women are at an exceptionally increased risk of revictimization and intimate partner violence (IPV) in adulthood (Velotti, Rogier, Beomonte Zobel, Chirumbolo, & Zavattini, 2022; Barrios, Gelaye, Zhong, Nicolaidis, Rondon, Garcia, Sanchez, Sanchez, & Williams, 2015). Relationship problems, poor satisfaction with interpersonal relationships, fears of intimacy, discomfort with emotional and physical closeness, inappropriate sexual behaviour, distorted perceptions of sexuality, and excessive or poor control within relationships are among the many long-term consequences of sexual trauma on intimacy (Talmon et al., 2021; Martinson, Craner, & Sigmon, 2016). Furthermore, many survivors of sexual abuse tend to struggle with romantic intimacy, emotional communication, trust, and confiding in their partners (Martinson et al., 2016).

Researchers have posited that HPA axis dysfunction plays a significant role in challenges with intimacy among survivors of sexual abuse wherein various forms of proximity to others may provide an environment for psychosocial stress that activates the HPA axis system (Martinson et al., 2016; Burnett, Mcmullin, Goedereis, & Schroeder, 2023). Martinson et al. (2016) proposed that inhibited physiological regulation is both caused by and perpetuates intimacy distress. The relationship between childhood physical abuse and increased pain during sex for women also reinforces how exposure to physical abuse during childhood impacts general health (Talmon et al., 2021). This is consistent with the psychodynamic conceptualisation of the capacity for the body to "remember" – which can be triggered by any vulnerable circumstances (Talmon et al., 2021).

In studies exploring intimacy among male survivors of childhood sexual abuse, perceptions, and experiences of intimacy in romantic relationships were evaluated (Petersson & Plantin, 2023). Difficulties that were identified included shame, jeopardised sexual identity, sexual compulsions, and emotional dysregulation (Petersson & Plantin, 2023). People who have survived childhood abuse, across genders and forms of abuse, experience greater encounters with shame (MacGinley, Breckenridge, & Mowll, 2019; Larsen et al., 2011). Shame results in wanting to keep parts of oneself hidden and has been found to contribute to feelings of

unworthiness in love (Larsen et al., 2011). This culminates in defensiveness and increased interpersonal conflict, which promotes further psychological distress and behavioural problems that negatively impact intimate relationships (Larsen et al., 2011).

Attachment issues, poor boundaries, and decreased relationship quality is even more likely to occur when more than one individual in a relationship experiences social and emotional difficulties (Larsen et al., 2011). However, disclosure of one's experiences of abuse has been found to have a positive effect on attempts at developing intimacy (Petersson & Plantin, 2023; MacGinley et al., 2019). Moreover, the development of emotional awareness and acceptance in the presence of a supportive and compassionate partner facilitates this (Petersson & Plantin, 2023). Changing notions regarding masculinity within social contexts has also been found to serve as a buffering role in helping male groups generate positive valuations of themselves in the context of sexual abuse histories (Petersson & Plantin, 2023).

Abuse that is of a psychological and emotional nature is central to and comorbid with all forms of child abuse (Momtaz, Mansor, Talib, Kahar, & Momtaz, 2022; Van der Kolk, 2003). This kind of trauma refers to a repetitive pattern of shortfalls from caregivers to provide a developmentally secure and supportive environment to a child, which frequently results in emotional and psychological problems (Van der Kolk, 2003; Isobel, Goodyear, & Foster, 2019; Norman et al., 2012). Emotional abuse and neglect during childhood is typically characterised by persistent denial of a child's needs for love, encouragement, a sense of belonging, and support (Davis et al., 2001). However, despite its high prevalence within non-clinical samples, emotional abuse has not received much empirical attention (Momtaz et al., 2022; Davis et al., 2001). This is largely due to the lack of universal definitions specific to the concept (Weathers & Keane, 2007).

Psychological trauma is difficult to measure considering that this type of maltreatment modifies a variety of behaviours (Van der Kolk, 2003). Patterns of behaviour that are considered emotionally and psychologically abusive can be divided into two distinct categories: terrorisation and unresponsiveness – which are either deliberate or neglectful in origin (Norman et al., 2012; Momtaz et al., 2022). Emotional rejection, depriving the child of reasonable autonomy, failing to mediate the child's behaviour, and inconsistent parenting styles (i.e., contradictory control) also fuel levels of emotional trauma (Momtaz et al., 2022). Prevalence rates in a study that intended to determine the risk factors and prevalence of child psychological

abuse in a rural area of Bangladesh were approximately 97% (Haque, Moniruzzaman, Janson, Rahman, Mashreky, & Eriksson, 2021). Furthermore, children who lived apart from their parents were exposed to significantly increased risks of neglect and psychological abuse (Haque et al., 2021). However, the results of this case study may be influenced by context-specific notions.

Incidents specific to psychological and emotional trauma are likely to inhibit the development of physical, mental, spiritual, moral, and social health (Norman et al., 2012). Additionally, expectations that are beyond the child's abilities, which may present through abusive expectations or high demand, or exploiting and forcing the child to satisfy caregiver needs are psychologically toxic (Momtaz et al., 2022; Van der Kolk, 2003). Substantial evidence illustrates associations between exposure to non-physical abuse in childhood and subsequent risk of a range of mental disorders, drug use, suicide attempts, and risky sexual behaviour (Norman et al., 2012; American Psychiatric Association, 2013). Childhood experiences of abuse are often defined by a violation of trust in significant relationships (Davis et al., 2001). By undermining a sense of security and trust in relationships, the potential negative effects of abuse on social interactions are emphasised (Davis et al., 2001). In order to advance our understanding of psychological abuse across socio-cultural lines, it is imperative that researchers continue to refine measures of psychological abuse in studies going forward (Heise, Pallitto, García-Moreno, & Clark, 2019).

Emotional intimacy is often understood as a paired interaction in which participants allow themselves to be emotionally vulnerable and respond with empathy and reaffirmation to the other (Criddle et al., 2022). However, data indicates that insecurities relating to attachment as a result of psychological trauma, such as avoidance or anxiety, may be of influence (Park, Impett, Spielmann, Joel, & MacDonald, 2021). Those with avoidant attachment styles emphasise their own freedom and independence, often to the point of discomfort during moments of intimacy while perceiving their relationship as low reward in value (Marganska et al., 2013; Park et al. 2021). Conversely, those with attachment anxiety may view their relationships with a high level of threat due to chronic worries about rejection (Park et al. 2021; Marganska et al., 2013). These traits both influence the likelihood of separation as well as manipulation of emotional attachment and dependency on ex-partners (Park et al. 2021).

Those having lived through childhood abuse do not necessarily have issues with sharing emotions and thoughts with a significant other (Yoo, Bartle-Haring, Day, & Gangamma, 2014; Rellini, Vujanovic, Gilbert, & Zvolensky, 2012). However, the extent of disclosure may range from processing emotions with the support of a partner to sharing with insensitivity and lack of tact (Vaillancourt-Morel et al., 2019). Additional data suggests that individuals, irrespective of sex, who have experienced intense childhood abuse feel more misunderstood, invalidated, uncared for and unaccepted by their partners (Vaillancourt-Morel et al., 2019; DiLillo, Peugh, Walsh, Panuzio, Trask, & Evans, 2009). This conglomerates into distrust, suspicion, as well as misinterpretations of a significant other's behaviour that causes difficulty in perceiving a partner as protective and compassionate (Vaillancourt-Morel et al., 2019).

Emotional abuse and emotional neglect can be considered as part of a spectrum (Naughton, Maguire, Mann, Lumb, Tempest, Gracias, & Kemp, 2013; Talmon et al., 2021) and are both positively correlated with expectancy of rejection, distrust, emotional inhibition, and indifference in social relationships (Talmon et al., 2021; Davis et al., 2001). Adults exposed to this form of trauma in childhood may also face difficulties in attempts to enhance intimacy (Davis et al., 2001; Talmon et al., 2021; Criddle et al., 2022). Known lifelong challenges associated with various forms of neglect in childhood include physical and mental health problems; impairments in language, social, and communication skills; and impacts on brain development and hormonal functioning (Naughton et al., 2013). These consequences can also perpetuate into the long term and negatively affect individuals in mental stability, physical health, societal functioning, and standard of living (Talmon et al., 2021).

There are studies indicative of the implications of childhood emotional abuse and neglect on social functioning, however, less is understood about the link between this kind of trauma and intimacy in adult partnerships (Davis et al., 2001). One of the primary symptoms in adults who were maltreated as children is a lack of sexual desire and lower levels of intimacy during sexual interactions – in contrast to the tendency to be involved in high-risk sexual activities (DiLillo et al., 2009; Davis et al., 2001). Studies indicate that women who have suffered from childhood neglect are more likely to view sex as a crucial element of their relationships (Talmon et al., 2021). However, this pattern of fluctuation between hypo and hypersexuality varies amongst individuals (Mullen, Martin, Anderson, Romans, & Herbison, 1994; Davis et al., 2001).

Literature specific to the ways in which adult experiences of intimacy may be affected by childhood trauma illustrated that varied forms of traumatic experiences in childhood may produce both similar and varied effects (Malinosky-Rummell & Hansen, 1993). Physical trauma may contribute to later aggression or feelings of worthlessness in relationships (Larsen et al., 2011; Malinosky-Rummell & Hansen, 1993) while sexual trauma may be associated with reduced relationship satisfaction, fears of emotional and physical closeness, risky sexual conduct, excessive or poor control within relationships, and difficulties with intimacy and trusting in partners (Talmon et al., 2021; Martinson, Craner, & Sigmon, 2016). Psychological trauma was identified as comorbid with all forms of child abuse (Momtaz et al., 2022; Van der Kolk, 2003) where insecurities that manifest in avoidance, anxiety, and distrust may influence experiences of intimacy (Park et al., 2021; Marganska et al., 2013). Neglect poses similar challenges to relationships in adulthood and may contribute to feelings of rejection, distrust, emotional inhibition, and indifference (Talmon et al., 2021; Davis et al., 2001; Norman et al., 2012; Larsen et al., 2011). This investigation was relevant to establishing an understanding of which components or areas of intimate experiences might be impacted by childhood trauma so as to guide the exploration of treatment approaches that may be appropriate.

Treating Childhood Trauma in Adulthood

A substantial portion of individuals seeking therapeutic treatment do so for the ramifications of traumatisation at some point in their history (Courtois, 2008). With the intention of identifying how Drama Therapy techniques may foster the development of healthy intimate partnerships in the context of childhood trauma, it was significant that therapeutic interventions typically utilised among traumatised populations and their effects were assessed. Different treatment approaches target different symptoms of trauma exposure and there is a plethora of established therapeutic models, which have been developed to facilitate these. For the purposes of this research interest, a few central and empirically validated trauma treatment approaches and case examples were investigated. This incorporated exploration of CBT, DBT, and psychodynamic approaches, which can be conducted in individual or group settings (Ford & Russo, 2006; Cook et al., 2005; Briere & Scott, 2015).

CBT is an empirically validated form of psychotherapy with well-documented evidence of its effectiveness in treating a myriad of difficulties (Bieling, McCabe, & Antony, 2022). CBT is informed by a branch of psychology, which aligns with the notion that human beings are

continually interpreting stimuli through the filters of their own experience (Sheldon, 2011). The interaction between genetics, physiological factors, and the environment, which impacts the development and preservation of motor, cognitive, verbal, and emotional capacities, is acknowledged within this framework as well (Kendall, 1985; Sheldon, 2011). CBT is exhibited in practice through the intentional shifting of problematic tendencies in one's behaviour by: modifying environmental contingencies, deconstruction of formally ingrained biases (which often result in negative reactive emotions), and the implementation of alternate and effective methods to interpersonal problem-solving (Sheldon, 2011; Kendall, 1985). In essence, this refers to changing how the client recognises and responds to particular stimuli (Sheldon, 2011; Corey, 2021).

Behaviourism, which connotes behavioural learning through one's environment, posits that the cognitive processes we have termed 'consciousness' are a curious consequence of the relationship between the body and environment (Skinner, 1985; Sheldon, 2011; Case & Bereiter, 1984). With this, what is understood as the 'mind' is actually the experience of the brain at work – filtering environmental information and sensory stimuli through classification and coding while anticipating the consequences of responses to these perceptions (Sheldon, 2011). These constant workings of the conscious, subconscious, and external context, make distortions in one's perceptions of reality unavoidable (Case & Bereiter, 1984; Sheldon, 2011). Consciousness is designed to answer questions, imperative to human evolution, regarding predictions of the future (Braddon-Mitchell, 2019; Sheldon, 2011). This is subject to "hard-wired" circuits, which prompt means of problem solving based on the history of the impacts of our behaviour (Skinner, 1985; Sheldon, 2011). However, a greater behavioural repertoire can be attributed to interactions with the social and physical contexts one is exposed to, which result in learning (Case & Bereiter, 1984; Sheldon, 2011).

Whether it be through classical or operant conditioning, vicarious learning or modelling, behaviours of all kinds are learned in the same way (Braddon-Mitchell, 2019; Skinner, 1985; Sheldon, 2011). With this, all cognitive behavioural approaches share the same basic characteristics and assumptions as traditional behaviour therapy (Weiten, 2016; Davey, 2014; Corey, 2021). This includes the use of present-oriented time-limited treatment, which reinforces the collaborative relationship between client and therapist; understanding that psychological upheaval is generally sustained by cognitive processes, intent on changing cognitions to develop desired shifts in affect and behaviour, and educational treatment specific

to targeted problems (Corey, 2021; Davey, 2014; Weiten, 2016). A strong therapeutic alliance and the utilisation of numerous cognitive and behavioural strategies are implemented to bring about change (Corey, 2021).

CBT has been proven effective across sociocultural environments in its success in minimising PTSD symptoms, long-term mental illnesses, decreasing anxiety, and shifting negative cognitions (Weiten, 2016; Larsen et al., 2011; Kar, 2011). Furthermore, it is considered safe and applicable to the treatment of both acute and chronic manifestations of PTSD with a number of studies illustrating physiological and functional neuroimaging alterations in response to CBT interventions (Kar, 2011; Davey, 2014). Non-responsiveness to the implementation of CBT has been reported in up to 50% of participants in some studies (Kar, 2011). However, factors such as population characteristics and comorbidity are highly influential (Kar, 2011). Variations in the techniques and processes in CBT implementation are common, however the basic aforementioned components are sustained (Corey, 2021). Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is one example of this and is an evidence-based treatment approach usually employed with traumatised children (Cohen & Mannarino, 2008).

TF-CBT is an adaptable paradigm characterised by: psychoeducation; skills training (coping, affect modulation, and relaxation); improving feelings of safety; exploration of the trauma narrative; cognitive processing of traumatic histories; and proficiency in trauma trigger management (Cohen & Mannarino, 2008). In a randomised controlled trial in the Democratic Republic of Congo (DRC) psychologically distressed former child soldiers, including other young males impacted by war, received fifteen sessions of group-oriented and culturally adapted TF-CBT (McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013). Results showed significant reductions in post-traumatic stress symptoms, depression and anxiety, general psychosocial distress, and behavioural problems as well as an increase in compassion and considerate behaviour (McMullen et al., 2013). These responses to treatment represent a much larger cohort of evidence validating the effects of TF-CBT. In order to more fully examine how CBT sustains its reputation among diverse populations, utilisation of a CBT group-centred treatment model titled Skill Training In Affect Regulation (STAIR) was explored.

In order to actively address skill development in affective and interpersonal modalities, the first stage of the STAIR approach pertains to: self-regulation and behavioural adaptation (Cloitre,

Koenen, Cohen, & Han, 2002; Cloitre, Stovall-McClough, Nooner, Zorbas, Cherry, Jackson, Gan, & Petkova, 2010). This process assists participants in exploring their fears, triggers, thoughts, feelings, and actions. Once identified and examined, emotional regulation skills are implemented (i.e., breathwork and mindfulness) (Trappler & Newville, 2007; Cloitre et al., 2010). This results in the development of trust, security, emotional regulation, recognition of triggers, and mitigation of trauma-induced behaviours (Velasquez Jr, Dosanjh, & Franklin, 2023; Cloitre et al., 2002; Trappler & Newville, 2007; Cloitre et al., 2010). In order to encourage the development of new behaviours, cognitions related to interpersonal contexts that perpetuate trauma-related narratives in current social environments are navigated in group sessions (Trappler & Newville, 2007). This second stage of the approach is referred to as the emotional processing of trauma or ‘‘Narrative Story Telling” (Cloitre et al., 2002; Trappler & Newville, 2007).

Among individuals diagnosed with schizophrenia with histories of extensive trauma at an in-patient facility, following the completion of 12 weeks of STAIR therapy, reduced tension, hostility, suspiciousness, and frustration were demonstrated (Trappler & Newville, 2007). Clients were reminded about the confidentiality, trust, and boundaries of the group dynamic and guided to replace maladaptive coping mechanisms with conscious strategies that instil feelings of calmness and security (Trappler & Newville, 2007). During sessions, clients were also prompted to source objects, places, and images that they found soothing to further decrease levels of arousal (Trappler & Newville, 2007). The process concluded with participants choosing strategies, which they had learned throughout treatment (e.g., breathing and grounding techniques), to share with the group (Trappler & Newville, 2007). The use of mindfulness and grounding techniques in this variation of CBT are also inherent to DBT.

DBT was initially designed in order to treat chronically suicidal individuals diagnosed with BPD (Dimeff & Linehan, 2001; Kothgassner, Goreis, Robinson, Huscsava, Schmahl, & Plener, 2021; Corey, 2021; Davey, 2014). It has been proven to be effective for a number of mental ailments, such as depression, eating disorders, PTSD, substance abuse and well as suicidal and self-harming behaviours (Weiten, 2016; Corey, 2021; Lenz, Taylor, Fleming, & Serman, 2014). DBT contains an amalgamation of behavioural and psychoanalytic techniques and places emphasis on the value of the psychotherapeutic relationship, engagement of resistance, and support of the client’s experiences (Corey, 2021; Weiten, 2016). Emotional regulation in DBT enables clients to find an emotional ‘‘comfort zone’’ that allows them to function, learn,

and stay connected with their immediate environment (Lenz et al., 2014; Corey, 2021). This replaces the dissociated state that traumatised patients frequently function within when triggered into repetitive patterns of old trauma dynamics (Corey, 2021).

DBT is correlated with broad approaches in treatment that highlight acceptance and change (Scheel, 2000; Corey, 2021; Dimeff & Linehan, 2001). Mindfulness techniques are shared to initiate acceptance of the present (Dimeff & Linehan, 2001; Corey, 2021), which assists clients in making changes to their attitude, behaviour, and environment while being mindful of their present condition. Through DBT, individuals who face particular issues with regulation of affect are educated on the importance of acknowledging and accepting the existence of simultaneous and polarised forces (Corey, 2021). This recognition allows clients the space to develop skills in integrating the contrasting notions of change and acceptance (Böhnke, Priebe, Rausch, Wekenmann, Ludäscher, Bohus, & Kleindienst; Corey, 2021) and develops emotional and behavioural regulation skills (Dimeff & Linehan, 2001; Görg et al., 2019).

Skills in DBT are typically divided into four categories: Mindfulness, Interpersonal Effectiveness, Emotional Regulation, and Distress Tolerance (Corey, 2021; Görg et al., 2019). CBT, behavioural techniques, and exposure therapy are present in different forms to assist clients in tolerating painful emotions (Corey, 2021; Lenz et al., 2014) while Zen Buddhist practices are used for the development of acceptance-based and mindfulness skills (Scheel, 2000; Corey, 2021; Lenz et al., 2014). This further promotes clients' awareness of the present; release of attachments to suffering; and acceptance of reality without judgement or distorted perceptions (Lenz et al., 2014; Corey, 2021). Structured therapeutic environments are crucial to DBT in addition to the client-specific goals (Corey, 2021). Evidence of this is apparent wherein, as was intended, DBT minimised episodes of disordered eating amongst traumatised women and reduced depressive symptoms (Lenz et al., 2014). Longer periods of DBT are imperative for more effective treatment of self-harm and suicidal ideation (Fox et al., 2020; Kothgassner et al., 2020).

Reviews of PTSD trauma treatments that are empirically supported, suggest that despite their efficacy for many patients, these treatments have high dropout rates (Smith, Koenigsberg, Yeomans, Clarkin, & Selzer, 1995; Warren, 1998). As proposed by Schottenbauer, Glass, Arnkoff, & Gray (2008), psychodynamic approaches may be of particular significance in confronting clinical presentations of PTSD that are not targeted by presently available

empirically validated methods – specifically with manifestations of complex PTSD. Psychodynamic therapy describes an array of treatment forms based on psychoanalytic theory, bar the prominent components of psychoanalysis (Corey, 2021). Following the cessation of psychodynamic treatment, clinical evidence posits that improvements tend to be retained in: improved feelings of self-worth, capacities for reflection, increased ability to control responses to trauma triggers, the development of mature boundaries, the internalisation of secure modelling of relationships, and better social performance (Schottenbauer et al., 2008; Shedler, 2010).

The therapeutic relationship is a relatively unchallenged and crucial element of psychodynamic therapy, which offers a window into the ways in which a person interacts with the stimuli around them (Marziali & Alexander, 1991; Corey, 2021). Transference and countertransference expose the ways in which early-life relationships affect individuals in the present (Corey, 2021; Marziali & Alexander, 1991). Transference refers to the unintentional process of 'transferring' one's feelings and attitudes towards a parent, situation, or other, onto the therapist (Jones, 2004; Corey, 2021). For the benefit of the therapeutic relationship and in the efforts of self-care, it is critical that practitioners are mindful of their own emotional responses to their clients (Rasool, 2022). Evidence of the value and implications of transference in psychodynamic-oriented therapeutic approaches is clear in multiple studies. In one example adult participants were exposed to Psychodynamic Music Therapy, in addition to standard care, and had pronounced improvement in depression and anxiety-related symptoms as well as in overall function (Erkkilä, Punkanen, Fachner, Ala-Ruona, Pöntiö, Tervaniemi, Vanhala, & Gold, 2011).

Investigation into and elaboration of clients' thoughts, emotions, developmental experiences, beliefs, personal history, dreams, ideas for the future, defence mechanisms, resistance, and unconscious materials are explored (Corey, 2021). Once patterns have been recognised and defined, people are assisted in reducing exposure to distress, creating more reliable mechanisms to cope, and regulating unhealthy patterns within their sphere of control (Marziali & Alexander, 1991; Corey, 2021). The necessary condition for a healing interpersonal experience is for one's internal states of being to be reflected in the external world (Edwards, 2016). Within many psychological practices, this is marked by mirroring between the therapist and client, which allows the client to become aware of their present state in the therapeutic space, predict and assess their expressive tendencies induced by their emotions, and modify

these notions to attain balance within the present (Edwards, 2016; Erkkilä et al., 2011). This intimate look into interpersonal relationships can help people understand their part in relationship patterns and empower them to transform that dynamic (Corey, 2021; Jones, 2004).

It is important to note that among groups wherein complex PTSD is normalised or among whom a history of interpersonal trauma has occurred, the relationship between the clinician and client may be compromised (Rasool, 2022). Diminished experiences of intimacy, from various kinds of relationships, may also impact the therapeutic relationship (Criddle et al., 2022). Coping mechanisms that may present in these clients can manifest as hyper- awareness of betrayal and reliance on affirmation (Solomon, 2003). These maladaptions serve to alert survivors of interpersonal childhood trauma of any potential signs of betrayal, which are often assumed to exist, even if evidence is lacking (Solomon, 2003). Among clients who demonstrate interpersonal instability, modelling of healthy attachment through a secure and supportive therapeutic relationship is crucial (Su & Stone, 2020; Corey, 2021). In therapy, this involves the incorporation of empathy, respect, validation, and compassion as well as communicating an understanding of how trauma affects the body and mind (Su & Stone, 2020).

In intimate partnerships contextualised by childhood trauma, when a partner fails to fulfil the role of affirming the other, this can cascade into periods of criticism and interrogation (Solomon, 2003). In psychodynamic couples therapy, clients are enabled to achieve catharsis through developed understanding of both their own and their partners' roles across their lifespans (Nielsen, 2017; Solomon, 2003). An expanded evaluation of an individual's family and significant others, who have been impacted by the trauma directly or indirectly, is typically encouraged (Mills & Turnbull, 2004). The effectiveness of relationship-based approaches stems from their mediation of developmental trauma defences and improving openness and intimacy within a relationship (Solomon, 2003; Nielsen, 2017). Members of a relationship are made more aware of their past and encouraged to share their histories and how they feel they may have impacted their current relationship, through guidance from the therapist who ensures that emotions are validated and recognised (Solomon, 2003). This informs emotional understanding between partners.

The aforementioned trauma treatment approaches - CBT, DBT, and psychodynamic techniques - may target different aspects of trauma exposure. However, what is emphasised across all techniques examined is that the therapeutic relationship, cultivation of awareness, skills

development, and non-judgemental acceptance of the present reality, are critical to effective therapeutic treatment (McMullen et al., 2013; Solomon, 2003; Su & Stone, 2020; Corey, 2021; Schottenbauer et al., 2008; Shedler, 2010). Additionally, it appears that modelling of empathy, compassion, validation, and respect on the part of the therapist influences the therapeutic alliance and relationships beyond the therapy space (Nielsen, 2017; Corey, 2021). This was relevant to the intention of identifying how Drama Therapy techniques may foster intimacy in partnerships contextualised by childhood trauma in that it depicts how predominant, and empirically-supported trauma treatments, attain goals. Furthermore, the literature explored demonstrates some of the effects that may be experienced by clients in response to therapy.

Drama Therapy and Trauma Treatment

With the purpose of identifying how Drama Therapy techniques may be used for intimacy recovery in adult relationships within the context of childhood trauma, established approaches specific to Drama Therapy were selected for this research and their effects evaluated. This included exploration of: the 9 core principles (Jones, 1996); the general structure of a Drama Therapy session (Jones, 1996) and dramatic ritual (Emunah, 2013); neuroscientific frameworks and breathwork (Van der Kolk, 2014; Rappaport, 2014); the Role Method (Landy, 1994); Narradrama (Dunne, 2009; Bezuidenhout, 2012); Developmental Transformations (DvT) (Johnson, 2009, 2014); Rehearsals for Growth (RfG) (Wiener, 2009); and Cognitive-Based Trauma Informed Drama Therapy (CBDT) (Frydman & McLellan, 2014).

Drama Therapy techniques, which are present in almost all Drama Therapy processes and important to note, are known as the Nine Core Principles (Jones, 1996). Jones (1996) is one of the major theorists in the field of Drama Therapy and is recognised for his contributions in defining core processes, forms, and structure. The Nine Core Principles of Drama Therapy as defined by Jones (1996) are the following: dramatic projection, the therapeutic performance process, drama-therapeutic empathy and distancing, personification and impersonation, interactive audience and witnessing, embodiment, playing, the life-drama connection, and transformation. Dramatic projection refers to endeavours wherein the client projects parts of themselves or lived reality into dramatic stimuli (Jones, 1996; Armstrong, Rozenberg, Powell, Honce, Bronstein, Gingras, & Han, 2016). Similarly, the therapeutic performance process concerns actively identifying what needs to be expressed and the manner in which that

expression takes shape (Jones, 1996). This can be established through embodiment, which denotes physical expressions of enactments (Armstrong et al., 2016). In Drama Therapy, dramatising the body or taking on another identity serves as an expression of imagination, which can help the client explore new perspectives (Jones 1996). This connects with the notion of playing, which refers to an expressive continuum that fosters a playful relationship with reality (Jones, 1996).

Personification and impersonation are means of dramatic representation with the former referring to the act of attributing human-like qualities to inanimate objects while impersonation is a demonstration of a person or the act of playing varied personae and/or roles (Jones, 1996). The principle of interactive audience and witnessing is crucial to Drama Therapy with both components experienced interchangeably by the client, group, and therapist (Silverman, 2006). This aspect of the drama-therapeutic process is often central to helping clients feel seen, acknowledged, and heard (Jones, 1996). Drama-therapeutic empathy and distancing is the ability to engage with and disengage from the process or material being dealt with (Silverman, 2006; Jones, 1996). This can be a structured component of sessions and, when used effectively, can mitigate anxiety and intense emotions that may be brought up within sessions (Jones, 1996). The life-drama connection is the ability to associate dramatic projections with one's real-life experiences (Silverman, 2006). Thus, transformation is grounded in the goals of Drama Therapy and the client's development through personal breakthroughs (Silverman, 2006).

With this in mind, it is apparent that variety is central to Drama Therapy and that, as a praxis, it can be process-oriented, performance-based, or both. Treatment is most commonly directed toward behaviour change, however the therapeutic aims and techniques employed are entirely dependent upon the client and context – wherein goals are flexible and centred upon personal, behavioural, social, and conceptual factors (Landy, 1994). Regardless of age, ability, and background, this adaptability makes Drama Therapy effective (Godfrey & Haythorne, 2013). Additional benefits of this form of psychotherapy, in both individual and group contexts, often include: reduced feelings of isolation; the development of problem solving skills; broadened emotional expression; exploration and identification of goals; increased feelings of connectedness; improved understanding of one's self and experiences; enhanced self-esteem and feelings of self-worth; the development of coping skills; safe interactions with others in a comfortable environment; and the use of creativity, imagination, and play (Landy, 1994; Jones,

1996; Emunah, 2013; Lahad, 2009; Dunne, 2009). The role of the therapist in Drama Therapy is that of a guide who utilises their knowledge and techniques in a manner that emphasises genuineness, acceptance, and deep understanding (Emunah, 2013). This can manifest in a more active presence within the therapeutic work or a more distanced position, which will also depend upon the client and session objectives (Jones, 1996; Landy, 1994).

A Drama Therapy session usually has six components, which refer to an introduction, warm up, bridge-in, main event, bridge-out, and reflection (Emunah, 2013; Jones, 1996; Frydman & McLellan, 2014). The introduction of a Drama Therapy session is an opportunity to lay out the aims, content, and process for the session and/or include dramatic ritual (Jones, 1996; Emunah, 2013). In group sessions, the introduction is typically carried out in a circle. The circle, used in most ancient rituals and which is symbolic of totality and the cyclic, is the most common formation of dramatic ritual in Drama Therapy (Emunah, 2013; Makanya, 2014). The circle also honours the start (or end) of the process and provides space for containment. Dramatic ritual is a therapeutic technique, which includes elements of both drama and ritual (Emunah, 2013). Therapists guide the process to ensure it remains safe, beneficial, and in line with treatment goals (Emunah, 2013). Central elements of dramatic ritual include the use of symbolism and metaphor, wherein symbolic representations allow clients the opportunity to gain insight into their present inner state of being and may implement spiritual or cultural elements where appropriate (Makanya, 2014; Schrader, 2012; Emunah, 2013). Much like traditional ritualistic practices, dramatic rituals are structured processes and can incorporate repetition (Emunah, 2013). The purpose of this endeavour is to draw focus to the session, ground clients in the present, and encourage deepened self-expression (Emunah, 2013; Schrader, 2012).

Warm ups in Drama Therapy refer to activities that help clients physically, emotionally, and mentally prepare for drama-therapeutic work (Leveton, 2010; Jones, 1996). This aspect is often divided into two sections: a general warm up activity and a focusing exercise (Lahad, 1999; Jones, 1996; Leveton, 2010). These activities may or may not relate to session goals and vary on account of client concerns, their flexibility in use of dramatic language, and their needs (Jones, 1996). Areas of focus during this process, which pertain to both body and mind, may include coordination, physical expression, concentration, and working with others (Jones, 1996). The bridge-in typically follows, or is incorporated into the warm up component, and is

a moment that encourages the client or client group to engage more directly with the objectives of the session (Jones, 1996; Lahad, 1999).

This leads into the main event, which culminates in deepened involvement in the session, and takes shape in varied forms (Crimmens, 2006; Jones, 1996; Foloştină, Tudorache, Michel, Erzsébet, & Duţă, 2015). For example, a group may work together as a whole with a specific theme and focus, or individuals may be tasked with creating their own material e.g., embodiment, narrative exploration, and mask-making (Jones, 1996).

The bridge-out indicates the closure of active work and concerns disengagement from any dramatic process. This helps the client develop a new relationship to the content, establishes distance from the material covered, and in some instances marks a pause in the active process (Jones, 1996). Sessions are frequently closed with a reflection (Crimmens, 2006; Frydman & McLellan, 2014; Jones, 1996). This contains two main elements, which denote further integration of the material navigated and preparation to leave the therapy space (Jones, 1996). Integration may be verbal, dramatic, take the form of a discussion, involve sharing feelings or connections, or require internal reflection in partial or total silence. This closing can also be a ritualised activity (Emunah, 2013; Jones, 1996). Throughout sessions, or within appropriate moments, many drama therapists incorporate the use of breathwork – particularly with the rise of neuroscientific perspectives on trauma treatment.

Neuropsychological perspectives on trauma treatment posit that the breath can be used to engage the safety system of the brain as a means of encouraging new ways of thinking and decreasing one's sensitivity to the stressors of their internal environment (Grof & Grof, 2023; Van der Kolk, 2014). In early anthropological work the breath is often referenced as an element of magic with strong links to spiritualism and shamanistic power (Oxley & Russell, 2020). Breath by nature is a repetitive, patterned, and rhythmic process that communicates with the body and regulates the nervous system (Munoz, 2023; Nestor, 2020). Techniques such as diaphragmatic breathing or deep belly breathing are commonly utilised and involve deep and slow breaths, which can help reduce anxiety and stress (Hopper, Murray, Ferrara, & Singleton, 2019). Rhythmic breathing patterns, such as inhaling for a certain count and exhaling for a certain count, may be used for emotional regulation, and establishing a sense of safety (Munoz, 2023; Hopper et al., 2019). Breathwork can conjure up intense emotional responses but with the guidance of a trained therapist can be used as an opportunity for integration.

In group settings, the process of breathing and standing together with others requires and stimulates interpersonal rhythms, intuitive awareness, and communication through the breath, body language, and facial expressions (Van der Kolk, 2014). In this way, transformation occurs through the subjective sensation of breath movement as opposed to the external roots of most psychological approaches (Crockett, 2022). This shifts individuals out of "fight-or-flight" states, expands relationship management, and promotes active presence in the moment (Van der Kolk, 2014). The social engagement system can also be activated, particularly in group work, to help clients relax and regulate in an experience of deep listening (Crockett, 2022). Some forms of Drama Therapy directly implement clinical conceptualisations of mindfulness practices, however, as is argued by Rappaport (2014), this state of conscious awareness is intrinsic to most Drama Therapy techniques.

Breathwork stems from mindfulness practices, which are rooted in Theravada Buddhism and Eastern philosophies and is thus not exclusive to drama-therapeutic exercises (Rappaport, 2014). However, as an approach in Drama Therapy, focus on the breath can be used as an integral component of sessions or as a self-standing process. The physical benefits of conscientious breathing are well-documented and known to improve immune function, modulate arousal, balance hormones, promote circulation and organ functioning, reduce muscle tension, and enhance overall psychological well-being (Victoria & Caldwell, 2013; Munoz, 2023; Grof & Grof, 2023). In recognition of the debilitating impacts of trauma on both the body and mind, breathwork provides an accessible and evidence-based approach in mitigating these effects (Van der Kolk, 2014). However, more direct techniques specific to Drama Therapy can also be utilised in the efforts of treating childhood trauma, such as the Role Method developed by Robert Landy (1994).

Role theory has roots in sociology and social psychology and is a concept utilised to explore the functions or roles that individuals occupy within social systems or groups (Biddle, 1986; George, 1993). As a framework, role theory enables an understanding of how individuals perceive and perform their roles in everyday life. Roles can refer to both formal (i.e., job title) and informal (i.e., within a friendship group or community) positions that are undertaken by individuals (George, 1993). These roles are contextualised by norms and expectations regarding their function, which are typically reinforced through larger group or societal values (Biddle, 1986). With this, and considering the interactions between roles within different social

systems, each and every role contains expectations, performance of the specific role, conflict, strain, and influences one's identity (George, 1993; Biddle, 1986; Landy in Johnson & Emunah, 2009). Role theory is useful in developing an understanding of the ways in which individuals adapt to their social environments, evaluating how group norms and values influence one's behaviour, and exploring the rise of conflict when people cannot meet the demands and expectations that different roles require (Biddle, 1986). This conceptualisation of role theory was significant in understanding the Role Method pertinent to Drama Therapy (Landy, 1994; Landy in Johnson & Emunah, 2009).

The Role Method is a practical implementation of role theory and is underpinned by particular assumptions (Landy in Johnson & Emunah, 2009). Within these assumptions, the personality is understood "as an interactive system of roles" (Landy in Johnson & Emunah, 2009: 67) wherein each role, which constitutes a particular pattern of thinking and behaving, is unique. While roles denote specific qualities, they are flexible and adapt to the shifting circumstances of an individual's life. Thus, roles can be understood through both their archetypal qualities as well as through their manifestations in response to an individual's present environment (Biddle, 1986; Landy in Johnson & Emunah, 2009; Pendzik, 2003). As a Drama Therapy treatment approach, it is typically determined that one or more roles that a client needs to take on in life is either underdeveloped, presently non-existent, or clashes with other roles currently being played (Landy in Johnson & Emunah, 2009). The objective within the therapy space is therefore to identify, develop, and access that role (Landy in Johnson & Emunah, 2009). There are various ways in which this can be achieved in Drama Therapy.

Landy (1994) outlines that the exploration of counterroles, which refer to the essential opposites of desired roles (i.e., hero and villain or protagonist and antagonist), is significant to the integration of the role one is trying to obtain. This is important in fostering the client's understanding that both the role and counterrole act as opposite parts of the same whole (Landy in Johnson & Emunah, 2009). Furthermore, in order for one's role repertoire to expand, engagement with, and understanding of, the thoughts, feelings, and behaviours of both components of a role is necessary to playing that role effectively in reality (Landy, 1994; Landy in Johnson & Emunah, 2009). The use and integration of the role of the guide throughout the Role Method process is equally significant to sessions whereby the guide operates as a liminal figure of objectivity between the role and counterrole (Armstrong et al., 2016; Landy in Johnson & Emunah, 2009). Through the drama-therapeutic principles of playing and role-play

(Jones, 1996), clients are encouraged to navigate roles in the therapeutic space and explore the cognition and affect that different roles may inhabit within particular contexts (Landy in Johnson & Emunah, 2009).

Another notion intrinsic to the Role Method is the understanding that every human being has the capacity to play all roles (Landy in Johnson & Emunah, 2009). Landy (1996) established a taxonomy of roles, which indicates role types and their subcategories identified throughout historical periods on numerous occasions to facilitate role exploration. It is equally imperative to acknowledge that, while anyone has the capacity to play all roles, the manner and degree to which this can be achieved will be influenced by stage of development, physical and psychological factors, present environment and sociocultural context, current roles accessible, and the client's willingness to engage in the process (Jones, 1996; Landy in Johnson & Emunah, 2009; Pendzik, 2003). Based on the Role Method, Landy (1996) also conceptualised an assessment tool to evaluate a client's role repertoire. This includes but is not exclusive to: understanding the client's capacity to take on and identify roles, the number of roles a client is able to access, the client's ability to attribute qualities and functions to roles and their subcategories, manner of role-playing, and the client's ability to correlate activities within the therapy space to everyday life (Pendzik, 2003). However, there are other assessment methods which incorporate different uses of role as well (Jones, 1996; Johnson, 1988).

While there is an abundance of documented theory and practice pertinent to the Role Method and other techniques specific to Drama Therapy itself, quantitative research supporting its value is limited (Armstrong et al., 2016; Feniger-Schaal & Orkibi, 2020). This can be partially attributed to the fact that many of the creative processes inherent in Drama Therapy are difficult to quantify (Armstrong et al., 2016). Despite this, there are many case studies which offer qualitative and descriptive analyses of the ways in which Drama Therapy achieves therapeutic goals (Johnson & Emunah, 2009; Godfrey & Haythorne, 2013; Jones, 1996; Landy, 1994). An example of the utilisation and effects of the Role Method is inherent in a case study evaluating a Drama Therapy approach in the treatment of addiction wherein, following a four-month process, the clients' dominant and opposite personality roles were identified, embodied, and led to the emergence of individual "clowns" (Gordon, Shenar, & Pendzik, 2018).

The clown is an archetypal role (Landy, 1996) and is symbolic of the human capacity for play, which is often 'lost' as one enters adulthood (Gordon et al., 2018). In this particular case the

clown role operated as the guide (between the role and counterroles that clients identified), which enabled clients to experiment with their roles through the expressive continuum of play and role-playing via embodied expression (Gordon et al., 2018; Landy in Johnson & Emunah, 2009; Jones, 1996). The role of the clown was identified as a useful tool with recovering addicts in that it normalised the paradox of human existence and served as a strategy for tolerating contradiction (Gordon et al., 2018). This was emphasised by client reflections described in the case studies, which highlighted experiences of deepened self-understanding, development of coping skills, and appreciation of creative means of expression (Gordon et al., 2018).

Similar assertions regarding the value of role play in Drama Therapy are apparent in UK- based studies evaluating the efficacy of Drama Therapy for children with Autism Spectrum Disorder (Godfrey & Haythorne, 2013; Bourne, Selman & Hackett, 2020). Results of both studies indicated that movement, playing, sensory work, role-play, clear boundaries, and a safe environment in Drama Therapy encouraged emotional expression and the development of social skills, which fostered positive relationships with others (Bourne, Selman & Hackett, 2020; Godfrey & Haythorne, 2013). This reinforced the importance of the Drama Therapy session structure and the value of therapeutic interventions for clients with varied needs (Landy, 1994; Godfrey & Haythorne, 2013). In an effort to explore varied Drama Therapy techniques specific to trauma treatment, a slightly different approach known as Narradrama was explored.

Narradrama is a Drama Therapy tool that is concerned with stories and, more specifically, the stories we tell ourselves (Dunne, 2009; White, 1998). Narradrama can be understood as a method of narrative therapy implementation, which utilises embodied and action techniques in combination with other creative arts rather than relying solely on verbal communication, for clients to share their stories (White, 1998; Bezuidenhout, 2012). It is centred around fostering respect and trust, making it particularly effective for individuals and groups exposed to trauma, wherein the therapist is non-directive and flexible (Van Wyk, 2008; Dunne, 2009). This enables clients to explore and express their emotions in a playful and safe manner. However, Narradrama remains intrinsically communicative through its combination of personal and distanced mediums (Brown & Augusta-Scott, 2006).

The intention is to create opportunities to learn, explore, and establish new experiences and skills by filtering out potentially problem-saturated narratives through processes of reauthoring

(Van Wyk, 2008). The nature of most narratives is future-oriented, which enables individuals to achieve change through narrative manipulation (Sguera et al., 2020). Change in identity is attained through alteration of the dominating narrative to implement new desires that shift identities (Sguera et al., 2020). This is achieved through externalisation tools, the creation of alternative stories, action-oriented interventions, and identifying and dramatising outcomes (Dunne, 2009). These processes reinforce notions of resourcefulness, capability, and aspirations beyond one's traumatic experiences (Dunne, 2009). Utilisation of myths and stories in a Drama Therapy session may also provide immense value in Narradrama processes, in that they provide the framework for healing, which enables clients to create connections between unconscious and emotional processes through a more distanced narrative exploration (Jennings, 1994; Van Wyk, 2008).

Narratives allow for the creation of a continuous and familiar plot line that delineates anticipated evolution (Sguera et al., 2020). Among experts, phase-based processes are regarded as the most effective in the treatment of trauma across age groups (Kliethermes et al., 2014). Narradrama, when conducted over multiple sessions, follows a nine-step approach that allows participants to engage in varying levels of personal insight and expression through a phased-paradigm (Carroll, 2023). These steps do not have to be conducted in a linear or sequential fashion, which provides a level of flexibility for both therapist and clients in the therapeutic space (White, 1998). Clients are regarded as the experts of their own life experiences while the therapist, and/or other participants if it is held within a group therapy process, function as observers to stimulate reflexivity (Carroll, 2023; Van Wyk, 2008). This is attributed to the fact that "our stories do not simply represent us, or mirror lived events – they constitute us, shaping our lives and our relationships" (Brown & Augusta-Scott, 2006: 9).

Narratives are inherently emotionally intimate, in that individuals express their thoughts, emotions, and behavioural patterns, with respect to specific events, with others (Criddle et al., 2022; Sguera et al., 2020). Emotional intimacy allows for the creation of personally relevant narratives, holding reflections of identity and desires that may be validated through social engagement with others (Sguera et al., 2020; Prager, 1995). Considering that intimate relationships serve as a unique context for self-disclosure, Narradrama has the potential to provide partners with a space to explore and share their stories with one another in ways that give prominence to individual perceptions of lived experience. Sguera et al. (2020: 860) summarises this succinctly by noting that "narratives are constantly being reformulated to

incorporate evolving perceptions of self, where the new self is a natural outgrowth of past selves and where the new makes sense in the light of the old". In a quantitative study, which examined the value of a group therapeutic interventions for the elderly, narrative elements and other Drama Therapy techniques were implemented (Keisari & Palgi, 2017). Fifty-five people, between the ages of sixty-two to ninety-three, participated (Keisari & Palgi, 2017). Results of this study illustrated a substantial improvement with regard to improved self-acceptance, relationships, and meaning in life, appreciation of ageing, and reduced depressive symptoms (Keisari & Palgi, 2017).

Another Drama Therapy technique that is trauma-centred is Developmental Transformations (DvT). DvT is grounded in existential theory where the present moment is regarded as an entirely unique event that has never existed before (Johnson, 2014). As human beings, we tend to make meaning of this unknown through repeated ideas, images, words, identities, and labels in an attempt to fabricate a sense of stability – irrespective of the fact that our perceptions are frequently inaccurate and poor representations of reality (Johnson, 2014). In these attempts at reducing ambiguity, we place additional expectations upon others and our environments to feel a sense of order and become rigid in what we deem "safe" (Reynolds, 2011; Johnson, 2014). In DvT, the assumption is that individuals need to overcome fear-based schemas as it is the impact and avoidance of fear, which creates problems in thoughts, feelings, behaviours, and relationships with others (Johnson, 2014: 68). With this, the goal of the approach is not to decrease the instability and unpredictability of life but rather to reduce our own internalised fears of life's very nature (Reynolds, 2011). This is especially relevant to trauma treatment in that the impacts of trauma frequently result in maladaptive coping strategies that are centred around the prevention of extreme fear and uncertainty.

DvT is "the transformation of embodied encounters in the playspace" (Johnson, 2009: 89) wherein the content and structure of the play is permanently fluctuating. As an embodied therapy, core aspects of this approach are grounded in the fact that sessions consist entirely of improvisational and dramatic encounters between the therapist and client(s) wherein the therapist is an active participant in the play (Johnson, 2009). The only time that the therapist 'intervenes' is through their own immersion in the client's space of play (Johnson, 2009). Play is incorporated as a way of challenging clients' inhibitions from accessing the fundamental experiences of being in the present moment and helps cultivate continuous energy and enthusiasm (Reynolds, 2011). Linear and 'realistic' stories are abandoned and participants are

encouraged to engage their physical bodies and capacities for imagination in an effort to literally create an experience together (Reynolds, 2011; Johnson, 2014). The aim of this kind of process is to increase client's self-confidence and their ability to manage themselves in transitional and unfamiliar spaces (Johnson in Johnson & Emunah, 2014). This is consistent with the goals of most trauma-treatment models where the purpose is the facilitation of desensitisation to fear-based perceptions.

An example of DvT is apparent in the case description of a nine-year old boy in a foster home who was exposed to domestic violence and drugs in his prior residence (Johnson in Johnson & Emunah, 2014). At four years of age, the boy's biological father attempted murder and was subsequently imprisoned and at six years old the child was sexually molested by his mother's partner (Johnson in Johnson & Emunah, 2014). This conglomeration of events resulted in behavioural difficulties. The Developmental Transformation sessions occurred in an empty room except for a pile of pillows and a cupboard (Johnson in Johnson & Emunah, 2014). Within the space, the therapist initiated a role play where roles were alternated (Reynolds, 2011; Johnson in Johnson & Emunah, 2014).

The therapist subtly weaved in themes of abuse to gauge the boy's responses (Johnson in Johnson & Emunah, 2014). While initially the boy focused on the spectacle and gore, he gradually opened up to express the real events he had experienced where the therapist responded with compassion, kindness, reaffirmation and physical care within this expression in the playspace (Johnson in Johnson & Emunah, 2014). Over time and as the sessions progressed the boy's disruptive behaviours diminished (Johnson in Johnson & Emunah, 2014). The summary of this case study was significant in illustrating that, among other examples of DvT, there was descriptive evidence highlighting the value and safety pertinent to play and how that may foster the communication of difficult experiences (Jones, 1996). These notions correlate with a Drama Therapy intervention grounded in improvisation as well.

Improvisation activities, specifically using theatrical interactive games, is also a therapeutic technique in Drama Therapy known as RfG (Wiener, 1994; Wiener in Johnson & Emunah, 2009). The technique is specific to personalised one-on-one therapy, however it was primarily crafted for the development of relationship and interpersonal skills (Wiener in Johnson & Emunah, 2009). It is highly applicable for assisting in the improvement of interpersonal capacities in that the skills required for an interpersonal relationship are similar to the skills

generated and fostered through improvisation (Wiener in Johnson & Emunah, 2009). According to Wiener (1994), some of these skills are as follows: being observant and perceptive to another's emotions, words, and actions; being adaptable in receiving and producing suggestions and ideas; and offering support and validation. It is proposed that RfG may have a number of positive effects on individuals (Wiener in Johnson & Emunah, 2009).

The nature of improvisational activities and games promotes playfulness in clients and provides a safe environment for spontaneity to be expressed and risks to be taken (Wiener, 1994). This can be attributed to the fact that the playspace offers a distanced experience from reality, which is liminal and always in flux (Jones, 1996; Johnson & Emunah, 2013). Additionally, improvisation generates and magnifies the trust between individuals as they co-create a fresh narrative, which is significant to the development of healthy interpersonal relationships (Wiener in Johnson & Emunah, 2009). An example of this technique's application in couples therapy is evident in the case of Tony and Sara (whose names have been changed) (Wiener, 2009).

Tony and Sara had been married for 6 years and Sara suggested the idea of couples therapy as she felt that Tony had grown distant (Wiener in Johnson & Emunah, 2009). Furthermore, she was having difficulty trusting Tony and found his new interests suspicious (Wiener in Johnson & Emunah, 2009). Through the Drama Therapy session structure (Jones, 1996), the couple were brought into a safe and comfortable space emotionally and physically before entering brief and structured improvisation performances with one other (Wiener in Johnson & Emunah, 2009). The therapist guided and directed the activities and assisted the clients in processing enactments after they had disengaged from the play (Wiener in Johnson & Emunah, 2009). 4 months post treatment, Tony and Sara reported relationship improvements (Wiener in Johnson & Emunah, 2009). This example indicates the particular potential RfG may have when it comes to rectifying interpersonal issues and increasing one's capacity for closeness in relationships. However, it is important to note that there is currently limited literature from varied sources that actively explored RfG. Moreover, quantitative data validating its effectiveness is sparse. With this, CBDT, which is based on the evidence-based CBT paradigm, was explored.

Inspired by the Vygotskian Psychological Approach, CBDT, develops executive functioning through theatrical role play in a safe and structured environment (Frydman & McLellan, 2014; Frydman, 2016; Wood & Schneider, 2015). Participants perform an improvised role play with

a finite narrative course (Frydman & McLellan, 2014). The creation of the narrative is achieved through improvisation and directing – which is an option for individuals declining to or not yet ready role play (Frydman & McLellan, 2014). This process creates a distancing effect from one's own life as the characters and narratives engaged with create space for the client(s) to express themselves in ways in which they are unable to in their current daily rhythms (Frydman & McLellan, 2014; Jones, 1996). Enactment presents the opportunity to see the possibilities outside of normal, constricted roles (Frydman & McLellan, 2014; Jones, 1996). It is argued by Frydman & McLellan (2014) that this allows for the development of strength and executive functioning through decision making.

Drama Therapy processes almost always culminate in reflection (Jones, 1996). Reflection is a stage in drama-therapeutic processes wherein emotional, mental, or psychological gains are reinforced through a sharing of experiences (Wood & Schneider, 2015; Frydman & McLellan, 2014; Frydman, 2016). Individuals are offered the time to note and meaningfully express their experience ensuring that their stories and characters explored have come to an end with closure (Frydman & McLellan, 2014). A case study, which utilised CBDT in the treatment of residentially homed adolescent girls reflected this (Frydman & McLellan, 2014). The home was a fractured and unsteady environment where complex trauma and verbal and physical altercations were common (Frydman & McLellan, 2014). Through the CBDT approach, the girls were ultimately able to share and effectively communicate their own complex histories with one another as well as identify the dynamics within their own community (Frydman & McLellan, 2014). What is significant to note about the CBDT approach is that it draws together many of the aforementioned elements pertinent to Drama Therapy, which also speak back to its value and potential as a healing modality in the treatment of trauma.

While this is not an exhaustive exploration of all Drama Therapy trauma-based treatment approaches, this review of drama-therapeutic literature provides a basis for some of the varied techniques that may be applicable. The Nine Core Principles of Drama Therapy (Jones, 1996); the general structure of a Drama Therapy session (Jones, 1996) and dramatic ritual (Emunah, 2013); neuroscientific frameworks and breathwork (Van der Kolk, 2014; Rappaport, 2014); the Role Method (Landy, 1994); Narradrama (Dunne, 2009; Bezuidenhout, 2012); DvT (Johnson, 2009, 2014); RfG (Wiener, 2009); and CBDT (Frydman & McLellan, 2014) each offer unique contributions that may be useful in dealing with trauma and contain elements that

are relational in nature, which may contribute to the purpose of building healthy intimate partnerships.

In the efforts of exploring how Drama Therapy techniques may facilitate the recovery of intimacy in adults impacted by childhood trauma and to identify what Drama Therapy tools and approaches may be most useful, further analysis of previously explored variables was required. This necessitated a discussion of the literature explored and the ways in which the effects and impacts of childhood trauma on intimacy, predominant trauma-treatment modalities, and Drama Therapy techniques relate. This was carried out through a thematic analysis of findings specific to a traditional literature review methodology.

Chapter IV: Method Section

Methodology

This research was approached through a qualitative study utilising a traditional literature review as a method. A literature review is placed within a defined research context and is used to address theoretical or practical questions by exploring previously established theories to explain some kind of phenomena (Knopf, 2006; Cronin, Ryan, & Coughlan, 2008). This methodology can also be implemented to explore existing knowledge pertinent to particular topics and determine what may be effective in dealing with certain problems for further research (Lim, Kumar, & Ali, 2022; Li & Wang, 2018). Literature reviews necessitate the exploration of previously published works and enable researchers to garner an overview of research that was formerly unfamiliar and provide insight into what is already known within specific fields, what is unknown or debated, and where potential gaps may lie (Garrod, 2023; Lim et al., 2022; Knopf, 2006; Cronin et al., 2008; Li & Wang, 2018).

According to Paul & Criado (2020), literature reviews are of importance in evaluating the thematic, conceptual, theoretical, and methodological significance of prior studies. Some forms of literature review, such as meta-analytical reviews, also incorporate quantitative measurements and data (Lim et al., 2022; Paul & Criado, 2020). This research followed the format of a traditional literature review, which is considered an informative and scientific qualitative method that is used for collecting, summarising, and reviewing research findings on a given research focus (Paul & Barari, 2022; Knopf, 2006; Rowe, 2014; Li & Wang, 2018). The literature review is thus a researcher's contribution to knowledge through a particular

frame – wherein knowledge refers to beliefs that an individual buys into based on their expertise or experience (Knopf, 2006). With this, it is important to note that many literature reviews are inherently subjective owing to the researcher's prior knowledge, biases, and life experiences – irrespective of attempts at genuine objectivity (Paul & Barari, 2022; Rowe, 2014). This applies to the selection and interpretation of information included as well (Garrod, 2023; Rowe, 2014; Paul & Barari, 2022).

Information presented in the literature review typically follows an anthological or thematic structure (Li & Wang, 2018). Within this research context, thematic analysis was implemented. Thematic analysis is a means of identifying and interpreting patterns of meaning within the data examined (Holton, 1988; Clarke, Braun, & Hayfield, 2015). It is carried out based upon the emergent themes within the studies being evaluated wherein the information is scaffolded through arguments (Li & Wang, 2018). An argument, in accordance with philosopher Stephen Toulmin's model, refers to a logical demonstration of evidence which supports one's reasoning (Toulmin, 1988; Kneupper, 1978; Li & Wang, 2018). The three central components of an argument include claims, evidence, and warrants (Kneupper, 1978) wherein warrants provide links between evidence and claims (Li & Wang, 2018). With this, the information presented in this research was developed around various arguments wherein themes were presented with supporting evidence from multiple sources (Clarke et al., 2015; Li & Wang, 2018).

Data Analysis

In order to mitigate potential biases and enhance the validity of this research, sources selected were based upon several factors (Kneupper, 1978). This included consideration of prominent authors within the fields of childhood trauma, intimacy, and Drama Therapy and the major schools of thought significant to those topics (Lim et al., 2022). This aided my efforts in selecting information that I deemed relevant and the way in which I structured the literature review. The kinds of publications utilised and explored included books, academic journals, peer-reviewed articles, empirically and qualitatively validated studies, and institutional repositories – all of which were a combination of hard copy and material retrieved online. In addition to making use of online content on other academic platforms accessible through the University of the Witwatersrand, I utilised Google Scholar. Considering that I approached this research through thematic analysis, the information selected was filtered by theme and relevance where possible i.e., high-visibility, prestige, and frequently cited (Knopf, 2006).

The time period in which research was generated was also significant while selecting data. While it was important to examine recent studies and garner an overview of developments in various fields, such as psychology, the useability of data was subject to accessibility. Similarly, when it concerned defining the features of core concepts like intimacy, it was more challenging to locate information that had been generated in the last five to ten years. With this, I expanded the time frame used to approach the data gathering process to obtain a more historical overview (Lim et al., 2022). The kinds of activities incorporated in gathering data included: reading, writing, collecting, describing, summarising, comparing, evaluating, thematic analysis, and organising. Considering that the topic at hand was also not defined by a particular geographical or linguistic context, sources included in the literature ranged in origin, methodologies and populations considered, and spanned interdisciplinary fields (Knopf, 2006). These factors influenced the structure of the literature review, which was organised thematically (Lim et al., 2022; Rowe, 2014; Knopf, 2006).

This research thus required a combined interpretive and pragmatic approach of analysis in that it assumes the existence of multiple socially constructed realities, wherein the truth is dependent on context, as well as the practical effects of ideas, wherein knowledge needs to be valued in terms of its practical use (Chilisa, 2012). A traditional literature review enabled the creation of an overview of information concerning: the impact of childhood trauma; how manifestations of childhood trauma influence relationships; identifying prominent treatment approaches specific to childhood trauma in adulthood; and locating what Drama Therapy techniques may be beneficial with regards to trauma treatment. This methodology of research helped me discover relationships between sources; identify major themes and concepts; develop my own ideas; and identify potential critical gaps in the available literature. Through the following analysis of how these notions relate to and/or contradict with one another, the ways in which Drama Therapy tools may be implemented with the purpose of fostering intimacy in partnerships was evaluated.

Chapter V: Findings & Insights

Summary & Analysis

In order to identify the major themes and concepts pertinent to the literature explored and evaluate how Drama Therapy may foster intimacy in the context of childhood trauma, a

summary and analysis of each central topic indicated in the literature review was necessary. This incorporated evaluation of findings specific to: the areas of impairment commonly linked to childhood trauma; the impact of different forms of childhood trauma on intimacy; predominant therapeutic approaches in trauma treatment; and Drama Therapy techniques utilised in the treatment of trauma. Through an extensive exploration of the ways in which childhood trauma may impact individuals, it is clear that childhood trauma can have lifelong influences in various domains.

As was identified in the existing literature, these impacts tend to be organised within particular groupings: emotional and behavioural dysregulation, cognitive and attentional difficulties, biological changes, shifts in perceptions of self and the external environment, and challenges in interpersonal relationships (Kliethermes et al., 2014; Briere & Scott, 2015; Marganska et al., 2013; Watts-English et al., 2006). Childhood trauma often leads to dysregulation in behaviour and emotion wherein individuals may experience further difficulties with coping skills, overwhelm from emotions, and challenges with expression and/or impulse control (Marganska et al., 2013; Watts-English et al., 2006; Ford & Russo, 2006; Dvir et al., 2014; Su & Stone, 2020). Cognitive and attentional difficulties in response to childhood trauma may incorporate memory problems, difficulty planning, limited curiosity, and poor engagement (Williams et al., 2020; Fan et al., 2021; Kliethermes et al., 2014; Su et al., 2019). Many of these difficulties can be linked to physical changes in the brain as a result of trauma. This may include changes in the hippocampus, prefrontal cortex, basal ganglia, and amygdala, which can impact mood, behaviour, and sleep patterns (Smith et al., 2021; Danese & Baldwin, 2017; Dillon et al., 2009; Zimmerman et al., 2019).

Distortions in one's perception of self and the world can also be attributed to trauma exposure in childhood, which amplifies feelings of low self-worth and trust issues that impact overall wellbeing and relationships (Whiteman et al., 2019; Su & Stone, 2020; Kliethermes et al., 2014; Brown et al., 2019; Kooistra et al., 2023). Disruptions to the formulation of healthy attachment during childhood may lead to challenges in forming secure relationships in adulthood – which can culminate in trust issues, unhealthy relationship patterns, and trauma re-enactment in intimate partnerships and relations with others (Erickson et al., 2019; Lahousen et al., 2019). Many of these areas of impairment are also linked to the development and chronic manifestation of PTSD, which underpins the complexity of challenges experienced as a result of untreated childhood trauma (Briere & Scott, 2015; Davey, 2014). Considering that the

symptoms associated with trauma exposure vary in duration and intensity (American Psychiatric Association, 2013), the significance of client-specific approaches with regards to trauma treatment was reinforced.

The impact of childhood trauma on intimacy was explored through a comprehensive overview. This emphasised the complex ways in which varied forms of childhood trauma of an interpersonal nature may influence one's ability to form and maintain intimate relationships (Wiffen & Oliver, 2013; Leifker et al., 2015; Criddle et al., 2022; Khaleque, 2004). Intimacy was defined as the capacity to share subjective thoughts and feelings with others; however, it was noted earlier in the report that physical, emotional, mental, experiential, and spiritual forms of intimacy are all equally significant (Prager, 1995; Reis, 2018; Loggins, 2022). It was also emphasised that intimacy is an important component of mental well-being and overall health, whereby difficulties in establishing and maintaining intimacy has the potential to affect various forms of relationships (Park et al., 2021; Khaleque, 2004). PTSD, in particular, has strong associations with distressed intimate relationships wherein interpersonal trauma may generate fears regarding emotional and physical closeness and difficulties in providing support to one's partner (Mills & Turnbull, 2004; Criddle et al., 2022; Leifker et al., 2015).

Literature pertaining to various forms of childhood trauma, including physical abuse, sexual abuse, psychological or emotional abuse, and neglect, and their impact on intimate relationships in adulthood were evaluated. Physical abuse was correlated with depression, feelings of worthlessness, cognitive and language difficulties, aggression, conduct disorders, and physical illnesses (Larsen et al., 2011; Rasool, 2022; Malinosky-Rummel & Hansen, 1993; Talmon et al., 2021; Sirotnak et al., 2004; Rivara et al., 2019). Similarly, childhood sexual abuse was found to have significant and long-lasting impacts, such as increased risk of suicide (Gawęda et al., 2020), and survivors may face later challenges with confiding in partners, trust, emotional communication, romantic intimacy, and shame (MacGinley et al., 2019; Martinson et al., 2013; Davis et al., 2001; Martinson et al., 2016; Talmon et al., 2021).

Emotional abuse and neglect, which are comorbid with all forms of abuse, may culminate in issues such as distrust, expectancy of rejection, emotional inhibition, and indifference in relationships (Park et al., 2021; Marganska et al., 2013; Norman et al., 2012; Yoo et al., 2014; Vaillancourt-Morel et al., 2019; DiLillo et al., 2009). Additionally, these impacts of childhood trauma have the potential to influence attachment styles in adulthood, which was previously

noted to affect an individual's engagement in healthy intimate relationships (Larsen et al., 2011). This review provided valuable insights into the relationship between childhood trauma and intimacy in adulthood. Furthermore, the literature underscored the significance of addressing trauma-related difficulties in therapeutic settings so as to improve the quality of one's intimate relationships.

Various therapeutic approaches, including Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), and psychodynamic techniques, in the context of treatment for adults navigating the effects of childhood trauma were explored in the literature examined. CBT was introduced as an empirically validated form of therapy that aims to modify cognitive processes and behaviour in order to address trauma-related symptoms (Bieling et al., 2022; Corey, 2021; Sheldon et al., 2011). CBT has demonstrated effectiveness among various populations (Weiten, 2016; Kar, 2011; Davey, 2014) and has inspired other forms of psychotherapy, such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) (Cohen & Mannarino, 2008; McMullen et al., 2013).

DBT was originally designed for individuals with Borderline Personality Disorder (BPD) (Dimeff & Linehan, 2001; Kothgassner et al., 2021) but has also been found effective in targeting trauma-related difficulties and a variety of mental health conditions (Corey, 2021; Lenz et al., 2014; Weiten, 2016). This is achieved through techniques geared towards emotional regulation, mindfulness, and acceptance (Scheel, 2000; Dimeff & Linehan, 2001; Lenz et al., 2014). Psychodynamic therapy was also evaluated and discussed as an approach that focuses on client's thoughts, early life experiences, and emotions in the efforts of facilitating self-awareness, coping mechanisms, and addressing relationship patterns (Schottenbauer et al., 2008; Shedler, 2010; Corey, 2021).

The therapeutic relationship was emphasised in all three trauma treatment approaches addressed, wherein the relationship between the client and therapist was identified as crucial in healing and addressing interpersonal trauma (Marziali & Alexander, 1991; Jones, 2004; Corey, 2021). This relationship serves as the foundation for effective treatment and plays a central role in developing positive therapeutic outcomes (Edwards, 2016; Erkkila et al., 2011). Aspects of the therapeutic relationship that facilitate this in the literature reviewed included: building trust, empathy and understanding, boundaries and consistency, collaboration, validation, problem solving, embracing resistance, and client empowerment (Su & Stone,

2020; Corey, 2021; Nielsen, 2017; Mills & Turnbull, 2004). Through these means, clients dealing with traumatic experiences from childhood are provided with a space of safety where therapists can empower them to work toward their goals (Solomon, 2003; McMullen et al., 2013; Su & Stone, 2020; Schottenbauer et al., 2008; Shedler, 2010). The insights and skills that clients gained in the therapeutic paradigms addressed, such as compassion, validation, and empathy, were also noted for their potential to benefit intimate relationships by fostering communication and a greater sense of understanding between partners. With the purposes of exploring how Drama Therapy may foster intimacy between partners in a relationship, varied Drama Therapy techniques were also explored.

Drama Therapy is a versatile approach to psychotherapy wherein sessions incorporate a broad range of principles and techniques (Jones, 1996; Landy, 1994; Emunah, 2013; Lahad, 2009). The Nine Core Principles of Drama Therapy established and categorised by Jones (1996) offer a solid framework for this therapeutic modality and the dramatic and psychological facets it incorporates. This was emphasised further through the analysis of the general Drama Therapy session structure, which highlighted the value of establishing a safe and structured environment for clients to actively interrogate their experiences and emotions through dramatic tools (Emunah, 2013; Jones, 1996; Frydman & McLellan, 2014; Leveton, 2010; Crimmens, 2006).

The utilisation of symbolism and ritual in Drama Therapy offers a unique aspect of depth, which may enable clients in gaining greater insight about their inner experiences and contribute to feelings of safety and being understood – particularly if these components are included with the client's spiritual and cultural context in mind (Makanya, 2014; Schrader, 2012; Emunah, 2013). The incorporation of breathwork and mindfulness in Drama Therapy is aligned with current research on trauma treatment and the role of the breath in nervous system regulation (Grof & Grof, 2023; Van der Kolk, 2014; Hopper et al., 2019; Munoz, 2023). Furthermore, this approach considers the mind-body connection with regards to trauma treatment and the potential benefits that the inclusion of breathwork in Drama Therapy may have in reducing stress and developing emotional regulation skills (Rappaport, 2014; Crockett, 2022; Victoria & Caldwell, 2013).

The Role Method was described as a dynamic technique that accounts for the complexity and flexibility of human positions in life (George, 1993; Landy in Johnson & Emunah, 2009). Through role exploration, clients are enabled to develop aspects of themselves that may be in

conflict with other roles their contexts demand (Landy in Johnson & Emunah, 2013). The exploration of counterroles and the guidance of a therapist were highlighted as central components of this approach (Landy, 1994; Landy in Johnson & Emunah, 2009). Clients are enabled to develop a deeper understanding of their thoughts, feelings, and behaviour patterns through different roles while expanding their role repertoires (Landy, 1994; Pendzik, 2003; Johnson, 1988). While it was noted that role expansion and portrayal may be dependent on various factors such as stage of development, the potential for growth is accessible for every person.

Landy's (1996) assessment tool utilising the Role Method is a valuable tool for therapists and evaluating client's progressions with regards to identifying and inhabiting different life roles. The case study exploring the use of clown therapy illustrated the value of the transformative and creative potential inherent to drama-therapeutic processes (Gordon et al., 2018). The examples of the use of role play among children with Autism Spectrum Disorder reinforce the versatility of this technique and how it may be adapted and applied to suit a wide range of client needs (Godfrey & Haythorne, 2013). This can include developments in emotional expression as well as social skills – both of which are central to experiences of intimacy.

Narradrama is another noteworthy Drama Therapy approach which was explored, which is based upon narrative exploration and storytelling (Dunne, 2009; White, 1998). As a therapeutic technique, Narradrama provides the space for individuals and groups to unpack and process their experiences (Bezuidenhout, 2012; Brown & Augusta-Scott, 2006). Within this modality therapists embody a flexible and nondirective approach to enhance safety and trust, which is essential when dealing with traumatic experiences (Carroll, 2023; Van Wyk, 2008; Sguera et al., 2020). As a method of narrative therapy that combines embodied techniques with other arts, various creative mediums can be incorporated. This is of particular significance for clients who may find it challenging to express their experiences via verbal means. The aim of Narradrama is to orient clients toward the future by releasing problem-dominated narratives and aligning with new aspirations and desires, which facilitates feelings of resourcefulness and empowerment (Dunne, 2009; Van Wyk, 2008; Sguera et al., 2020). Myths and stories can also be included within Narradrama processes as they may provide another essential layer of distance from traumatic material (Jones, 1996; Jennings, 1994; Van Wyk, 2008).

Stories about lived experiences are innately emotionally intimate, especially within the context of sharing with others (i.e., the therapist or group) (Criddle et al., 2022; Prager, 1995). However, the expression of one's thoughts, feelings, desires, and past with others in the Narradrama approach was emphasised as pertinent to being validated and affirmed by others, which fosters intimacy (Keisari & Palgi, 2017). Within group contexts these acts of exploring and sharing typically strengthens connections (Keisari & Palgi, 2017). In the case where Narradrama was utilised among older adults, increased self-acceptance and reduced symptoms of depression were noted (Keisari & Palgi, 2017). In summary, Narradrama was identified as a unique technique for clients to explore, reframe, and transform their personal stories (Carroll, 2023; Dunne, 2009).

Three additional Drama Therapy techniques were discussed, which included: Developmental Transformations (DvT), Rehearsals for Growth (RfG), and Cognitive-Based Trauma Informed Drama Therapy (CBDT). These techniques all offered innovative experiential methodologies with regards to trauma treatment, personal advancement, and the development of relationships (Johnson, 2014; Reynolds, 2011; Jones, 1996; Johnson in Johnson & Emunah, 2014; Wiener, 1994; Wiener in Johnson & Emunah, 2009; Frydman & McLellan, 2014; Wood & Schneider, 2015). DvT, for example, emphasises the unique potential of every moment and was particular in the literature about its potential effectiveness for reducing fear-based perceptions and promoting spontaneity (Johnson, 2009; Reynolds, 2011). This is attributed to the utilisation of improvisational play wherein the therapist actively participates and only intervenes when deemed necessary (Johnson in Johnson & Emunah, 2014). Play is implemented for its value in challenging inhibitions and prompting clients to engage with the unknown as a means of developing client confidence and skills in unfamiliar contexts (Jones, 1996; Johnson, 2009; Johnson in Johnson & Emunah, 2014). This use of improvisation was also significant to the technique referred to as RfG.

RfG was originally developed to facilitate interpersonal and relationship skills on a one-on-one basis (Wiener, 1994; Wiener in Johnson & Emunah, 2009). Through improvisation activities and theatrical game play, clients are encouraged to delve into their capacities for spontaneity and risk taking within the safety of the therapeutic environment (Jones, 1996; Wiener, 1994; Wiener in Johnson & Emunah, 2009). This encourages the development of healthy relationships by promoting playfulness and trust in others (Wiener in Johnson & Emunah, 2009; Jones, 1996). RfG has also been used to address issues in couples therapy and, while

there is limited literature exploring and validating its effects, it shows potential in enhancing closeness in interpersonal connections and developing interpersonal skills (Wiener in Johnson & Emunah, 2009).

CBDT was the last of the drama-therapeutic approaches explored and combines cognitive-behavioural techniques with principles and methods pertinent to Drama Therapy (Frydman & McLellan, 2014; Frydman, 2016; Wood & Schneider, 2015). Within this paradigm, participants are encouraged to experiment with improvised role play and a structured narrative (Frydman & McLellan, 2014). Through the enactment of dominant roles participants are invited to explore the possibilities beyond their usual roles (Landy, 1994). This is proposed to foster decision-making skills and executive functioning (Frydman & McLellan, 2014; Frydman, 2016; Wood & Schneider, 2015). The process of reflection, wherein clients share their experiences with one another, is described as a means of providing closure to old roles and narratives while welcoming emotional and psychological gains (Frydman & McLellan, 2014; Wood & Schneider, 2015). The utilisation of CBDT was sparsely documented, however the case study mentioned highlighted how the combined effects of role and narrative exploration enabled understanding and communication among adolescents with traumatic histories (Frydman & McLellan, 2014).

This analysis of findings specific to the areas of impairment commonly linked to childhood trauma; the impact of different forms of childhood trauma on intimacy; predominant therapeutic approaches in trauma treatment; and Drama Therapy techniques utilised in the treatment of trauma, highlights themes within the literature. In order to identify and evaluate how Drama Therapy may foster intimacy in the context of childhood trauma, this summary and analysis was significant and informed the discussion to follow.

Discussion & Themes

Through careful and thorough examination of the literature and evaluation of the summaries of topics central to this research, links between sources and the themes inherent within this research became clearer. The prominent themes recognised from the literature explored, which informed this discussion included: the relationship between childhood trauma and intimacy; trauma-informed treatment approaches, Drama Therapy techniques and intimacy; the

significance of the therapeutic relationship; the role of vulnerability and narrative; and the integration of CBT into Drama Therapy methods. Furthermore, the themes identified contribute to a holistic framework of the ways in which Drama Therapy may foster intimacy between partners in the context of childhood trauma.

From the analysis of literature incorporated into this review, it became evident that childhood trauma impacts intimacy in various ways. This can include but is not exclusive to: emotional and behavioural dysregulation, cognitive and attentional difficulties, biological changes, poor self-worth, and difficulties in forming healthy relationships and attachment to others (Kliethermes et al., 2014; Briere & Scott, 2015; Marganska et al., 2013; Watts-English et al., 2006). Common responses to childhood trauma that may have an impact on an individual's experiences of intimacy that have been identified in this research are feelings of low self-worth, aggression, distrust, poor emotional communication, expectancy of rejection, emotional inhibition, indifference in relationships, and general challenges with intimate exchanges of all forms (Kliethermes et al., 2014; Briere & Scott, 2015; Marganska et al., 2013; Watts-English et al., 2006; Dvir et al., 2014; Su & Stone, 2020). These difficulties all have the capacity to impact an individual's life and their capacity to attain and maintain relational intimacy, which is significant to relationship closeness and general relationship satisfaction (Erickson et al., 2019; Lahousen et al., 2019).

In order to address the impacts of childhood trauma, effective therapeutic methods such as Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), and psychodynamic approaches were discussed. Through the navigation of psychological and emotional consequences in response to childhood trauma, all approaches investigated have the capacity to foster intimacy as it is often unprocessed and unresolved trauma, which inhibits intimate experiences and one's ability to develop close relationships Wiffen & Oliver, 2013; Leifker et al., 2015; Criddle et al., 2022; Khaleque, 2004). With this Drama Therapy was identified as a psychotherapeutic intervention, which is utilised in the treatment of trauma, which may offer a distinct and creative way of developing intimacy amongst individuals and groups. Through Drama Therapy techniques, such as Narradrama or the Role Method, individuals are enabled to process their traumatic histories in a creative experiential manner (Dunne, 2009; Van Wyk, 2008; Sguera et al., 2020; George, 1993; Landy in Johnson & Emunah, 2009). With this, the potential benefits of exploring one's trauma within a space

grounded in expression and transformation may contribute to development in engaging in positive intimate relationships.

The role of the therapeutic relationship is also emphasised and considered crucial across various therapeutic approaches, including Drama Therapy (Marziali & Alexander, 1991; Jones, 2004; Corey, 2021; Edwards, 2016; Erkkila et al., 2011). The effectiveness of trauma treatment is highly dependent on the strength of the therapeutic relationship, which should be grounded in understanding, empathy, and compassion, and can be used to model healthy interactions (Su & Stone, 2020; Corey, 2021; Nielsen, 2017; Mills & Turnbull, 2004). This is also inextricably linked to the versatility of Drama Therapy, which allows the medium to be adapted to suit particular client needs (Jones, 1996; Landy, 1994; Emunah, 2013; Lahad, 2009). As clients are encouraged and enabled through techniques designed to foster transformation, spontaneity, and personal growth, emotional expression and social skills can be developed (Jones, 1996; Landy, 1994). Progressions in confidence and insights attained throughout processes may further help clients develop their capacities for engaging in intimate relationships.

Vulnerability is another common thread throughout the literature examined wherein the experience of vulnerability may pose both a challenge and opportunity for individuals with histories of childhood trauma (Larsen, et al., 2011; Emunah, 2013; Jones, 1996). Drama Therapy, as well as the other therapeutic approaches discussed, offers a structured and supportive context (Landy, 1994; Emunah, 2013; Jones, 1996). Vulnerability with others is a means towards transformation and personal empowerment and through vulnerability clients can begin to develop resilience and reframe their narratives (Dunne, 2009). Sharing plays a central role in intimacy and necessitates one's ability to share their thoughts, feelings, and experiences with others in meaningful ways (Prager, 1995; Reis, 2018; Loggins, 2022). While childhood trauma may impede an individual's capacity to share their experiences with others, Drama Therapy, and the dramatic tools inherent to the discipline may make it easier for clients to explore and share their experiences. This is also central to the idea behind Narradrama, which is grounded in personal stories, and how experimentation with one's life story can lead to healing and consequently greater capacities for intimacy.

Further correlations were also noted between the integration of Cognitive-Behavioural techniques and Drama Therapy, as was evident in Cognitive-Based Trauma Informed Drama Therapy (CBDT), wherein the different therapeutic approaches complimented one another

(Weiten, 2016; Kar, 2011; Davey, 2014; Cohen & Mannarino, 2008; McMullen et al., 2013). This collaboration of techniques presents clients with a well-rounded approach for navigating trauma-related difficulties and highlights the potential for greater collaboration and integration of techniques between the fields of psychology and Drama Therapy with regards to the treatment of trauma.

Through this discussion of the themes in the literature, it is my opinion that therapeutic approaches, which prioritise the value of the therapeutic relationship and the development of skills specific to emotional expression, narrative exploration, and interpersonal connectedness have the potential to foster intimate relationships between partners. This is owing to the fact that it is often unprocessed and unresolved trauma, which inhibits intimate experiences and one's ability to develop close relationships. All the therapeutic approaches explored have the capacity to foster intimacy through varied means of navigating trauma. With regards to Drama Therapy, these notions are fitting as well in that connectedness, emotional expression, and narrative exploration, are emphasised through varied creative techniques that may provide clients with traumatic histories distance from their material and encourage vulnerability and sharing. The prominent themes identified illustrated this through the relationships between childhood trauma and intimacy; trauma-informed treatment approaches, Drama Therapy techniques and intimacy; the significance of the therapeutic relationship; the role of vulnerability and narrative; and the integration of evidence-based CBT into Drama Therapy methods.

Chapter VI: Analysis of Findings

Review & Implications

In order to review the implications of the discussion and themes identified above in this research, key points that I deemed significant to trauma treatment and intimacy that may inform therapeutic interventions and practices were evaluated. This included the incorporation of trauma-informed approaches in intimacy development; the role of the therapeutic relationship and supporting healthy attachment; and Drama Therapy as a versatile tool for narrative exploration, vulnerability and sharing, and transformation and empowerment.

Through a developed understanding of the relationship between childhood trauma and intimacy, the value of trauma-informed techniques in therapy is significant. Furthermore, this

highlights the necessity for therapists to be adequately trained in addressing trauma-related difficulties and understanding how this may impact an individual's capacity to form and maintain relationships (Kliethermes et al., 2014; Briere & Scott, 2015; Marganska et al., 2013; Watts-English et al., 2006; Dvir et al., 2014; Su & Stone, 2020; Erickson et al., 2019; Lahousen et al., 2019). As a model for positive interpersonal relationships and intimacy, the therapeutic relationship is crucial to trauma treatment (Marziali & Alexander, 1991; Jones, 2004; Corey, 2021; Edwards, 2016; Erkkila et al., 2011; Su & Stone, 2020; Nielsen, 2017; Mills & Turnbull, 2004). With this, the emphasis for therapists to establish a safe, trusting, and compassionate environment is reinforced (Su & Stone, 2020; Corey, 2021; Nielsen, 2017; Mills & Turnbull, 2004; Jones, 1996; Landy, 1994). This is pivotal for clients to feel encouraged to share their experiences and vulnerabilities (Larsen, et al., 2011; Emunah, 2013; Jones, 1996; Prager, 1995; Reis, 2018; Loggins, 2022). Additionally, therapists can utilise the therapeutic alliance to help clients navigate attachment-related issues, which has the potential to improve client capacities for intimacy as well (Su & Stone, 2020; Corey, 2021; Nielsen, 2017; Mills & Turnbull, 2004).

The versatility and creativity pertinent to Drama Therapy emphasise its value as a tool for mitigating the impacts of childhood trauma and intimacy issues (Jones, 1996; Landy, 1994; Emunah, 2013; Lahad, 2009). Through the incorporation of varied dramatic techniques and the use of storytelling, clients are enabled to process their traumatic histories and foster the emotional expression skills essential to intimacy through various means (Bezuidenhout, 2012; Brown & Augusta-Scott, 2006; Carroll, 2023; Van Wyk, 2008; Sguera et al., 2020). Narradrama, which is a form of the use of storytelling in Drama Therapy, is a useful tool in helping clients explore and reframe their stories through processes of sharing (Dunne, 2009; Bezuidenhout, 2012; Brown & Augusta-Scott, 2006). This endeavour in and of itself necessitates vulnerability, which can be a catalyst for personal growth (Larsen, et al., 2011; Emunah, 2013; Jones, 1996; Prager, 1995; Reis, 2018; Loggins, 2022), and thus has the potential to foster intimacy.

This is significant in illustrating how Drama Therapy may foster intimacy between partners in the context of childhood trauma. Other techniques in Drama Therapy that were explored in the literature indicate potential for this as well through grounding in interaction, safety, trust, play, sharing, and connection (Jones, 1996; Landy, 1994; Lahad, 2009; Emunah, 2013; Frydman & McLellan, 2014; Leveton, 2010; Crimmens, 2006; Landy in Johnson & Emunah, 2009; Godfrey & Haythorne, 2013; Dunne, 2009; White, 1998). Moreover, the Drama Therapy

techniques explored indicate a focus on transformation and empowerment, wherein support from the therapist and/or client group may reinforce a client's willingness to engage with their journey toward healing, resilience, and growth, wherein both techniques and support from others can contribute to intimacy.

The incorporation of trauma-informed approaches in intimacy development; the role of the therapeutic relationship and supporting healthy attachment; and Drama Therapy as a versatile tool for narrative exploration, vulnerability and sharing, and transformation and empowerment, suggest that Drama Therapy techniques may facilitate the development of healthy intimate partnerships in adults dealing with childhood trauma through trauma-informed methods. From the literature examined, it appears that techniques that emphasise emotional regulation, navigating traumatic experiences through safe and structured means, sharing of personal stories, the development of interpersonal skills, empathy and understanding, and support through personal transformation, are key to fostering intimacy in therapy. These notions also appear to be intrinsic to Drama Therapy and all the techniques examined. This is important in denoting how Drama Therapy contributes to the larger scope of literature regarding trauma treatment as well as highlighting how trauma treatment and Drama Therapy may foster intimacy, which is a central component of relationships.

Limitations & Future Directions

There are however several limitations to this research. This is inclusive of the fact that, as a literature review, this research is not an empirically validated study, which limits its scientific validity and applicability. Additionally, only a selection of literature pertaining to the key topics (i.e., intimacy, childhood trauma, therapeutic modalities specific to psychology as well as Drama Therapy) was utilised. While attempts were made to reduce biases in data selection, these efforts were not absolute. Thus, the literature examined is not representative of entire bodies of research that may provide more accurate insights. Similar limits of this study include the fact that Drama Therapy lacks in scientifically and empirically supported studies validating its efficacy. The establishment of empirically supported research in the field of Drama Therapy is thus a necessary step in aligning with other modalities significant to trauma treatment, generating further research, and contributing further to the conversation of addressing the broader societal issues that childhood trauma poses.

Considering the fact that broad notions pertaining to childhood trauma, intimacy, therapeutic techniques across disciplines, and Drama Therapy were utilised, this study offers only a general overview of how childhood trauma may impact intimacy, and the ways in which therapeutic techniques may foster intimate experiences in the context of childhood trauma. This highlights the potential for further research, which would be more specific in terms of the forms of childhood trauma being addressed and particular techniques being evaluated. Considering that only a portion of Drama Therapy techniques were evaluated in this research, this study was also not entirely indicative of which techniques may best benefit traumatised populations with the intention of fostering intimacy. However, from the studies examined, it is my opinion that as a result of Drama Therapy's flexible nature, that almost all trauma-informed Drama Therapy techniques hold the potential for fostering intimacy.

With regards to the role of Drama Therapy in trauma treatment, it appears that various techniques are also similar in approach to the psychological mediums explored. This reinforces the significance of developing research, which examines and scientifically explores the ways in which Drama Therapy may be of benefit to individuals navigating the effects of childhood trauma and how these techniques correlate with other evidence-based paradigms. This draws attention to the need for Drama Therapy programmes and collaboration on a postgraduate level, with other departments, to collaborate on future research so that the potential benefits of multiple perspectives can be effectively examined and utilised in the efforts of trauma treatment. This has the further potential for fostering intimacy in clients' relationships, which is of central importance to human health.

Chapter VII: General Conclusion

This research was approached through a qualitative study utilising a traditional literature review as a method. Within this research context, thematic analysis was implemented, which aided my efforts in selecting information that I deemed relevant and also the way in which I structured the literature review. A traditional literature review enabled the creation of an overview of information and helped me to discover relationships between sources and identify major themes and concepts.

The first chapter of this research provided a general introduction to the major topics of interest. This included defining the central features of childhood trauma, intimacy, trauma treatment

modalities, and Drama Therapy. These topics were under consideration for the purposes of identifying how Drama Therapy may foster intimacy between partners in a relationship in the context of childhood trauma. In order to facilitate this, I explored how childhood trauma may manifest in adulthood. Different forms of childhood trauma and how those impact experiences of intimacy, predominant treatment modalities specific to trauma, and approaches in Drama Therapy that consider the effects of trauma and how they present in relationships were also explored. Additionally, what it is about Drama Therapy that may foster individual capacities to develop and maintain intimacy was evaluated. This chapter also identified the relevance of this research on various levels.

This research was deemed relevant for numerous reasons. Fundamental to our mental, emotional, and physical health, having close interpersonal relationships with others provides us with belonging and emotional connection (McMillan & Chavis, 1986). Without these relationships, a variety of mental and physical ailments may culminate (Ditzen et al., 2011). This reinforced the significance of understanding the ways in which intimacy and relationships may be fostered within the context of childhood trauma. Similarly, a lack of or poor interpersonal relationships were noted for inhibiting functioning, health, and children's development (Karney et al., 2018). Childhood trauma has numerous impacts, which extend beyond the social, health, economic, and educational consequences of child maltreatment. Intergenerational trauma was described as the process through which parents with unresolved trauma project their trauma onto their children (Isobel et al., 2019). The replication of trauma-informed behavioural patterns raises broader public health concerns and emphasises the cyclical impact that trauma inflicts on individuals and society at large. This highlighted the significance of identifying varied trauma treatment modalities and their effects.

In order to support this research, theories specific to Drama Therapy, childhood trauma, and intimacy were evaluated in the second chapter. Here, Drama Therapy was identified as a dynamic psychotherapeutic approach used in trauma treatment that incorporates interaction, play, art, and dramatisation into the healing process through varied techniques (Landy, 1994; Jones, 1996; Emunah, 2013). In order to facilitate exploration into how Drama Therapy may benefit traumatised individuals with the purpose of enhancing intimacy in relationships, further information was considered through a literature review.

The purpose of the literature review was to evaluate what prior research has addressed (Knopf, 2006). While childhood trauma does not necessarily result in lifelong difficulties, typical areas of impairment were identified as: dysregulation in behaviour and emotion, cognitive and attentional difficulties, biological changes, altered perceptions of self and the external world, and deficits in attachment and relationships (Watts-English, Fortson, Gibler, Hooper, & De Bellis, 2006; Briere & Scott, 2015; Kliethermes et al., 2014; Marganska et al., 2013). In order to expand upon this further, literature specific to the ways in which adult experiences of intimacy may be affected by childhood trauma were examined. Common responses to childhood trauma that may have an impact on an individual's experiences of intimacy that were identified in the literature included: feelings of low self-worth, aggression, distrust, poor emotional communication, expectancy of rejection, emotional inhibition, indifference in relationships, and challenges with intimacy of all forms (Kliethermes et al., 2014; Briere & Scott, 2015; Marganska et al., 2013; Watts-English et al., 2006; Dvir et al., 2014; Su & Stone, 2020).

Trauma treatment approaches, including CBT, DBT, and psychodynamic techniques, were examined and appeared to target different aspects of trauma exposure. However, what was emphasised across all techniques examined is that the therapeutic relationship, cultivation of awareness, skills development, and non-judgemental acceptance of the present reality, are critical to effective therapeutic treatment (McMullen et al., 2013; Solomon, 2003; Su & Stone, 2020; Corey, 2021; Schottenbauer et al., 2008; Shedler, 2010). Empathy, compassion, validation, and respect on the part of the therapist also influences the therapeutic alliance and relationships beyond the therapy space (Nielsen, 2017; Corey, 2021). This was relevant to the intention of identifying how Drama Therapy techniques may foster intimacy in partnerships contextualised by childhood trauma in that it depicted how predominant and empirically-supported trauma treatments attain goals.

The incorporation of breathwork and mindfulness in Drama Therapy is supported by research on trauma treatment and the role of the breath in nervous system regulation (Grof & Grof, 2023; Van der Kolk, 2014). This considers the mind-body connection with regards to trauma treatment and the potential benefits that the inclusion of breathwork in Drama Therapy may have in reducing stress and developing emotional regulation skills (Rappaport, 2014; Crockett, 2022). The Role Method was described as a dynamic technique that accounts for the complexity of human positions in life where clients are enabled to develop aspects of

themselves that may be in conflict with other roles their contexts demand (Landy in Johnson & Emunah, 2013). Clients are encouraged to develop an understanding of their thoughts, feelings, and behaviour patterns through different roles while expanding their role repertoires (Landy, 1994; Pendzik, 2003; Johnson, 1988). Narradrama was also described as a unique technique for clients to explore, reframe, and transform their personal stories (Carroll, 2023; Dunne, 2009).

Three additional Drama Therapy techniques were discussed, which included: Developmental Transformations (DvT), Rehearsals for Growth (RfG), and Cognitive-Based Trauma Informed Drama Therapy (CBDT). These techniques all offered creative experiential methodologies with regards to trauma treatment, growth, and fostering relationships (Johnson, 2014; Reynolds, 2011; Jones, 1996; Johnson in Johnson & Emunah, 2014; Wiener, 1994; Wiener in Johnson & Emunah, 2009; Frydman & McLellan, 2014; Wood & Schneider, 2015).

This was significant to highlighting how Drama Therapy may foster intimacy between partners in the context of childhood trauma. Furthermore, other Drama Therapy tools that were explored in the literature indicated potential for this through grounding in interaction, safety, trust, play, sharing, and connection (Jones, 1996; Landy, 1994; Lahad, 2009; Emunah, 2013; Frydman & McLellan, 2014; Leveton, 2010; Crimmens, 2006; Landy in Johnson & Emunah, 2009; Godfrey & Haythorne, 2013; Dunne, 2009; White, 1998) – notions which were identified as central to intimacy development. Moreover, the Drama Therapy techniques explored indicated a focus on transformation and empowerment, wherein support from the therapist and/or client group supports clients on their journeys toward healing and growth, which may also foster intimacy.

Inclusion of trauma-informed approaches in intimacy development, the role of the therapeutic relationship and supporting healthy attachment, and Drama Therapy as a versatile tool for vulnerability, transformation, and empowerment, suggest that Drama Therapy techniques may facilitate the development of healthy intimate partnerships in adults dealing with childhood trauma through trauma-informed methods. Similarly, techniques that develop emotional regulation and explore traumatic experiences through safe and structured means, foster individual capacities for sharing personal stories, as well as the development of interpersonal skills, empathy and understanding, and provide support through personal transformation, foster intimacy within the therapy space. This appears to correlate with all the Drama Therapy

techniques examined. This shows how Drama Therapy contributes to the larger scope of literature regarding trauma treatment as well as highlighting how trauma treatments and Drama Therapy may foster intimacy, which is a central component of relationships.

Through a discussion of the themes in the literature review in Chapter VI, the prominent themes identified illustrated this through the relationship between childhood trauma and intimacy, trauma-informed treatment approaches, Drama Therapy techniques and intimacy, the significance of the therapeutic relationship, the role of vulnerability and narrative, and the integration of evidence-based CBT into Drama Therapy methods. Since broad notions pertaining to childhood trauma, intimacy, therapeutic techniques across disciplines, and Drama Therapy were utilised, this study offers only a general overview of how childhood trauma may impact intimacy and the ways in which therapeutic techniques may foster intimate experiences in the context of childhood trauma. This highlights the potential for further research, which is more specific in terms of the forms of childhood trauma being addressed and techniques being evaluated.

Through this research exploration, I have gained and developed valuable insights. However, I am of the opinion that further specified research is needed in this area as the current literature is limited in scope and application. This is exemplified by the small sample of literature and Drama Therapy techniques explored in this research. Moreover, it is evident through this research report, that Drama Therapy techniques can be used advantageously in both contributing to the alleviation of symptoms of childhood trauma and managing the trauma itself. With this and through the literature examined, Drama Therapy techniques may facilitate intimacy by contributing to the management of trauma-induced manifestations.

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