

https://dspace.org/

Re: playing trauma: the potential of using re-enactment as a possible way of processing childhood trauma in drama therapy

Bradshaw, Mirella Elizabeth

2022
https://hdl.handle.net/10539/34094

Downloaded from a DSpace repository. https://dspace.org/

RE:PLAYING TRAUMA: THE POTENTIAL OF USING RE-ENACTMENT AS A POSSIBLE WAY OF PROCESSING CHILDHOOD TRAUMA IN DRAMA THERAPY

Mirella Elizabeth Bradshaw

Supervisor: Professor Vivien Marcow Speiser

A research report submitted to the School of Arts, Faculty of Humanities, University of the Witwatersrand in partial fulfilment of the requirements for the degree of Master of Arts by coursework and research report in the field of Drama Therapy

2022

FACULTY:	Humanities
SCHOOL:	Wits School of Arts
STUDENT NAME:	Mirella Elizabeth Bradshaw
STUDENT No:	2388443
DEPARTMENT:	Drama for Life
COURSE:	Research Report in Drama Therapy
COURSE CODE:	WOSA7082A
SUPERVISOR:	Vivien Marcow Speiser
TOPIC:	Research Report
	Re:playing trauma: The potential of using re-enactment as a possible way of processing childhood trauma in drama therapy

Plagiarism Declaration

1. I know that plagiarism is wrong. Plagiarism is to use another's work and to pretend that it is one's own.
2. I have used the author date convention for citation and referencing. Each significant contribution to and quotation in this essay from the work or works of other people has been acknowledged through citation and reference.
3. This reflection is my work.
4. I have not allowed and will not allow anyone to copy my work with the intention of passing it off as their own work.
5. I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I failed to acknowledge the source of the ideas or words in my writing.



February 2022

…….. ……..

Signature Date

Abstract

Evidence suggests that the presence of childhood trauma may be linked to the development of a variety of mental illnesses later in life; borderline personality disorder is one of these such illnesses with a broad scope of literature supporting this link. Further, due to the high rates of trauma present in South African society compounded by the COVID-19 pandemic, it is the author's view that innovative approaches to working with trauma are currently of vital importance. Psychology research speaks to the potential of exposure therapy in trauma treatment, while literature from both drama therapy and psychology emphasizes the importance of an embodied approach in trauma work. Therefore, through an examination of relevant literature, this research sought to understand the potential use of re-enacting trauma within drama therapy as part of the therapeutic process. Using the method of an integrative literature review, relevant literature was analysed using thematic analysis. This research found that re-enactment could be considered as a useful tool in processing trauma, provided that the exposure is done in a gradual way and care is taken to try to not re-traumatise the client. Further, the literature pointed to the value of using role to support re-enactment, and the importance of providing the client with an opportunity to rescript their trauma towards regaining a sense of agency and control. Recommendations for further research are suggested.

Acknowledgements

First and foremost, I would like to thank my supervisor, Professor Vivien Marcow Speiser, for her invaluable guidance and support throughout my research process. Thank you for constantly challenging me to re-think, re-visit and re-explore. I am deeply grateful for your contribution to my development, not only as a researcher, but as a becoming drama therapist. It has been an honour to work under your supervision.

Secondly, I would like to thank my classmates – Berdine André, Sanelisiwe Dlamini, Lebogang Mokgatle, Michela Nordmann, Elayne Sinclair, Nobantu Shabangu and Lerato Sibuli. Walking this drama therapy journey together has been the greatest gift. Each one of you has helped mould me into the drama therapist that I am becoming. Your handprints are all on my heart, and I cannot wait to witness all the lives that you will go on to touch through this work.

I would also like to thank my outstanding lecturers and the Drama For Life community. I would especially like to thank my drama therapy lecturers: Nonkululeko Faith Busika, for your fierce passion and commitment that has always ignited our fire for drama therapy and helped to keep our candles burning when the wick seemed too short; Karen de Kock, for your honest humour, your deep authenticity and ever-grounding presence that continuously guided us throughout this Masters year; Welma de Beer, for always bringing us back to the body, your footprints are all over my research through inspiring my interest and appreciation for embodiment; and Linda Mdena, for your guidance over the past two years and gentle nurturing of our drama therapy seeds from the first day that we entered your classroom.

Last, but certainly not least, I would like to thank my friends and family for their unwavering support in pursuit of my drama therapy dream.

Table of Contents

Plagiarism Declaration i

Abstract ii

Acknowledgements iii

Table of Contents iv

List of Tables and Figures ix

Glossary x

Research Title xi

Key Words xi

1. Introduction 1

2. Background: Overview of Theoretical Considerations from the Literature 3

2.1 Trauma 3

2.1.1 The South African Context 4

2.2 Borderline Personality Disorder 5

2.2.1 Borderline Personality Disorder and the Link to Trauma 7

2.2.1 Current Treatment Approaches for Borderline Personality Disorder 7

2.3 Theoretical Considerations from Drama Therapy 9

2.3.1 Re-enactment and Abreaction 9

2.3.2 Distancing 10

2.3.3. Life-Drama Connection 11

2.3.4. Embodiment 12

2.4 The Importance of the Therapeutic Alliance 13

3. Rationale 14

4. Statement of Intention 15

4.1 Problem Statement 15

4.2 Possibility Statement 15

5. Research Aims and Objectives 16

5.1 Aim 16

5.2 Objectives 16

6. Research Questions 17

6.1 Primary Research Question 17

6.2 Sub-Questions 17

7. Method 18

7.1 Data Collection 18

7.1.1 Search Strategy and Data Sampling 18

7.1.2 Inclusion Criteria 19

7.1.3 Exclusion Criteria 19

7.2 Data Analysis 20

7.2.1 Phase 1: Familiarising Yourself with the Data 21

7.2.2 Phase 2: Generating Initial Codes 21

7.2.3 Phase 3: Searching for Themes 21

7.2.4 Phase 4: Reviewing Themes 21

7.2.5 Phase 5: Defining and Naming Themes 22

7.2.6 Phase 6: Producing the Report 22

7.3 Review of Method 22

7.3.1 Reflections on the Integrative Literature Review Process 22

7.3.2 Reflections on Data Sampling Techniques 23

7.3.3. Reflections on Thematic Analysis and Inductive Coding 24

8. Ethical Considerations 25

9. Results 26

9.1 Overview of Results 26

9.2 Overview of Themes 27

9.3 Themes Present in the Literature 28

9.3.1 Theme One: Trauma and the Body: Exploring Embodiment 28

9.3.2 Theme Two: Understanding Avoidance Behaviour 30

9.3.3 Theme Three: Desensitisation and Exposure 31

9.3.4 Theme Four: Distancing 33

9.3.5 Theme Five: Emotions and Affect 37

9.3.6 Theme Six: Use of Role 40

9.3.7 Theme Seven: Rescripting Trauma 44

9.3.8 Theme Eight: The Function of the Therapeutic Relationship 47

9.3.9 Theme Nine: Challenges and Considerations related to Re-enactment 52

10. Discussion 54

10.1 Responding to the Research Questions 54

10.1.1 What is the Role of the Therapeutic Relationship in Childhood Trauma Work? 54

10.1.2 What is the Function of Embodiment in Trauma Work? 56

10.1.3 Can Re-enactment be Useful in Processing Past Trauma, including Childhood Trauma, in Drama Therapy? 59

10.1.4 Could Re-Enactment Hold Value in Assisting BPD Clients with Trauma Histories to Process Past Childhood Trauma? 62

10.2 Additional Valuable Findings 64

10.2.1 Potential Target Population 65

10.2.2 The Use of Role 65

10.2.3 Altering the Course of Events 66

10.3 Final Points of Discussion 66

10.3.1 The Balance Between Containing and Evoking 66

11. Conclusion 68

12. Implications for Future Research 69

13. Challenges and Limitations of Study 70

Reference List 71

List of Tables and Figures

Table 1: Phases of Thematic Analysis……..20

Table 2: Themes……...……..…27

Figure 1: *Word cloud representing the most frequently occurring words across the coded data*……...26

Figure 2: *A more refined word cloud representing the most frequently occurring words across the coded data*……...27

Glossary

Abreaction	Re-living a traumatic experience, typically within psychoanalysis, to process the event and release emotional disturbance attached to the event
Embodiment	The use of one's body as the medium for expression
Re-enactment	Acting out or re-playing past events within drama therapy
Role	A drama therapy tool that invites the assuming of another's characteristics, behaviours or traits; role is often broader than character and refers to the social categorisation or labelling of typical behaviour or common identifying characteristics

Research Title

Re:playing[1] *trauma*: The potential of using re-enactment as a possible way of processing childhood trauma in drama therapy

Key Words

Childhood trauma, re-enactment, abreaction, therapeutic relationship, borderline personality disorder

[1] A play on the words "replaying" and the term "re:" meaning "with regard to"

1. Introduction

"Trauma shapes our lives. It shapes the way we live, the way we love and the way we make sense of the world. It is at the root of our deepest wounds. Virtually all our afflictions, mental illnesses, physical diseases stem from trauma." (Maté, 2021).

I have developed a particular interest in trauma and its relationship to mental illness throughout my Masters year training to become a drama therapist. Many of the themes that arose from my own work and clinical placements centred around trauma and attachment wounds. Through our critical engagement with mental illnesses and diagnostic manuals in our various courses, I have begun to question the way in which mental illnesses are framed. It had appeared to me as if many mental illnesses, such as personality disorders including borderline personality disorder (BPD) and substance use disorders, possibly shared similar roots in past traumatic experiences.

Without wishing to disregard the value that diagnoses and diagnostic manuals can hold, I have similarly become aware of this line of critical engagement in the literature, suggesting that various mental illness diagnoses can often mask the presence and role of trauma (Allsopp et al., 2019; Schermer, 2004). My thinking has been profoundly influenced by the work of Maté (The Wisdom of Trauma, 2021), who speaks extensively to the role that trauma plays in the development of mental illnesses.

The link between childhood trauma and adult mental illness has been widely documented in the literature (Bentall et al., 2012; Bentall et al., 2014; Palmier-Claus et al., 2016; Varese et al., 2012; Gunderson et al., 2000; Salters-Pedneault, 2020; Herman et al., 1989). Supported by the literature, I am of the belief that trauma experienced during childhood can play a central role in the development of a variety of mental illnesses. There is, of course, debate as to whether this link is correlative or causative. As a drama therapist training within South Africa, my scope

of practice lies in treatment rather than diagnosis. My intention is therefore not to determine the causality of this link, but rather to respond to the reported link itself from within my own field and my own scope of practice.

I am therefore interested in understanding the role that drama therapy, and the drama therapist, may hold in helping adult clients to process their childhood trauma. While drama therapists hold a plethora of valuable tools in their repertoire that could potentially respond to trauma, I am particularly interested in that of re-enactment through embodiment. Re-enactment is central to the work of drama therapy (Jones, 2007; Sajnani & Read Johnson, 2014). In my own practical experience through our training, I have found re-enactment to be of great value in processing past trauma. I wish to understand whether re-enactment may similarly be a valuable tool for other people or populations when held within the context of the therapeutic relationship. Through a review of the relevant literature, I therefore wish to explore the potential of using re-enactment as a possible way of processing childhood trauma for adult clients in drama therapy.

Additionally, I am interested in understanding how this work may apply to the treatment of a mental illness that may be rooted in childhood trauma. Through my engagement with our coursework, my interest in personality disorders has grown as we have engaged with case studies of clients presenting with personality disorders. From the various personality disorders, BPD has been shown to have particularly strong links to childhood trauma (NHS, 2019; Gunderson et al., 2000; Salters-Pedneault, 2020; Herman et al., 1989) and this link interests me as a training therapist. As such, this research will explore the potential of using re-enactment as an adjunctive form in the treatment of BPD within drama therapy.

2. Background: Overview of Theoretical Considerations from the Literature

In this section, I discuss the theoretical considerations integral to the background of this study, and outline some of my assumptions and beliefs in relation to the research topic.

2.1 Trauma

Trauma is derived from the Greek word 'τραῦμα' meaning 'wound' (Kolaitis & Olff, 2017). While initially referring to physical wounds, the word now refers similarly to emotional wounding (Merriam-Webster, 2021). Trauma can be understood as the emotional response to a tragic or highly stressful event (American Psychological Association, n.d.). Such events could include sexual abuse, bullying, natural disasters or the death of a loved one. The symptoms or manifestations of trauma may differ between individuals and may last for differing lengths of time. According to the American Psychological Association (n.d.: para. 1), typical symptoms experienced shortly after the event include "shock and denial", while "unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea" are more likely to manifest at a later stage.

Integral to the concept of trauma is objectivity and subjectivity (Boals, 2018). Objectivity refers to the event itself or the likelihood that the event may be deemed traumatic by most people, while subjectivity refers to the individual's experience or perception of the event. It is important to note that an event may not be deemed objectively traumatic, but may be perceived and experienced to be subjectively traumatic by the individual. Trauma research has emphasised the importance of subjectivity in the experience and manifestation trauma (Rubin et al., 2008). This is important to the positioning of this study, as I as the researcher believe that the right to define an event as traumatic lies with the individual. It is furthermore my assumption that the use of re-enactment within drama therapy could be posited as a useful approach in the treatment

and amelioration of childhood trauma. This assumption was investigated through the relevant literature.

2.1.1 The South African Context

This research intended to review the relevant literature in order to ascertain whether re-enactment held within the context of a therapeutic relationship could be recommended as a part of a process within drama therapy that could possibly hold value in a variety of contexts. Since this research is nonetheless occurring within the South African context, it is therefore important to understand the relationship between trauma and the South African context.

High rates of violent crimes, gender-based violence, road accidents and deaths from illnesses, such as HIV/AIDS and tuberculosis, are present within the South African context (Kaminer & Eagle, 2010). The current COVID-19 pandemic has exacerbated these risk factors, with increased rates of unemployment and gender-based violence (Farber, 2020; Minisini, 2021; Ramafoko, 2020). In the first few months of 2020's hard lockdown, 2,2 million people experienced job losses (Smit, 2021). Unemployment reached a high of 34,9% in the third quarter of 2021 (StatsSA, 2021). South Africa reportedly now has the highest unemployment rate in the world (Bloomberg, 2021; World Bank, 2021).

While rates of underreporting are thought to skew GBV-related data (saferspaces, 2022, Wilkinson, 2016; Lancaster, Gould, Vetten & Sigsworth, 2015), rates of GBV have seen a rise under lockdown. The government's GBV and femicide command centre recorded over 120,000 victims of GBV in the third three weeks of the hard lockdown in 2020 (Farber, 2020). This compounded South Africa's already high rates of GBV. Estimates suggest that between 12% and 28% of women have reported being raped in their lifetime, while between 25% and 40%

of women have experienced sexual and or physical intimate partner violence (safterspaces, 2022).

Furthermore, South Africa has a history of political violence under the Apartheid regime whose legacy continues to permeate South African society today. Gross human rights violations against black South Africans and South Africans of colour were carried out by the Apartheid government (Moodley & Kling, 2015). Through segregation and the control of multiple spheres of society such as education, employment, migration, etc., the Apartheid government aimed to exploit and disempower. The effects of systems such as the Bantu education system are still felt today (Thobejane, 2013) with higher rates of poverty and economic disempowerment among Black South Africans (Maromo, 2019). Intergenerational trauma is a reality for many South African families today in the aftermath of not only Apartheid, but South Africa's history of colonisation (Hoosain, 2018). These various factors, both past, lingering in the present, and current, paint a picture of a society with deep trauma wounds.

2.2 Borderline Personality Disorder

Personality disorders are defined by the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013: 645) as "enduring [patterns] of inner experience and [behaviour] that deviates markedly from the expectations of the individual's culture". They are "pervasive and inflexible, [have] an onset in adolescence or early adulthood, [are] stable over time, and [lead] to distress or impairment" (American Psychiatric Association, 2013: 645). Personality disorders are considered notoriously difficult to treat among many psychologists (Dingfelder, 2004; Svrakic, 2002). From the various personality disorders, BPD is often considered one of the more challenging personality disorders to treat (Avalon Malibu, 2017). Due to the connotations or stigma around the challenges of BPD treatment, some therapists

will avoid working with this client group, or limit the number of clients with BPD in their case load (Rodriguez, 2016).

BPD, also known as 'emotionally unstable personality disorder', is marked by "a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity" (American Psychiatric Association, 2013: 645). The diagnostic criteria for this personality disorder are as follows (American Psychiatric Association, 2013: 663):

> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating [behaviour] covered in Criterion 5.)
>
> 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
>
> 3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
>
> 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self mutilating [behaviour]covered in Criterion 5.)
>
> 5. Recurrent suicidal [behaviour], gestures, or threats, or self-mutilating [behaviour].
>
> 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
>
> 7. Chronic feelings of emptiness.
>
> 8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
>
> 9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

BPD is often co-morbid with mood disorders such as anxiety, depressive, or bipolar disorders, as well as eating disorders such as bulimia, substance-use disorders, post-traumatic stress disorder (PTSD) and other personality disorders (American Psychiatric Association, 2013; National Collaborating Centre for Mental Health, 2009).

Through a further review of the literature, I seek to deepen my understanding of BPD, and to explore whether re-enactment within drama therapy might benefit this population.

2.2.1 Borderline Personality Disorder and the Link to Trauma

BPD is thought to be caused by a variety of factors, including genetics, issues with brain development or neurotransmitters such as serotonin, and environmental factors (NHS, 2019). The environmental factors contributing to BPD appear to be largely rooted in childhood trauma (Gunderson et al., 2000; NHS, 2019; Van der Kolk et al., 1994). High rates of sexual, emotional and physical abuse, as well as emotional and physical neglect, are reported in those with BPD (Gunderson et al., 2000; Salters-Pedneault, 2020). A study conducted by Herman et al. (1989) found that 87% of participants with BPD had a history of childhood trauma. While childhood trauma is considered to be a contributing factor to a variety of personality disorders, this link appears to be the strongest in BPD (The University of Manchester, 2013). It is therefore my assumption that addressing childhood trauma within the context of the drama therapeutic space and therapeutic relationship may prove to be a useful component or area of focus in BPD treatment.

2.2.1 Current Treatment Approaches for Borderline Personality Disorder

A variety of options are available to clients with BPD seeking treatment, both in the fields of psychology or psychotherapy, and arts-based therapies. Within traditional psychotherapy, the typical options for treatment include various types of psychotherapy such as Dialectical

Behaviour Therapy, Schema-Focused Therapy, Mentalisation-Based Therapy and Transference-Focused Psychotherapy (Salters-Pedneault, 2020). Dialectical Behaviour Therapy is a form of Cognitive Behavioural Therapy (CBT) that focuses on building skills that assist clients in managing their emotions, stress and relationships. Schema-Focused Therapy combines CBT and psychoanalytic theories to help clients to challenge the maladaptive beliefs and behaviours caused by unmet childhood needs, thus encouraging more adaptive ways of functioning. Mentalisation-Based Therapy encourages clients to identify thoughts and feelings, both their own and those of others, to assist clients in understanding how these may impact behaviour. Transference-Focused Psychotherapy is rooted in psychodynamic therapy and allows a client to understand how early, formative relationships may impact current relationships; the client may transfer feelings and patterns from early relationships onto, among others, their therapist which may provide the therapist and client with important insight towards building healthier relationships. This approach's focus on the therapeutic relationship supports my intention to explore the role of the therapeutic relationship within childhood trauma treatment. Further, Schema-Focused Therapy's engagement with unmet childhood needs, which I consider an example of childhood trauma, supports the notion that focusing on past childhood trauma could potentially be valuable within treatment.

Creative arts therapies, such as drama therapy, music therapy, art therapy, and dance and movement therapy, also provide further treatment options for BPD (National Health Service, 2019). Through embodiment or creative expression, clients may be able to process negative experiences, feelings or thoughts, and develop further strength and healthy ways of being. Morris (2018) outlines six key intervention strategies within her drama therapy work for borderline clients, specifically releasing tension and repressed emotion via methods such as parachute play; symbolic tools and projective methods to explore aspects of the self; ritual, story and myth, sensory work to encourage grounding; play; poetry, song and creative writing.

Morris (2018) also speaks to the use of self-revelatory performance in her work, reporting an example of a group of clients with BPD which she guided in creating a piece to engage with the stigma that they experience around their diagnosis.

Additionally, Morris (2018) details the possible causes of BPD that inform her drama therapy work with this population, highlighting the high rates of abuse or mistreatment of these individuals in their childhood. Morris (2018) states that this can often manifests in a low sense of self-esteem, a fragile sense of self, and negative core beliefs.

2.3 Theoretical Considerations from Drama Therapy

Drama therapy is the intentional and specialised use of the dramatic medium to promote psychological healing and growth (Emunah, 1994). Finding its roots in both theatre and psychology, Emunah (1994: 3) states that its "tools are derived from theatre" while "the goals are rooted in psychotherapy". Drama therapy can be used for a wide range of clients, both individuals and groups, and both adults and children (Jones, 2007). Drama therapy makes use of a broad range of tools and approaches. Relevant to the background of this research is re-enactment or abreaction, distancing, and life-drama connection. I explore the literature on drama therapy below in order to formulate a conceptual and theoretical understanding of the use of re-enactment within the therapeutic relationship.

2.3.1 Re-enactment and Abreaction

Abreaction is a tool present in both psychotherapy and drama therapy. First conceptualised within psychoanalysis by Freud and Breuer, abreaction is "the therapeutic process of bringing forgotten or inhibited material (i.e., experiences, memories) from the unconscious into consciousness, with concurrent emotional release and discharge of tension and anxiety" (American Psychological Association, 2020: n.p.n). This is typically achieved in

psychoanalysis through hypnosis. In their later work, Freud and Breuer did not conceptualise abreaction as a tool or process that could exist on its own within therapy, and stated that further work or approaches are needed in healing trauma (Schimelpfening, 2020). As such, abreaction is typically seen as a tool that forms part of a larger treatment process, rather than being a treatment plan in and of its own.

Within drama therapy, abreaction takes on an embodied nature. Considered one of the therapeutic powers of play, Schaefer (1999) describes abreaction as the re-enactment or re-playing of traumatic experiences in the therapy space in order to process these events and gain a sense of control over them. Moreover, abreaction is a phenomenon that occurs naturally within human behaviour. For instance, after 9/11, children could be seen acting out the terror attacks in their play by "building towers with blocks and crashing toy airplanes into them" (Schaefer & Drewes, 2009: 6). This could suggest that abreaction is a natural and important form of processing. Abreaction could exist along the continuum from under-distanced to more distanced work (Jones, 2007). The process of abreaction could be held within a variety of approaches within drama therapy, such as self-revelatory performance or developmental transformations (Emunah, 2016; Sajnani & Read-Johnson, 2014).

Importantly, so as to provide a clear distinction from the use of the term 'abreaction' as is intended within the field of psychoanalysis, this study rather uses the term 're-enactment' thus aligning more closely with the process of 'abreaction' as described within drama therapy literature.

2.3.2 Distancing

Distancing is one of several core therapeutic processes within drama therapy (Jones, 2007). Distancing refers to the client's proximity to the therapeutic material. Various distancing tools

can be used, such as metaphor, symbol or dramatic projection, which allows the client to distance themselves from the therapeutic material. This can allow for a different way of viewing the material, or can allow for a safer or more comfortable way of processing heavy or traumatic material. For example, a therapist could bring a story about loss into the therapy space for a client who may be grieving the loss of their mother. Rather than directly working with the loss of their mother, the client could engage with the story, thus using story as a distancing tool.

Under-distancing refers to a more clear, intimate or direct way of working with therapeutic material. An example of more under-distanced work can be found within a psychodramatic tool utilised within drama therapy such as the empty chair technique, in which a client may imagine that a certain person is sitting on a chair, such as their late mother, and may have a conversation with them in order to process their feelings of loss (Giacomucci, 2021). Therapeutic material can be both over-distanced or under-distanced depending on the therapeutic intention.

2.3.3. Life-Drama Connection

An additional one of the core therapeutic processes described by Jones (2007), life-drama connection refers to the way in which a client's personal material intersects with the dramatic material. The connection may be explicit in which a client may directly represent or express an issue from their life in the drama, or it could be implicit in which the material may initially seem quite removed from their real life and the connection could only be discovered at a later point.

Life-drama connections can be left unnamed or uninterpreted, or the therapist may guide the client to reflect on the points of connections. Life-drama connections often occur in the verbal

reflective space. In relation to distancing, this could be thought of as less distanced work. An understanding of life-drama connection is important to the background of this research, as it informs the understanding of distancing, which becomes an important aspect of this study.

2.3.4. Embodiment

Alongside distancing and life-drama connection, embodiment is acknowledged by Jones (2007) as one of the core therapeutic processes in drama therapy. Siegal (1984: n.p.n) states that "because a person lives with, in and through the body, their total being is affected by life's bodily experience". The body is therefore conceptualised within drama therapy as the container of self and the vehicle of expression. Working with and through the body is therefore an important element of drama therapy work.

Jones (2007) states that drama therapy's relationship to embodiment can be divided into three areas. The first area, "developing the potential body" (Jones, 2007: 229), refers to the client strengthening and exploring their relationship with their body, possibly to achieve a greater expressive range or a sense of comfort, freedom and confidence in their body. Jones (2007) states that fostering a sense of ownership and connection to the body may be important for clients who have experienced trauma. This is particularly true when the body was the site of the trauma, as traumatic experiences can lead to a state of disembodiment (Stupiggia, 2019).

The second area, "body transformation" (Jones, 2007: 229), speaks to "the therapeutic potentials and benefits of the client taking on a different bodily identity within the dramatherapy". Through taking on or embodying roles or characters outside of the self, clients may be able to explore new bodily qualities, emotions and experiences. This may deepen and grow their own embodied self, as these qualities and experiences can be incorporated into their

own concept of the embodied self or could serve as an experience through which to further understand the self.

The third area, "work that explores the personal, social and political forces and influences which affect the body" (Jones, 2007: 229), refers to the way in which identity is held and shaped through the body, and how drama therapy can assist in this exploration. This could include factors such as race or gender. In essence, the third area addresses problematic or negative experiences and memories connected to a client's physical identity.

2.4 The Importance of the Therapeutic Alliance

The therapeutic relationship is considered in the literature to be one of the most important, if not the primary factor, that determines the success of therapy and its capacity to promote change and healing (Cooper & Leeser, 2011; Langhoff et al., 2008; Safran, Muran, & Rothman, 2006). Yalom (1989: 112) has stated that "it's the [therapeutic] relationship that heals". This study is therefore conducted with the assumption that in order for meaningful or successful therapy to occur, or for re-enactment to hold potential value, a good therapeutic alliance is an essential pre-requisite. The role of the therapeutic alliance is explored further in this study.

3. Rationale

It is my view that given the prevalence and incidence of traumatic events within the South African context as discussed in the background to this study, as well as the effects of the current COVID-19 pandemic, that innovative approaches to working with trauma are currently of vital importance. Through this research, I hope to contribute to the understanding of trauma work and approaches that are already being used in both the South African and global contexts.

Additionally, the literature points to the value of body-based approaches in trauma work (Van Der Kolk, 2014; James and Read Johnson, 1997; Haen, 2007). Re-enactment, which through my review of the literature I understand to be an embodied approach, could therefore respond to the need for embodied trauma treatment approaches stated in the literature. This research may therefore potentially aid in furthering the understanding of how drama therapeutic approaches, specifically re-enactment, could assist in trauma treatment.

Further, this study could potentially bear unique and important contributions to the field of drama therapy, as from my review, there does not appear to be literature addressing the use of re-enactment as a tool to process childhood trauma in adults with BPD. This research could therefore provide a possible expansion to treatment options available for clients with BPD presenting with trauma histories. Further, as a client group that has historically been labelled as 'difficult to treat' (Avalon Malibu, 2017; Dingfelder, 2004; Svrakic, 2002) and turned away from treatment because of this (Rodriguez, 2016), a wider range of treatment options is of great importance in empowering clients with choice and agency. It is my view that a relationship between childhood trauma and BPD seems to exist, and that drama therapy could be of use in addressing this relationship and thus treating BPD.

4. Statement of Intention

4.1 Problem Statement

Literature suggests that experiences of childhood trauma can be linked to a variety of mental illnesses in adults, particularly BPD (Bentall et al., 2012; Bentall et al., 2014; Palmier-Claus et al., 2016; Varese et al., 2012; Gunderson et al., 2000; Salters-Pedneault, 2020; Herman et al., 1989). From a preliminary review of the drama therapy literature, it would appear that there is a need for further research on this topic.

4.2 Possibility Statement

Re-enactment could potentially have a valuable role to play in processing childhood trauma when held within the context of the therapeutic relationship in drama therapy.

5. Research Aims and Objectives

Through an analysis of the literature, this research addresses the following aims and objectives.

5.1 Aim

The aim of this research was to explore whether re-enactment could hold potential value in processing childhood trauma within the context of drama therapy and the therapeutic relationship, and whether it could be postulated to assist in the healing of BPD clients presenting with trauma histories.

5.2 Objectives

i. To understand the role that the therapeutic relationship plays in processing childhood trauma within drama therapy

ii. To understand, through a review of the literature, the function of the body within trauma work

iii. To determine whether re-enactment in drama therapy may hold value in processing childhood trauma in clients with BPD and trauma histories

6. Research Questions

6.1 Primary Research Question

i. Can re-enactment be useful in processing past trauma, including childhood trauma, in drama therapy?

6.2 Sub-Questions

i. What is the role of the therapeutic relationship in childhood trauma work?

ii. What is the function of embodiment in trauma work?

iii. Could re-enactment hold value in assisting BPD clients with trauma histories to process past childhood trauma?

7. Method

This research utilised an integrative literature review as method. Integrative literature review is a research method that "reviews, critiques, and synthesizes representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic are generated" (Torraco, 2005). This method involved reading and collecting data from various sources and subsequently analysing the data through thematic analysis (Braun & Clarke, 2006). Once themes had been generated, the data was then reflected upon and discussed with regard to this study's research questions. The research process that I followed, in line with my method, is discussed in further detail in this section. This study was therefore a theoretical undertaking, and did not include research participants.

7.1 Data Collection

7.1.1 Search Strategy and Data Sampling

Several databases were searched to ensure that all relevant articles were found. These included Academic Search Premier, Sage Journals Online, Proquest Social Science Journals, Google Scholar, as well as the University of the Witwatersrand's library search engine. I initially input the following search terms into the aforementioned data bases: drama therapy, childhood trauma, trauma, re-enactment. I found that these search terms did not yield many relevant articles. I therefore refined the search terms further to include 'exposure' and 'desensitisation', finding that this was the vocabulary being used in the literature on re-enactment work; these refined search terms therefore led to a greater number of relevant sources.

Two sampling methods were utilised in the data collection of relevant sources. Firstly, I used purpose sampling. Purposive sampling, also known as judgement sampling, is a non-probability sampling technique in which the researcher selects sources, often participants but

in this case literature, that they view as being information-rich or possibly being useful to the study (Etikan, Musa, & Alkassim, 2016; Palinkas et al., 2013). Secondly, I utilised snowball sampling. Snowball sampling, or chain-referral sampling, is a technique in which one source may lead the researcher to another source, i.e. articles that seemed relevant to my research that were cited in articles that I had sampled purposively were subsequently also included into my selected sources (Handcock & Gile, 2011).

7.1.2 Inclusion Criteria

Peer-reviewed journal articles and books were included. Grey literature was also included in the form of relevant student papers and dissertations, as well as institutional and professional association websites.

7.1.3 Exclusion Criteria

This study did not have specific exclusion criteria for literature save for information from unreputable websites.

7.2 Data Analysis

The data obtained from the literature was analysed through Braun and Clarke's (2006) thematic analysis. The steps of this process are described below in Table 1.

Table 1: *Phases of thematic analysis*

Phase	**Description of the process**
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Note. Adapted from "Using Thematic Analysis in Psychology" by V. Braun and V. Clark, 2006, *Qualitative Research in Psychology*, 3, p. 87. Copyright 2006 Edward Arnold (Publishers) Ltd.

7.2.1 Phase 1: Familiarising Yourself with the Data

In the first phase of analysis, I familiarised myself with the data. This involved reading and re-reading the sources that I had collected to ensure that I had a clear understanding of each source. This phase also allowed me to make certain that each source was relevant to my research and aligned with my inclusion criteria. After reading each source, I created a document, writing down a brief overview or summary of each source. In this way, I was able to make notes on my initial ideas.

7.2.2 Phase 2: Generating Initial Codes

In the second phase of analysis, I made use of ATLAS.ti, a qualitative data analysis software, in order to code the data. I used inductive coding, or open coding, to analyse the data. Inductive coding is an approach to coding data in which the researcher analyses the data and subsequently generate codes from the data set, rather than analysing the data through a predetermined set of codes as is the case in deductive coding. Through this use of inductive coding, I generated the initial codes.

7.2.3 Phase 3: Searching for Themes

In the third phase, I began to capture the themes present in the dataset. This involved grouping the codes in ATLAS.ti into code groups. Each code group was given a name. These code groups became my initial themes.

7.2.4 Phase 4: Reviewing Themes

In the fourth phase of analysis, I reviewed each theme or code group. I verified that each code was, in fact, relevant to the theme. This involved moving coded extracts between themes to ensure relevance. Similarly, I made certain that each theme was representative of its codes and

the dataset as a whole. I additionally combined some themes or code groups where two themes were very similar to ensure a succinct reflection of the data. Importantly, I also reviewed my themes in the context of the research questions to ensure relevance to the study.

7.2.5 Phase 5: Defining and Naming Themes

In the fifth phase of the analysis, I reviewed and refined my themes. This phase was a continuation and deepening of the previous phase. I also reviewed my theme names to ensure that they accurately encapsulated the data which they were representing.

7.2.6 Phase 6: Producing the Report

The final phase of analysis culminated into the results section to follow. This phase involved determining which codes or extracts would best represent both the dataset and the theme. The review of the themes and results in relation to the research questions were captured in the discussion section of this report. In this final phase, I also used ATLAS.ti to generate word clouds from the coded extracts to create a visual representation of the results.

7.3 Review of Method

After having completed the analysis and moved through the six phases as described above, I believe that it is important to openly reflect on the successes and drawbacks that I experienced from my choice of method. It is my view that this adds to the integrity of the research.

7.3.1 Reflections on the Integrative Literature Review Process

Within the scope and constraints of this research, I believe that an integrative literature review was the method best suited to answering my research questions. It allowed me to draw on the

invaluable insight already present in published literature, and it granted this research access to the work of highly experienced therapists and practitioners.

7.3.2 Reflections on Data Sampling Techniques

Data sampling for this research was initially a challenge. Many of the relevant sources that I found were in books and therefore behind paywalls. With the limited or restricted access to university and departmental libraries due to COVID-19, accessing the relevant literature for this report was difficult. I could imagine that this is a challenge that many researchers conducting literature reviews during the pandemic may possibly be facing.

I initially struggled to source relevant articles. However, after reviewing and refining my search terms based on the vocabulary that I saw that the relevant literature was using, I was able to source plentiful literature. In this way, I believe that purposive sampling was effective as a data sampling method. The limitation of purposive sampling is that it is a nonprobability method of sampling relying on the researcher's own judgement in selecting sources. However, this is an issue that I believe is more relevant to participant-based research, rather than literature-based research. I am not of the opinion that my selection of sources was biased; however, it is of course possible that another researcher completing this study may have selected a differing set of sources.

I found the use of snowball sampling to be greatly helpful in finding literature, as articles that I had already selected would refer to additional literature which would often turn out to be relevant and information-rich. Furthermore, I think that the inclusion of snowball sampling helped to offset the selection bias that could be present in purposive sampling. For example, if my search terms were creating a biased sample, using snowball sampling broadened the pool of literature.

7.3.3. Reflections on Thematic Analysis and Inductive Coding

I believe that thematic analysis (Braun & Clarke, 2006) was the method of analysis best suited to this report and answering its research questions. I also believe that it complimented my research method of integrated literature review. Kiger and Varpio (2020: 8) state that thematic analysis "is a powerful method for [analysing] data that allows researchers to summarize, highlight key features of, and interpret a wide range of data sets". Due to my working with a wide range of literature to answer various research questions around how a specific drama therapy tool (re-enactment) functions, I deemed this method of analysis to be more applicable than other methods, such as Interpretive Phenomenological Analysis (IPA) which is more focused on the understanding of experience (Padgett, 2017). Further, I have utilised thematic analysis twice before in two research papers for my Honours degrees. I therefore am familiar with this method of analysis, and am confident in my ability to execute it correctly, adding to the trustworthiness of this report.

I also believe that inductive coding was an appropriate choice for this research. Inductive coding allows for a 'bottom-up' style of analysis in which themes emerge from the data, rather than analysing the data through a predetermined set of themes (Creswell, 2009). I believe that this gives greater agency to the voices present in the data and, importantly, serves to mitigate some of the effects of researcher bias that may arise through deductive analysis in which data is analysed through the lens of predetermined codes. Noting and having previously stated my own assumptions and biases coming into the study, working to offset the effects of biases was important to the integrity of my work.

8. Ethical Considerations

As this study is a theoretical undertaking and did not involve human participants, no risks were noted in this research and an ethical waiver was granted from the Wits School of Arts and HREC non-medical. My ethical clearance number is WSOA20210913. Further, all the literature that was used was publicly available.

However, this study was conducted with the awareness that literature reviews may have implications in the field should therapists choose to read and implement this research in their practices. As such, the needs and safety of the studied population, people with histories of childhood trauma and people with BPD, were held central to the ethical considerations throughout this study.

Further, I understand that the assumptions, positionality and biases that a researcher may hold can lower the academic rigour of a study if not properly monitored. As such, this research was conducted with cognisance of my own biases; if present, they were clearly stated as such to ensure full disclosure and self-reflexivity. In order to ensure the academic rigour of this study, I selected a method of data analysis, thematic analysis (Braun & Clarke, 2006), that allows for a greater level of objectivity and academic rigour. Further, working under the guidance of my supervisor allowed for my research analysis and findings to be monitored by an experienced researcher and therapist.

9. Results

9.1 Overview of Results

The sources that met the study's inclusion criteria were analysed in accordance with Braun and Clarke's (2006) six phases of thematic analysis with the assistance of ATLAS.ti, as described in the methodology section. The results of this analysis are presented in this section.

Word clouds were generated through ATLAS.ti to provide an overview of the most prominent concepts or ideas that emerged across the data set. These words clouds can be seen below. Two word clouds are presented, providing first a broader image of the data, moving towards a more refined representation.



Figure 1: *Word cloud representing the most frequently occurring words across the coded data*



Figure 2: *A more refined word cloud representing the most frequently occurring words across the coded data*

9.2 Overview of Themes

Nine themes and two sub-themes were found across the data set, as tabulated below.

Table 2: *Themes*

Theme	**Sub-theme**
1) Trauma and the Body: Exploring Embodiment	
2) Understanding Avoidance Behaviour	
3) Desensitisation and Exposure	
4) Distancing	4.1) Projective Tools
5) Emotions and Affect	
6) Use of Role	

Theme	Sub-theme
7) Rescripting Trauma	
8) The Function of the Therapeutic Relationship	8.1) The Therapeutic Relationship within Treatment for Borderline Personality Disorder
9) Challenges and Considerations related to Re-enactment	

9.3 Themes Present in the Literature

9.3.1 Theme One: Trauma and the Body: Exploring Embodiment

In defining embodiment, the literature states that "the internal space of the body is not just filled with physical organs; it is filled with the self-existent qualities of being, and with energy and consciousness" (Tantia, 2019: 137). Embodiment was singled out as one of the factors that makes drama therapy unique, and aids in its success through bringing about a sense of "felt awareness" in clients (De Witte et al., 2021). The literature further points to the success of embodiment in symptom-relief. Research posits that therapy that brings an awareness of one's body, and the feelings and emotions experienced in the body, may lead to a longer lasting reduction in psychiatric symptoms than talk-based psychotherapy (Tantia, 2019).

Other researchers reflect the value and necessity of working with the body in trauma-related treatment. Van der Kolk (2014) explains that trauma is stored on a bodily level, necessitating the need for body-based approaches within trauma treatment. He states that (Van der Kolk, 2014: n.p.n):

> …researchers have noted that a trauma is stored in somatic memory and expressed as changes in the biological stress response. Intense emotions at the time of the trauma initiate the long-term conditional responses to reminders of the event, which are associated both with chronic alterations in the physiological stress response and with the amnesias and hypermnesias characteristic of posttraumatic stress disorder (PTSD). Continued physiological hyperarousal and altered stress hormone secretion affect the ongoing evaluation of sensory stimuli as well. Although memory is ordinarily an active and constructive process, in PTSD failure of declarative memory may lead to organization of the trauma on a somatosensory level (as visual images or physical sensations) that is relatively impervious to change. The inability of people with PTSD to integrate traumatic experiences and their tendency, instead, to continuously relieve the past are mirrored physiologically and hormonally in the misinterpretation of innocuous stimuli as potential threats.

While the above quotation refers to the manifestation of trauma into PTSD, this embodied experience of trauma can hold true for clients with trauma histories outside of the official PTSD diagnosis (Van der Kolk, 2014).

Van der Kolk (2014) states that a cognitive response to a bodily concern may be unsuited. In other words, one cannot 'think' one's way out of trauma. Past trauma needs to be processed on an embodied level. James and Read Johnson (1997) state that drama therapy is recognised as forming an important part of the treatment regime for clients with PTSD as "many traumatic memories are coded nonverbally in [kinaesthetic] and visual forms".

Further, embodied treatment is reported to hold much value in working with clients in the hyperaroused state to which Van Der Kolk (2014) refers. Haen (2007) explains that clients in hyperaroused states may have difficulty responding to verbal or cognitive treatment. Instead, Haen (2007: 239) suggests that embodiment may be more effective in treating traumatised clients by "creating safe pathways for expression and cognitive reprocessing, allowing

for…a…middle path between the extremes of re-experiencing and avoidance". Working on an embodied level allows a client to gain access to these memories in order for them to begin to process them. Pitre, Sajnani and Read Johnson (2015: 44) explain that embodied work through physical movement "activates [kinaesthetic] and sensory stimuli that make…remembering more vivid" which may be important in desensitisation work, as will be discussed in the third theme, 'Desensitisation and Exposure', as memory is shifted from implicit to explicit.

While desensitisation work is recommended in the literature, it is necessary to highlight that desensitisation or exposure is intended to be a gradual process with cognisance of the body. Van der Kolk, McFarlane and Weisaeth (2012: 18) state that "if treatment focuses prematurely on exploration of the past, this will exacerbate rather than relieve traumatic intrusions". As such, they state that it is first and foremost essential for clients who have experienced trauma to first regain a sense of safety within their bodies. They provide suggestions as to how this sense of safety could be achieved, listing various activities that assist clients in "[dealing] with issues of passivity and helplessness" (Van der Kolk, McFarlane & Weisaeth, 2012: 18). These include activities such as physical challenges, such as obstacle courses and therapeutic massage. The two suggested activities that align most with drama therapeutic work are play and exploration, and artistic and creative pursuits.

9.3.2 Theme Two: Understanding Avoidance Behaviour

The literature states that trauma can manifest in avoidance. Tull (2020) explains that avoidance is a learnt response to trauma that serves as a coping mechanism to keep one safe, even after the traumatic event has passed. Darwin (1998: n.p.n) refers to avoidance as "inappropriately prolonged escape". In reference to individuals with PTSD, James and Read Johnson (1997: 383) explain that "in order to protect themselves from pain, [individuals] dissociate the self from the traumatic material through amnesia, splitting or isolation". Glass (2006) poses that

the symptoms of PTSD are not only exacerbated, but can possibly even be caused by the avoidance of trauma-related stimuli. Avoidance can affirm to the individual that the danger is still present, even after it has passed (Tull, 2020). Not only may individuals avoid stimuli that trigger memories of the trauma, but may engage in avoidance behaviours such as substance abuse to numb negative emotional states (Van der Kolk, McFarlane, & Weisaeth, 2012).

Consequently, trauma treatment might take the approach of avoidance reduction. This was seen in the literature in trauma-centred developmental transformation therapy (Pitre, Sajnani & Read Johnson, 2015: 43), which intends to "reduce [clients'] avoidance of the traumatic memories through a supportive process which includes a graduated approach to the traumatic material, highly embodied play and participation in the play by the therapist".

9.3.3 Theme Three: Desensitisation and Exposure

The literature reviewed responds to the proposed need to reduce avoidance by suggesting that clients in therapy for trauma could benefit from desensitisation and exposure. Pitre, Sajnani and Read Johnson (2015: 41) state that "exposure therapy is currently the primary treatment for posttraumatic stress disorder", citing a 2007 study from the Institute of Medicine that showed exposure therapy to be the only treatment approach that had success in treating PTSD.

Exposure therapy aims to "desensitise clients to that trigger their memories of traumatic events" (Pitre, Sajnani & Read Johnson, 2015: 42). Foa et al. (2010) explain that by confronting a client with trauma-related stimuli, one creates an opportunity with the therapy space for "corrective information to be integrated and thus to modify the pathological elements of the trauma memory" (Foa & Rothbaum 1998: 85). Foa and Rothbaum (1998: 83) further state that the aim of such therapy would be to address the two incorrect beliefs that "the world is extremely dangerous" and "I am extremely incompetent", as these beliefs reinforce one another in a

damaging cycle. Glass (2006) states that the aim of exposure therapy is to reduce the conditioned response to trauma-related stimuli or triggers.

Traditionally, exposure can either be in vivo or imaginal (American Psychological Association, 2017). In vivo exposure refers to a client coming into contact with their fear stimuli in real life, while imaginal exposure refers to a client vividly imagining or creating a mental image of their fear stimuli. Drama therapy provides the unique opportunity for a third type of exposure referred to as "in vitro exposure" (Pitre, Sajnani & Read Johnson, 2015: 42). In vitro exposure creates a simulated reality within the therapy room in which a client may be invited to role play exposure to their feared stimuli. As such, in vitro exposure exists in the space between in vivo and imaginal exposure. Trauma-centred developmental transformation therapy (Pitre, Sajnani & Read Johnson, 2015) specifically focuses on treating trauma through in vitro exposure. Pitre, Sajnani and Read Johnson (2015: 43) state that "the establishment of a powerful, imaginal playspace appears to offset the challenges posed by direct exposure in standard approaches".

The need for gradual exposure was stated across the literature reviewed (Pitre, Sajnani & Read Johnson, 2015; Glass, 2006). This means first beginning with work that is quite removed from the trauma or work in which the reference to the trauma is quite indirect, and gradually moving towards more direct engagement with the trauma. One of the tools suggested to aid in this process of gradual exposure was distancing, as will be discussed in the fourth theme of 'Distancing'. For example, Pitre, Sajnani and Read Johnson (2015) provide the case of a 6-year-old client who experienced sexual and physical abuse. Over the course of twenty sessions, the therapist gradually made more direct references to the abuse. Initially, the therapist and client played out scenes of a monster from a nightmare chasing a child, in a distanced and fairy tale-like manner. In the latter sessions, the client was able to work more directly with the

trauma, using the object of a pillow to re-enact scenes of his sexual abuse, gaining a sense of desensitisation and mastery over the trauma.

9.3.4 Theme Four: Distancing

The fourth theme included literature that addressed the function of distancing in desensitisation and exposure work in drama therapy, and additionally discussed projective tools through which distancing can be utilised. These tools were sandtray play, story, symbol and metaphor, which will be discussed later in the sub-theme, 'Projective Tools'.

The tool of distancing appeared in the literature reviewed. Distancing, or aesthetic distance, is defined by Glass (2006: 58) as "the point at which the client can have access to [their] feelings and also maintain an observer stance". Landy (1994: 114) states that "at aesthetic distance one retains the role of the overdistanced, cognitive observer and the role of the undersdistanced, affective actor". A client can therefore dually hold the roles of witnessing their own trauma and witnessing themselves engage with it, and the role of agent that is re-experiencing or re-enacting their trauma. While these roles are dually held, a client can lean more into the role of observer or actor as the work shifts its proximity to the trauma. This can give the client the agency to regulate their affect (James & Read Johnson, 1997; Pitre Sajnani & Read Johnson, 2015) as will be discussed in the following theme, 'Emotions and Affect'.

Consequently, the literature expresses that distancing allows for gradual exposure as the therapy work can either take on an over-distanced stance in which the trauma is worked with or referenced in an indirect way, or it can take on an under-distanced approach in which the trauma is directly referenced and engaged with. The literature suggests that trauma work tends to begin with a more over-distanced approach and gradually shifts to more under-distanced work as a client becomes desensitised to their traumatic material (Glass, 2006; Pitre, Sajnani

& Read Johnson, 2015). This gradual shift from over-distanced to under-distanced work was seen in the case of the 6-year-old boy presented in the previous theme, 'Desensitisation and Exposure'. Glass (2006: 58) states that "it is [her] contention that in the initial stages of treatment for trauma, over-distancing techniques are most effective, particularly in establishing safety and observing ego functions, in preparation for exposure treatment", while "under-distancing techniques are more effective toward the latter phases of treatment when exposure to stimuli is associated with the trauma is experienced". Glass (2006) maintains that over-distancing remains nonetheless useful throughout treatment in providing safety when clients may become too flooded with emotion.

9.3.4.1 Sub-theme: Projective Tools

The literature expresses that distancing is integrally connected to projective tools such as sandtray play, symbol and metaphor. In order to understand the function of projective tools, projection itself is first discussed.

Projection, included in Jones's (2007: 137) core therapeutic processes of drama therapy, is defined as "the placing of aspects of ourselves or our feelings into other people or things". This can happen in unconscious ways, for example through transference and countertransference within the therapeutic relationship. Yalom (1985) suggests that people unconsciously project their own disowned attributes onto others. Although unconscious, it is suggested that the purpose of this is to either dispose of these attributes or to make them more manageable. One can also unconsciously impose emotional states onto objects. Jones (2007) provides the example of Munch's painting *The Scream*. Munch states that the painting was inspired by his walking past a sunset, and it appeared to him as if the sunset were "a loud, unending scream piercing nature" (Dunlop, 1977). Jones (2007) states that one way of interpreting this would be

to assume that Munch projected his own feelings of anxiety or torment onto the sunset. In other words, what was present in himself, he saw in another.

However, Jones (2007) explains that the aim of projection differs between psychotherapy and drama therapy. Within psychotherapy, the aim is to bring the client's awareness to their unconscious projections, and then to discuss and analyse these disowned parts of the self that were projected onto others. Jones (2007) explains that while this can take place within drama therapy, projection is often utilised consciously or intentionally as a valuable technique within drama therapy.

Jones (2007: 138) states that in drama therapy, projection "encourages the projection of an inner emotional trauma or problem into a dramatic representation". Projection within drama therapy can therefore be thought of as "the external representations of inner conflicts" (Jones, 2007: 140). The internal finds shape and expression on the external. Jones (2007) explains that in doing so, a client may express difficult emotional experiences with greater ease, and through this, find a sense of release. Projection therefore takes on an expressive rather than defensive form. This could occur in the therapy space through taking on the roles of others, or working with objects such as masks or puppets. In essence, projection is a tool through which distance can be achieved in drama therapy, rather than projection referring singularly to therapeutic phenomena such as transference.

Glass (2006) explains that projection can be used within trauma work to re-enact traumatic experiences in a distanced manner, explaining that this allows for a sense of containment as the projection exists outside of the self and is therefore more approachable. Sandtray play is one of the ways in which projection can be used. A tool initially emerging from psychoanalysis and play therapy (Hartfield, 2019), sandtray play has similarly been adopted into drama therapy work. Toscani (1998) describes her psychodramatic work using sandtray play with an adult

trauma survivor. Influenced by Jungian psychology, sandtray play is a technique in which a tray of sand, along with various objects or miniature figurines, is brought into the therapy space, and the drama is carried out in the sand. Toscani (1998: 21) states that in the initial stages of therapy "it is frequently easier for [clients] to use objects to represent qualities or persons and through their manipulation begin to take on those roles or qualities and actually have a 'little drama.'" She goes on to say that "the emotional distance provided by objects creates a safety and objectivity they might not feel in so immediate a medium as psychodrama, where the body itself is involved" (Toscani, 1998: 21). Despite the distancing and containing effect afforded by sandtray play, Toscani (1998) states that this work is nonetheless emotionally powerful and successful in bringing about healing and psychological transformation.

Projected work can also provide a safe framework through which to express such powerful emotions (Toscani, 1998). Toscani (1998) describes how her client was able to safely enact physical revenge on her perpetrator, allowing her the space to express these demonstrations of anger safely. She explains that the client was able to discern between reality and the fictional world of the drama that they had created in the sandtray; while she was enacting revenge through projection in the therapy space, she would not do so in the real world. Toscani (1998: 26) states that "that one reason we were doing a Sandrama was to provide even more of a distance and yet to afford her the opportunity to vent her rage within a very contained space—just so it would not leak out into the world toward herself or anyone else."

Alongside techniques such as sandtray play, the literature reviewed describes other distancing tools for projective work, such as symbol and metaphor (De Witte et al., 2021) as well as story, that are used in trauma work. For example, Glass (2006) describes using myth and story with clients in order to gain access to strengthening and affirming roles, which the literature suggests can be important in supporting re-enactment work as will be discussed in theme six, 'Use of

Role'. De Witte et al. (2021) also state that symbol and metaphor can be used to create distance by providing an external source to hold difficult emotions. Pitre, Sajnani and Read Johnson (2015) describe the use of symbol and metaphor in their work, such as making using a pillow to apply gentle pressure to symbolise sexual assault, as discussed earlier.

9.3.5 Theme Five: Emotions and Affect

The theme of emotions and affect emerged from the analysis of the literature reviewed. This theme encapsulated the areas of emotional arousal, nervous system regulation, emotional regulation and catharsis, as will be reported below.

The literature explains that trauma can manifest in differing states of autonomic and emotional arousal (Siegel, 1999; Ogden, 2009). On the one hand, those who have experienced trauma may find themselves in a hyperaroused state. Most similar to the typical symptoms of PTSD, such as hypervigilance, flashbacks, as well as anxiety, hyperaroused individuals are characterised as being overly-aroused. Ogden (2009: 2) suggests that hyperaroused individuals experience "dysregulated emotions". On the other hand, hypoarousal refers to individuals being in a state of under-arousal in the aftermath of trauma. Ogden (2009: 2) states that "hypoaroused clients endure another kind of torment, stemming from a dearth of emotion and sensation—a numbing, a sense of deadness or emptiness, passivity, and immobilization". She explains that prolonged hypoarousal is thought to lead to depressive states. Individuals can oscillate between states of hyperarousal and hypoarousal. Siegel (1999) suggests that healthily functioning individuals find themselves in the window of tolerance. This window falls between the two extremes of hypo- and hyperarousal, and refers to a zone in which "various intensities of emotional and physiological arousal can be processed without disrupting the functioning of the system" (Siegel, 1999: 253).

Ogden (2009) states that the arousal state in which a client finds themselves in impacts the direction of treatment. She states that "clients must first learn to modulate dysregulated arousal so that it returns to a window of tolerance. Once arousal is thus stabilized, clients can expand their window of tolerance by working with painful traumatic memories, repressed or dissociated emotions, and new physical actions" (Ogden 2009: 2).

The literature reviewed states that therapy should aim to expand the window of tolerance (Bromberg, 2006, cited in Ogden 2009: 2-3):

> therapy must address such difficult issues in an atmosphere that is "safe but not too safe" in order to expand the window of tolerance. If their emotional and physiological arousal consistently remains in the middle of the window of tolerance (for example, at levels typical of low fear and anxiety states), clients will not be able to expand their capacities because they are not in contact with disturbing traumatic or affect-laden attachment issues in the here-and-now of the therapy hour. However, if arousal greatly exceeds the regulatory boundaries of the window of tolerance, experience cannot be integrated.

While a large part of the literature reviewed speaks to the importance of containing and 'down regulating' emotional arousal through containing mechanisms as spoken to in the previous theme, the importance of stimulating emotional arousal is also addressed. De Witte et al. (2021) refer to emotional arousal as a therapeutic factor in experiential therapy. Experiential therapy is defined in the literature as "an immersive, hands-on form of therapy that uses expressive tools and modalities" (Gupta, 2021). Gupta (2021) states that therapies such as drama therapy and other expressive arts therapies could be conceptualised as experiential therapies. Pitre, Sajnani and Read Johnson (2015: 44) report that "effective [desensitisation] requires the emotional arousal of the client". As such, they suggest the need to progressively work towards

more under-distanced references to the traumatic material in order to evoke the necessary emotional arousal for desensitisation.

Further, the literature additionally speaks to the importance of clients learning to regulate their emotional affect within the therapy space. James and Read Johnson (1997: 384) suggest that as clients have the tool of distancing at their disposal, they may hold the agency to "titrate the intensity of affect by manipulating the art form". Pitre, Sajnani and Read Johnson (2015: 44) state that trauma-centred developmental transformation therapy draws on "the natural exuberance of play as a support to the child's self-regulation of affect".

The literature reviewed also suggests that emotional arousal can facilitate catharsis. Catharsis is defined in the literature as "emotional release" (De Witte et al., 2021: 15). This can be seen in the previous case presented by Toscani (1998) in which her client used the sandtray play to enact revenge through physical violence on a puppet that symbolised her perpetrator. In reference to this scene, Toscani (1998: 26) states that:

> it was now time for Barbara to enact her revenge, to discharge what had been mostly pent up for almost 37 years and had had its only outlet in self-destructive [behaviours] and suicide attempts. This was a moment of great import, of a ritual necessary to release her from an identification with a victim-identity to one of health that she had been steadily growing into.

In this study, through the emotional arousal of the state of anger, it is reported that the client experienced an emotional release or process of catharsis.

Catharsis is mentioned elsewhere in the literature. For example, Barbato (1945: 397) states that that the technique of re-enacting trauma in therapy is a "procedure…of catharsis and [desensitisation]". Glass (2006: 60) states that exposure therapy aims to retrieve repressed

feelings around the trauma, explaining that “expressions of vulnerability or anger or sadness can become triggers for the memory of the trauma itself, and therefore forbidden”.

9.3.6 Theme Six: Use of Role

The use of role emerged from the literature reviewed. Role is defined in drama therapy as “persona rather than person, character rather than full-blown human being, part rather than whole. It is a container of two realities, the everyday and the fictional/imaginative, holding them in a paradoxical relationship to one another” (Landy, 1991). In essence, the use of role can be seen when a client may take on the persona or character of another person in drama therapy. This could be a specific person or it could be an archetypal role, such as mother or healer. Clients may take on various roles within a session, stepping into and out of role, through a process of roling and de-roling. The elements of role that emerged from the literature reviewed were the Therapeutic Spiral Model and the Trauma Survivor’s Intrapsychic Role Atom (Toscani, 1998), as well as the use of role reversal and doubling. These will be discussed below.

The use of role in trauma re-enactment emerged from the literature reviewed. This theme was most salient in Toscani’s (1998) work, which was also cited in Glass’s (2006) work. Toscani (1998) states that her trauma re-enactment work is held by the framework of the Therapeutic Spiral Model and the Trauma Survivor’s Intrapsychic Role Atom (TSIRA). Relevant to the theme of role, Toscani (1998: 22) states that TSIRA is “a map of all the roles or parts-of-self necessary for safe re-enactment of core trauma scenes and intense affect”. Toscani (1998) says that safety measures are important when working with clients who have severe trauma histories so as to not re-traumatise them. TSIRA provides such a safety measure.

TSIRA denotes that before trauma re-enactment work can take place, a client needs to have a specific range of supportive roles established and available to them (Toscani, 1998). These supportive roles are called prescriptive roles, and include restorative, containing and observing roles. Toscani (1998: 23) states that restorative roles "increase and reclaim the client's spontaneity, resilience, energy, support and connection to their spirit. These may be qualities of personal, interpersonal, transpersonal, cultural strengths all geared toward providing an environment for healing." Containing roles, on the other hand, "provide a psychological and, if necessary, physical holding space for the protagonist who is working on trauma so that s/he is not overwhelmed by memories, dissociated affect or uncontrolled regression" (Toscani, 1998: 23). One such containing role is the containing double who symbolises the archetypal mother. In individual therapy, the containing double role is held by the therapist, while in a group setting, it may be held by a group member. Finally, observing roles "provide a constant, cognitive state of awareness, perceiving all the primary process material and making sense of it without judgment" (Toscani, 1998: 23). The primary observing role that is drawn upon is the observing ego, and represents the archetypal father. Toscani (1998: 23) explains that the containing double and observing ego roles provide the client with "a necessary narrative and cognitive component that is often missing when a trauma survivor experiences a flashback or any situation that recreates the affective quality of the original trauma". The aim of TSIRA is for the client to integrate these prescriptive roles into their everyday life outside of therapy.

Toscani (1998) explains that once the supportive, or prescriptive, roles have been established, the trauma-based roles are then intervened upon. She defines trauma-based roles as "the roles that result from trauma—primitive and maladaptive defensive roles, victim and perpetrator roles" (Toscani, 1998: 22). While prescriptive roles may not be readily available to clients, trauma-based roles are more accessible in that these roles tend to be internalised as a result of trauma. Toscani (1998) explains that trauma-based roles arise out of a client's presenting

symptoms. Clients tend to fall back into victim-perpetrator roles when an experiences reminds them of their past trauma. The negative feelings related to the trauma experience are held by the victim role while the role of the perpetrator is internalised, and manifests as self-abusive or otherwise abusive behaviour. Toscani (1998) states that primitive and maladaptive defence roles consequently exist in attempt to combat the victim-perpetrator roles. Primitive defence roles include "dissociation (Sleeping-Child), denial, multiple states of consciousness and other [defences] and symptoms of trauma", while maladaptive defence roles "are higher level [defence] mechanisms" including "roles that overcompensate (Rescuer and Adult-Child roles, such as caretaker, overachiever, entertainer, etc.) and those that are ineffective (Absent Parent or Protector)".

The third and final role category present in TSIRA are integrative roles. Toscani (1998) states that integrative roles are the ultimate goal of therapy. Similar to prescriptive roles, integrative roles are "functional, adaptive roles that the client wants to have accessible" (Toscani, 1998: 23). These roles often encapsulate and concretise a client's therapeutic goals.

Throughout the re-enactment of the traumatic event, these roles are present and called upon as needed. For example, in her sandtray work with her client in treatment for trauma, Toscani (1998) invited the client to find objects that represent her prescriptive roles and to place them in the sandtray before they engaged in re-enactment work and brought the perpetrator into the sandtray. Similarly, in the client's early expression of rage, Toscani (1998: 25) took on the role of the containing double to "[slow] down her process with…statements such as, "I know I want to kill that man, do him real damage (reflective), but I know that right now I can take a deep breath (here and now) and realize that I don't want to hurt myself in the process (containment)."

Outside of the TSIRA framework, the use of role was present in further trauma re-enactment work as discussed by other researchers. Role reversal was a prominent tool in the literature.

Role reversal, a term or technique originating from psychodrama, refers to a client stepping out of the role that they may currently be assuming, typically themselves, and taking on the role of another (Kellermann, 1994). Role reversal traditionally refers to complementary and interdependent roles, such as mother and daughter, but has grown to encapsulate seemingly non-complementary, yet nonetheless related, roles.

Glass (2006) speaks to the use of role reversal both to provide strengthening resources to the client and to contain emotional flooding. For example, Glass (2006) states that a client may have difficulty envisioning themselves in any, or as any, positive roles. In such a case, the therapist could utilise role reversal and ask the client to take on the role of a friend, family member or imaginary person who encapsulates strength or wisdom. Through embodying strength via role reversal, strength may become an attribute that clients may more readily see themselves as possessing or being able to embody. Glass (2006) states that re-enactment therapy needs to assist clients in expanding their role repertoire to include assertive and mastery roles that can support their healing. Further, Glass (2006) states that during the enactment of traumatic material, clients may use role reversal to step out of their own role which may be in too close a proximity to the event, and step into the created positive role.

Pitre, Johnson and Sajnani (2015) also speak to function of role reversal between victim and perpetrator. They explain that in early on in the desensitisation process, child clients may prefer to assume perpetrator roles and place the therapist in the victim role. In the role of perpetrator, the child may assume dominance over the therapist. They state that the identification with perpetrator over victim demonstrates avoidance. As the exposure and desensitisation process deepens, Pitre, Johnson and Sajnani (2015: 43) state that "the child inevitably becomes interested in having a turn at [the victim role] as well, and allows themselves to re-play the

fearful situation from the vulnerable position, a moment that is called the rounding". The willingness to assume the victim role reflects effective desensitisation progress.

In addition to role reversal, the use of doubling is also stated in the reviewed literature. Doubling is defined as "role enactment in which one person (the protagonist) portrays himself or herself and an auxiliary assumes the protagonist's persona, acting alongside as a double (Kipper & Ritchie, 2003: 15-17). Through role taking such as doubling, a therapist may also hold a supportive and reflective space for their client, such as the containing double used in the TSIRA model (Toscani, 1998). Glass (2006: 66) also writes about the use of doubling and states that while a client may be re-enacting a scene, the therapist may take on the role of their double, making statements such as "I say I'm not angry, but my fists are clenching".

9.3.7 Theme Seven: Rescripting Trauma

Rescripting trauma was a theme that was evident throughout the literature reviewed. Rescripting trauma refers to either changing a client's perception around the traumatic event or its impact on their identity, or altering the unfolding of events during the traumatic re-enactment to gain a sense of agency or power over the trauma. Irwin (1977) suggest that the pure act of re-enactment itself provides a sense of mastery over trauma-related anxiety. She explains that re-enactment of past life experiences naturally occurs in children's play "attempting to allay anxiety by mastering them" (Irwin, 1977: 431). Drawing on the psychoanalytic theory of play, Waelder (1933, cited in Irwin, 1997: 427) states that "play [provides] an opportunity for the child to assimilate piecemeal what, in real life, may have been too difficult to integrate in one fell swoop. By moving from a passive to an active position in play, the child attempts to control the outcome, allay anxiety and thereby (to quote Waelder) digest 'the undigested meal.'" These views are echoed by Erikson (1963: 222) who states that

“child's play is the infantile form of the human ability to deal with experience by creating model situations and to master reality by experiment and planning".

Such mastery is demonstrated in a client’s willingness to take on the role of the victim during re-enactment after initially opting only to take on the perpetrator role due to the distance, power, control and, consequently, avoidance it provides. Pitre, Johnson and Sajnani (2015: 47) write about their work with a traumatised child who at first “used roles of power over the therapist as a means of protecting himself”, but as the therapy progressed, was able to readily step into the role of the victim without distress, showing the mastery gained.

The literature reviewed explores the importance of clients being able to reframe their identity from that of passive victim to that of active participant or survivor. Irwin (1977) shares the example of a child client who had experienced the trauma of falling out of a moving taxi which his mother only realised once the taxi had driven a block further. Additionally, the child had experienced his mother being taken to the hospital several times in a police ambulance, thinking that she was being taken to jail. Irwin (1977: 432) describes how the following scene played out in their fourth group therapy session:

> the group was playing out a fantasy in which a "bad mother" (the therapist) was jailed because she failed to "feed" her children. Suddenly, Greg stirred from his solitary position in the corner and quietly took "mother" by the hand from the jail—"No jail, mommy—no jail," he said. He led her to the housekeeping corner and "fed" her bananas and chicken—all the play food he could find.

She explains that through this scene, the client was able to shift his identity from passive witness or victim to active participant or saviour. Irwin (1977: 432) states that this enabled the client to regain control and mastery over the traumatic memory, “and ‘rescue’ his mother, as he would have liked to have been rescued in the past. She descried how the client also began

to re-enact taxi scenes in which he would play the taxi driver and drive the other group members to the hospital, making sure to lock all the doors and take good care of his passengers. Irwin (1977: 433) states that this allowed him to "[become] active instead of passive, [relive] the experience and [supply] a different, healthier ending."

Pitre, Sajnani and Read Johnson (2015) state that through dramatic play, a client may have the opportunity to defend themselves in a way that they were not able to in the past. They suggest that through role reversal, a child could either take on the role of the perpetrator or a role such as a superhero when confronted with a 'threat' in the play. Thus, they are able to successfully approach and overcome the threat, rescripting their response to trauma.

Other authors speak to the importance of altering the unfolding of events during re-enactment. For example, Toscani (1998) shares her work with a woman in treatment for severe trauma, as discussed in the theme of 'Distancing'. In the re-enactment, the client reassumes her power over her perpetrator by physically taking revenge on the puppet in the role of her perpetrator. While the therapist and client are both aware that the client would not carry out this physical assault in reality, Toscani (1998) explains that acting it out in the play space allows the client to regain her control of the situation and the trauma, and release pent up anger. The client was therefore able to reduce her affiliation with the victim identity.

The literature reviewed suggests that re-enactment can also be rescripted by stating how events should ideally have occurred. For instance, the Pesso Boyden System Psychomotor, a therapeutic system, creates the role of the ideal parent which a therapy group member assumes (Pesso Boyden Training UK, 2021; Jencius & Duba, 2003). In the role of the ideal parent, they might say something along the lines of, "If I had been your ideal father, I would have blessed you and blessed that power", or "If we had been your ideal parents, you would have had our undivided attention" (Pesso Boyden Training UK, 2021; 2:10, 8:44). Through this, a new

memory is created alongside the old, traumatic memory. Rather than attempting to deny or re-write the old memory, a parallel positive memory is created with the intention of nurturing and healing the wounds of trauma. The intention is to be able to look back on traumatic past experiences while feeling safe in the present.

Alternate views were presented in the literature reviewed. In their re-enactment and exposure work with war veterans in treatment for PTSD, James and Read Johnson (1997: 385) state that "the major focus of Developmental Transformations is not the specific re-living or problem-solving of life experiences, nor achieving catharsis, but rather embracing an attitude of acceptance and tolerance of the multifaceted aspects of the self, good and bad, profound and superficial." As such, their intention is to assist clients in tolerating and accepting 'the bad', rather than solving problem-solving. Rescripting trauma thus occurs through reshaping one's attitude or perspective towards the trauma.

9.3.8 Theme Eight: The Function of the Therapeutic Relationship

The literature suggests that "isolation is one of the fundamental hallmarks of trauma; so, too, is silence" (Stepakoff, cited in Marcow Speiser & Speiser, 2021). It is also suggested in other literature that a great deal of past trauma is rooted in attachment relationships (Pesso Boyden Training UK, 2021). As such, the importance of witnessing, universality and relational support was reflected in most sources.

It is also stated in the literature reviewed that a strong therapeutic alliance is important in determining the possible success of therapy. De Witte et al. (2021: 2, 9) state that therapy happens "within a therapeutic relationship" or "functions in the context of a strong therapeutic alliance". Similarly, Van der Kolk, McFarlane and Weisaeth (2012: 18) voice that "the foundation of treatment is the safety of the therapeutic relationship".

The literature reviewed poses that witnessing is one of the mechanisms through which the therapeutic relationship functions. Witnessing forms one of Jones's (2007) core therapeutic processes of drama therapy. Witnessing can take place in various forms, one of which includes being witnessed by the therapist or group members. Jones (2007: 102) states that "the experience of being witnessed within a dramatherapy session can be experienced as being acknowledged or supported". De Witte et al. (2021) state that witnessing is a reflective process present in all creative arts therapies.

Witnessing can give way to feelings of universality, as evident in the literature. In their work with war veterans, James and Read Johnson (1997) describe how the shared common traumatic experience held by the group members gave rise to feelings of universality, or not being alone. In one of the scenes that unfolded in their therapeutic process, the idea of universality is present in the following excerpt (James & Read Johnson, 1997: 393): "William: We have killed! We have all killed!...You are not alone!". This moment in therapy progressed into the following dialogue (James & Read Johnson, 1997: 393):

> Therapist/leader: Will you, Mark, let us help carry your pain?
>
> Mark: Yes.
>
> Therapist/leader: Then give us some of the burden (a reference to the earlier image in the session). Hand your burden to us!

A therapeutic relationship, be it one that exists between the therapist and client, or the group members themselves, serves to share the load of trauma by having others who can help you to carry it. As described in the sixth theme, 'Use of Role', a therapist can draw on techniques such as doubling to create a holding, supportive and reflective space for their client. Glass (2006: 66) provides an example of how doubling can be used, suggesting that a therapist may make

statements such as “I say I’m not angry, but my fists are clenching”, while doubling for a client during a re-enactment scene.

In a similar light, Pitre, Sajnani and Read Johnson (2015: 44) state that a therapist can actively participate in role reversal with the client, “the aim [being] for the child not to feel alone in telling their story”. Further, they state that a therapist can model desensitisation to their client. Through the therapist’s active participation in the re-enactment, taking on both victim and perpetrator roles, they can model desensitisation to their clients.

Additionally, the literature reviewed expresses that the therapist can also model love and support within the therapeutic relationship. James and Read Johnson (2015) describe how in their work with veterans, the group moves through various phases in the treatment process, the second of which being a shame phase. They state that the shame phase is “[characterised] by the expression of vulnerability through themes of impotence, loneliness, regret, guilt, fear and doubt” (James & Read Johnson, 2015: 389). Within this phase, they state that it is important for the therapist to model positive regard and acceptance towards the clients as they express their feelings around their past trauma. This acceptance and support can be modelled in role as captured in the excerpt from their therapy session below (James & Read Johnson, 2015: 391):

> Henry: (to his dead grandfather, played by the therapist) I miss you; I wonder if you know what I have done?
>
> Therapist/grandfather: Yes, I have been up here in heaven watching over you. You have had a hard time.
>
> Henry: I don’t know if I can forgive myself; can you forgive me?
>
> Therapist/grandfather: Can you forgive yourself? (the group brings Henry over to the therapist) I love you grandson; I will always love you. (The therapist takes Henry in his arms for several seconds.)

James and Read Johnson (2015) state that this interaction had a positive and strengthening effect on the therapeutic alliance.

Toscani (1998) also voices the importance of modelling support to clients through developing a united team. For example, Toscani (1998) uses collective pronouns to demonstrate this support. This is seen in the following excerpt (Toscani, 1998: 25): "I suggested that Barbara pick objects for her sandtray scene that represent her strengths, personal, interpersonal and transpersonal, before we would go in and even 'bring that man into our space.'" Toscani (1998: 25) states that this use of collective pronouns, 'we' and 'our' in this case, "indicated to her [client] that she would not be abandoned by [her], a woman, to fight alone, as she had by her mother, an Absent Parent role".

Finally, the literature reviewed suggests that the therapeutic relationship can provide an opportunity through which to heal attachment wounds. It is suggested that attachment and relationship trauma often lie that the root of most trauma (Pesso Boyden Training UK, 2021). The Pesso Boyden System Psychomotor attests that "the healing has to happen in the right kinship relationship" (Pesso Boyden Training UK, 2021: 1:08), thus calling for trauma to be rescripted and attachment wounds to be healed through the introduction of the ideal parents, as discussed in the seventh theme, 'Rescripting Trauma'. In essence, the literature suggests that secure attachment can be developed through the therapeutic relationship. In the above paragraph, it can also be seen how the therapist models positive attachment to the client through showing their clients the support that their parents may not have shown them (Toscani, 1998).

9.3.8.1 Sub-theme: The Therapeutic Relationship within Treatment for Borderline Personality Disorder

The theme of the therapeutic relationship was also present in the literature on BPD. Some of the literature reviewed suggests that healing attachment should be a central focus in the treatment of BPD. Van der Kolk et al. (1994) emphasise the importance of working with early relationship patterns or trauma within therapeutic treatment. They propose that BPD is a "function of having been terrified during one's development" (Van der Kolk et al., 1994: 720). They suggest that both children who have been abused and children who are pathologically shy may experience the world to be a terrifying place. Rather than these factors being the direct cause of BPD, Van der Kolk et al. (1994: 721) state BPD results from the "continuation of terror into adulthood". They express that it is important for both the therapist and client to understand the impact of past trauma on the present through the following quotation: "therapy must clarify how current stresses are experienced as a return of past traumas and how small disruptions in present relationships are seen as a repetition of prior abandonment" (Van der Kolk et al., 1994, n.p.n).

Yeomans et al. (1994) express that BPD clients have a particularly high therapeutic dropout rate. The dropout rate is reportedly twice as high in comparison to other neurotic or personality disorders, and four times higher than clients with schizophrenia. It is stated that approximately only 33% of clients with BPD continue treatment after 3 months. They suggest that this is because "the borderline patient is unstable in interpersonal relations, a phenomenon likely to be repeated with the therapist" (Yeomans et al., 1994: 16). They recommend a strong and positive therapeutic alliance as an essential mitigating factor in reducing the high dropout rates.

9.3.9 Theme Nine: Challenges and Considerations related to Re-enactment

The final theme that emerged from the analysis of the literature was that of the challenges and considerations related to re-enactment. One of the concerns that arose related to exposure through re-enactment was the risk of re-traumatisation. Haen (2007) cautions against exposure with male sexual abuse victims, and suggests that the amount of time spent of addressing abuse-related memories should be limited. Toscani (1998) states that traumatised clients are a vulnerable client group, and without safety measures in place, re-traumatisation can ensue from re-evoking the traumatic memory in the therapy space. Van der Kolk, McFarlane and Weisaeth (2012) similarly caution against early engagement with past traumatic material as this may aggravate traumatic intrusions. They also state that regaining a sense of safety in the body should be the first priority in trauma treatment, and premature exposure could lead to the client's body feeling unsafe.

Toscani (1998) also warns against introducing the perpetrator role into the space too early on in treatment. She explains that placing the client in a situation within therapy where they have to face or take on the perpetrator before they have sufficiently developed strength and a belief in their own power and agency can be traumatising for a client. Additionally, Toscani (1998) states that the perpetrator identity may be internalised in a client after experiencing trauma. She explains that a trauma identity may also be laden with taboos. She states that "breaking a taboo before the person is ready to let go of the identification with the aggressor (person, culture, religion, etc.), e.g., telling their story or expressing rage, can be life-threatening because of the guilt that ensues" (Toscani, 1998: 25). She warns that this could potentially result in suicide.

One source in the literature states that abreaction should not be used as an isolated treatment tool (Schimelpfening, 2020). Schimelpfening (2020: para. 1) defines abreaction as "an emotional, unconscious reaction that you have in response to a stimulus that brings back a

painful situation you have experienced before". Schimelpfening (2020: para. 13) goes on to say that "abreaction is rarely used in isolation as a therapeutic tool. Simply eliciting a reaction to a stimulus does nothing to address the emotions and [behaviours] associated with the past trauma". She explains that clients additionally need to learn coping skills and learn to integrate their traumatic experiences. The literature also suggests that while re-enactment can be successful in reducing the conflicts related to past trauma, it would be incorrect to say that the scars of trauma can be erased (Irwin, 1977).

The literature also points to some of the potential negative effects of exposure therapy (Gupta, 2021). This source discusses exposure therapy practised traditionally within psychotherapy, rather than within drama therapy. Gupta (2021) states that symptoms could return over time after treatment, especially if treatment was terminated prematurely. Additionally, Gupta (2021) explains that conditions present in a therapy room may not reflect those of reality. As such, the simulated exposure may not be representative of reality. While a client may therefore be able to tolerate and successfully desensitise themselves to exposure within the therapy room, this tolerance may disappear when confronted with exposure in the real world.

An additional challenge to re-enactment that arose from the literature was the lack of empirical research. De Witte et al. (2021: 2) state that "there is a clear need for more empirical evidence on the effects and applicability of therapeutic interventions rooted in the action-based approach such as [creative arts therapies]". This statement does not specifically refer to re-enactment work, but alludes to a lack of empirical evidence being collected and published in support of some of the techniques and methods of creative arts therapies, drama therapy included.

10. Discussion

This section begins by discussing how the results respond to the research questions. I then discuss the new or interesting findings that were not addressed in my research questions, but that I believe are nonetheless pertinent to a thorough review of the topic. Alongside this discussion, I frame how my assumptions and biases that were present prior to the commencement of this study were challenged through the analysis of the results.

10.1 Responding to the Research Questions

This study aimed to interrogate one primary research question, and three subsequent sub-questions. The primary research question was, 'Can re-enactment be useful in processing past trauma, including childhood trauma, in drama therapy?'. The sub-questions asked, firstly, 'What is the role of the therapeutic relationship in childhood trauma work?', secondly, 'What is the function of embodiment in trauma work?', and thirdly, 'Could re-enactment hold value in assisting BPD clients with trauma histories to process past childhood trauma?'

After having conducted the analysis and reviewed the results, I believe that the logical fashion in which to address these questions is to begin by addressing the first sub-question, followed by the second sub-question, and then to address the primary research question and third sub-question. This is the order in which the information consequently builds upon the previous question.

10.1.1 What is the Role of the Therapeutic Relationship in Childhood Trauma Work?

The results overwhelmingly indicated that a strong therapeutic alliance is essential in any and all therapy work. This came across strongly in the eighth theme: 'The function of the therapeutic relationship'. It was interesting to note that I did not need to source extensive

additional literature on the function of the therapeutic relationship, as it was present in most sources dealing with re-enactment. In response to my research question, it would appear that one of the primary roles of the therapeutic relationship is to allow the client's wounds to be seen and witnessed. The relationship provides a safe space within which to navigate and facilitate the healing of these wounds. Moreover, in the case of the childhood trauma being related to attachment wounds, as the literature suggests is common, the therapeutic relationship models secure and positive attachment to the client. In essence, the relationship becomes a space to re-learn or re-experience healthy attachment. It was also apparent from the literature that within a group therapy setting, the relationship between group members also serves to create positive and healing attachments.

Along with allowing a client to feel seen and accepted, the therapeutic relationship allows a client to feel as if they are not carrying the burden of their trauma alone. The therapist confronts and faces the trauma alongside the client. This may ease a client's ability to face their trauma, as having another person to share your burden may make facing the past less overwhelming.

The research strongly indicates not only the value, but the necessity of the therapeutic relationship. I would furthermore argue that re-enactment would not only be unsuccessful without a strong therapeutic relationship to hold it, but could possibly even be harmful. As re-enactment work can take clients to vulnerable places, a strong and supportive relationship is certainly a pre-requisite to this sort of work. I would further conclude from the results that it may even be valuable to spend the initial therapy sessions with a client establishing and building a strong therapeutic relationship before beginning to delve into and engage with a client's traumatic material.

10.1.2 What is the Function of Embodiment in Trauma Work?

This research question was largely responded to in the first theme of this study, namely 'Trauma and the Body: Exploring Embodiment'. Interestingly, I had assumed that most studies exploring trauma re-enactments would refer to the relationship between the body and trauma. However, I found that the literature on trauma and the body was largely separate from the re-enactment literature. This is not to say that the literature on re-enactment did not refer to embodiment, but rather that it generally did not unpack its function or the way in which working with and through the body itself was valuable or therapeutic.

Three important aspects arose from the results. These included the relationship between the body and trauma, the importance of nervous system regulation or states of arousal, and regaining a sense of safety in the body. In relation to the first aspect, the literature maintains that a firm relationship exists between the body and trauma (Van Der Kolk, 2014). It is explained that trauma is stored on a somatic level. It is therefore suggested that in order to process trauma on the level at which it exists, treatment should assume a body-based approach. I would therefore argue that re-enactment could be an appropriate and valuable trauma treatment option as it functions through embodiment. This arguably could make it more suitable in processing and addressing trauma than other approaches or techniques which opt for a talk-based approach. While it could of course also be argued that talk-based work is nonetheless embodied as purely existing, conversing and moving through this world is embodied (Duffy, 2014), I would make the argument that talk-based therapy is, for the most part, unconscious embodiment. I would propose that trauma work could benefit from assuming an intentional and aware approach to embodiment. This is supported by the research which suggests that the awareness of embodiment may lead to longer lasting psychiatric symptom reduction (Tantia, 2019).

However, it must be noted that the existing relationship between trauma and the body makes the argument for embodied treatment, not necessarily embodied re-enactment. Addressing the third aspect of regaining a sense of safety in the body, the literature states that the first priority in trauma treatment should be assist the client in reclaiming a sense of safety in their bodies (Van der Kolk, McFarlane & Weisaeth, 2012). The literature suggests that treatment should not take the client back to an exploration of past trauma too early on in the treatment plan, as this can create a sense of the body being in danger. This makes an argument against the premature use of re-enactment. An important finding of this study is therefore understanding the correct timing of re-enactment; it may be harmful if it is used too early in the treatment plan.

On the other hand, it could also be argued that re-enactment could, in fact, assist in returning a sense of safety to the body. In order for the client to truly feel safe, one could argue that the client needs to feel safe on an embodied level by helping the body to understand that the danger has passed. One can be told and may even understand on a cognitive level that the danger has passed, but through re-enactment that allows the body to return to the once traumatic place and experience that that place may no longer pose the same danger to them, a feeling of embodied safety may gradually return. This line of thinking is supported by Tull (2020) who states that avoidance can affirm to the individual that the danger is still present even after it has passed.

The topic of nervous system regulation arose from the results. The literature explained that trauma can lead to nervous system dysregulation, leading to a state of either hyperarousal or hypoarousal (Van Der Kolk, 2014). Haen (2007) explains that clients experiencing nervous system dysregulation may respond poorly to verbal therapy, and may fare better with an embodied approach. I believe that this creates a compelling argument for the use of embodied work with traumatised clients. This argument responds directly to this particular research

question, ‘What is the Function of Embodiment in Trauma Work?’, by explaining that embodiment may be the most effective level on which a therapist can communicate with a traumatised client.

In stepping back and reviewing the question of embodiment in re-enactment as a whole, I feel the need to state that I had expected the literature on embodiment in re-enactment, and in fact drama therapy as a whole, to be abundant. It had been my assumption approaching my research topic that understanding embodiment’s function in re-enactment would form a fundamental component of my research. From the preliminary literature that I consulted and the background information that I found on my topic, embodiment appeared to be a core aspect. However, it was interesting to note that a large portion of the data emerged from the fields of psychology or psychiatry, rather than drama therapy.

One of the primary sources consulted in this research about the body and trauma was Van der Kolk’s (2014) work coming from his experience as a psychiatrist. Interestingly, Van der Kolk, in my opinion, is the primary source for body-trauma understanding that has been referenced in my drama therapy Masters training, alongside Porges’s work on polyvagal theory (2009). Porges, too, is a fellow psychiatrist. While literature on embodiment written about from the field of drama therapy was drawn on in my research (Jones, 2007), this literature is quite dated and was one of the only sources from drama therapy discussing embodiment that I reviewed.

It was, of course, not in the scope of my topic to collect or review drama therapy literature on embodiment alone. With this said, embodiment was a present concept and I did review some of the more prominent and influential sources that drama therapists draw on, and it appears to me that the drama therapy literature on embodiment appears to be lacking. I am hesitant to make this statement definitively because, as stated, I did not conduct an in depth search for embodiment literature. However, I can say with greater conviction that embodiment and its

function appears to be largely undiscussed in the literature on re-enactment. While the importance of embodiment appeared to me to be implicit in the literature, it was not clearly stated that re-enactment functions through embodiment, nor was it stated why embodiment may be a useful tool through which re-enactment is facilitated. I do not believe that this gap in the literature means that embodiment is not important to re-enactment work, but rather that this may be an underdeveloped or underexplored area of the work. This, I believe, was an interesting and important finding of this research.

10.1.3 Can Re-enactment be Useful in Processing Past Trauma, including Childhood Trauma, in Drama Therapy?

The primary question that this research sought to answer was, 'Can re-enactment be useful in processing past trauma, including childhood trauma, in drama therapy?' After having reviewed the results, I would make the argument that a definitive or prescriptive answer to this question may not be appropriate. I would argue that using re-enactment to process past trauma, including childhood trauma, in drama therapy may be a highly valuable experience for many clients, while for others this may not be the case. I will explain and unpack this argument below.

Firstly, the efficacy of exposure therapy was evident from the results. It was furthermore evident from the results that exposure, and exposure therapy, is a useful way of framing and understanding re-enactment. Exposure and desensitisation appeared to be the preferred vocabulary used by drama therapists in reference to this sort of work. The arguments as to why exposure therapy may be the treatment of choice in processing past trauma were clear, as seen in the third theme of 'Desensitisation and Exposure'. This compelling evidence could lead one to concluding that re-enactment could generally be useful in processing past trauma. However, the results clearly stipulated that re-enactment and exposure should be facilitated in a specific manner and at a specific point.

It is suggested that re-enactment should occur in gradual stages, slowly moving from more distanced to more direct references to the trauma. However, the pace at which this gradual exposure should occur is not specified. Trauma and human material are not uniform, and neither are clients. Prescribing a pace at which to progress through exposure, I would argue, is therefore not possible. I believe that a therapist would need to be very in tune with the needs of their client, and that a healthy power balance and open communication would need to exist in the therapeutic relationship for a therapist to ascertain the appropriate timing of progressing through gradual re-enactment or exposure. Therefore, while re-enactment or exposure has been demonstrated to have positive results in the literature, I believe that it needs to be practised responsibly and gradually in the therapy space. In this regard, I would argue that re-enactment can be useful in processing past trauma, including childhood trauma, in drama therapy, so long as it is done gradually and at a pace with which the client is comfortable. This pace would need to be determined jointly by the therapist and the client.

Another important consideration in attempting to answer this question is understanding what precisely is being re-enacted. A large portion of the literature suggests that past events may be more effectively processed if the course of events or the detail of the event can be altered in the re-enactment. For example, Toscani (1998) maintains that it is important for clients to access supportive and strengthening roles during re-enactment using TSIRA. In this sense, clients are 'going back to the site of the trauma', but this time, they may have the resources necessary to confront the trauma in a way that shifts the power balance in their favour.

Supported by the seventh theme, 'Rescripting Trauma', it could therefore be argued that re-enactment may hold most value when the events are not re-enacted as they happened, but possibly rather as they should have happened, or as the client may have wished them to happen. While I do believe that this is a compelling argument, I also believe that this could be dangerous

territory upon which to tread. Rescripting trauma in this manner could lead to a sense of victim blaming through suggesting that had the victim acted differently at the time, they could have defeated the perpetrator. This could be traumatic for clients, noting the internalised perpetrator that often manifests in victims in the aftermath of trauma (Toscani, 1998). Similarly, being able to 'defeat the perpetrator' this time around also be cathartic, as evident in the case of the woman who enacted revenge on her perpetrator, as discussed in the results. In this regard, I would therefore argue that enacting trauma in a way that returns a sense of agency to the client may be both healing and cathartic, but a therapist should carefully monitor the work to ascertain that a client would not perceive a rescripting as a judgement delivered on their past actions.

In final response to the primary research question, I argue that re-enactment could be useful in processing past trauma, including childhood trauma, in drama therapy if it is done gradually, and in a way that reinstates power in the client. Strong support of this approach exists within the drama therapy literature on re-enactment and the psychology literature on exposure therapy. It is further suggested in the literature that exposure therapy may, in fact, not only be the most effective, but possibly the only effective, treatment option for clients with PTSD (Pitre, Sajnani & Read Johnson, 2015: 41).

However, therapy is not a 'one size fits all' approach. This could be an approach that may not resonate with a particular client. Further, if not practised carefully within the context of a strong therapeutic alliance and with a consideration for the potential of re-traumatisation, re-enactment might be harmful to a client's healing.

10.1.4 Could Re-Enactment Hold Value in Assisting BPD Clients with Trauma Histories to Process Past Childhood Trauma?

Literature addressing re-enactment work with BPD clients who have trauma histories did not appear to exist in the literature reviewed. This therefore seems to be a novel gap in the literature. This posed an interesting challenge to my research, as there was no direct data to analyse on this question, and thus the topic of BPD appears to be somewhat absent in my results section. Rather than presenting direct results, the appropriate way to address this question became to extrapolate and integrate the results that were present into an informed discussion in this section of the research report, as is presented below.

I would argue that if a client with BPD were to have a trauma history, that re-enactment work could potentially benefit them in the therapy space, as it could with clients outside of this particular diagnosis. In this regard, I was challenged around my decision to include BPD in this research. In my reflection as a researcher, I questioned my initial impulse with my research, thinking that the elements that make re-enactment treatment valuable should certainly be true across diagnoses. While there are merits to this argument, I do believe that the inclusion of BPD in this research was valuable, and I continue to believe that there are unique elements to a diagnosis of BPD that support the need to continue to investigate and determine whether this approach may hold value in working with such clients.

Firstly, the typical treatment options available and prescribed for BPD are largely focused on present symptom management. This is an important and essential part of treatment, but if a client were to have a trauma history, as the literature suggests many individuals with BPD do (Gunderson et al., 2000; Salters-Pedneault, 2020; Herman et al., 1989; Van der Kolk, 1994), I believe that only, or primarily, focusing on the present may neglect an important element of their diagnosis. Supported by the literature reviewed, one could go so far as to say that this may

neglect treating a causal element in favour of symptom management. I therefore believe that this research holds value in the body of work addressing BPD treatment in that it creates an additional treatment option for clients with a seemingly unique focus on past trauma. This is certainly novel within the field of drama therapy, in which such literature is lacking.

What was evident from the results of this study was that a strong therapeutic alliance is important in all therapy work, particularly in trauma-based treatment. I would argue that this may be even more important in BPD treatment. As discussed previously, the literature states that attachment issues may be prevalent in clients with BPD. Returning to the diagnostic criteria present in the DSM-V (American Psychiatric Association, 2013: 663), it is stated that clients with BPD may present with:

> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating [behaviour] covered in Criterion 5.)
>
> 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

I believe that this supports the need for a strong therapeutic alliance, not only to support the work of re-enactment, but as a healing component in and of itself. While the manner in which re-enactment occurs would largely unfold in the same way with a BPD client, I would therefore recommend that more focus be placed on the therapeutic relationship with these clients. As clients with BPD have a high therapeutic dropout rate (Yeomans et al., 1994), it may be important to spend a greater amount of time developing a secure therapeutic relationship prior to commencing re-enactment work.

In discussing the possible relevance of re-enactment work with BPD clients, the literature explains that clients with BPD experienced feelings of terror in their childhood and that BPD

consequently results from the "continuation of terror into adulthood" (Van der Kolk et al., 1994: 721). I would therefore argue that re-enactment work may hold value in addressing this feeling of terror. The literature explains that exposure within therapy assists clients in understanding that the danger that they assume to still be present as a result of past experiences, has often, in fact, passed. Re-enactment within drama therapy may therefore assist BPD clients in addressing this feeling of continued terror by reinstating a sense of felt and embodied safety in the present through experiencing that the danger may be over.

As discussed earlier, I maintain that re-enactment may potentially hold great value for many clients, but that specific therapy approaches may not resonate with every client. This remains true for clients with BPD; what works for one client may not work for another. However, after reviewing the literature and conceptualising re-enactment with BPD clients, I would propose that re-enactment may hold value with this population as, firstly, it may address past trauma which appears to be absent in other treatment approaches for this disorder, and secondly, through the exposure component, it may assist clients in regaining a sense of safety in the present as they learn that the past danger may be in fact that, in the past. When held within the context of a strong therapeutic alliance, this work may hold the potential to be a greatly healing experience for clients with BPD.

10.2 Additional Valuable Findings

The findings of this research yielded additional interesting results that had not been addressed in my research questions, but which I nonetheless believe are important to discuss as they pertain to the understanding of re-enactment. Some of these findings served to challenge the initial assumptions that I held prior to conducting this research, as will be discussed below.

10.2.1 Potential Target Population

This research intended to understand the use of re-enactment with adults with trauma histories, and particularly adults with BPD and trauma histories. While this research showed that re-enactment work within drama therapy could potentially be valuable for these populations, it additionally showed that trauma re-enactment work could similarly hold value in working with children. This was an unexpected finding of this research as it challenged my assumptions. I had thought that trauma re-enactment work may be unhelpfully evocative for younger clients, yet this assumption was challenged by the research which showed that trauma re-enactment work holds the potential to be highly valuable in assisting young children in processing traumatic experiences (Pitre, Sajnani & Read Johnson, 2015). This is supported by the literature that suggests that children naturally use re-enactment, or abreaction (Schaefer & Drewes, 2009: 6), to process traumatic experiences, as could be seen in the aftermath of 9/11 in which children could be witnessed "building towers with blocks and crashing toy airplanes into them" in their play.

This finding would suggest that not only could this work be valuable for children, but that it may also be valuable in processing more recent trauma, as is demonstrated by the work done with children engaging with their recent traumatic experiences. This work may therefore potentially be similarly valuable for both clients with trauma histories that occurred a long time ago, and also more recently.

10.2.2 The Use of Role

I had not anticipated the value and importance that role could play in supporting trauma re-enactment work. Through the TSIRA model (Toscani, 1998) the literature demonstrated how role could be used to assist and support a client in trauma re-enactments through allowing them

to draw on resources that may appear to be external, such as the archetypal mother or father, but can emanate similarly from internally. This assists clients in developing internal resources and coping skills that can aid in their healing journeys, not only inside the therapy space during re-enactments, but ultimately outside of the therapy space too. I believe that the use and function of role was therefore an important additional finding from this study.

10.2.3 Altering the Course of Events

An important finding of this research, captured in the theme of 'Rescripting Trauma', was that re-enactments may provide a redemptive opportunity for clients to regain their sense of power and control over the trauma by altering the course of the events during the re-enactment. For example, instead of experiencing the possible defeat that clients may have experienced during the actual trauma, an opportunity is now afforded to them to 'rewrite' their stories. I do not believe that the intention of this is to negate what happened to them and how this forms part of their life story, or to suggest that had they acted differently in the past they may not have experienced the trauma, but rather to allow them to take action in the present, restoring a sense of control. Clients are able to re-face the trauma, be it a perpetrator or otherwise, with the new resources that they possess, for example, by utilising roles of strength. An important finding from this study is therefore that trauma re-enactments may be more valuable when they serve to rescript trauma rather than to purely recreate the circumstances of the trauma.

10.3 Final Points of Discussion

10.3.1 The Balance Between Containing and Evoking

Coming into this research, I had thought that it would be important to emotionally contain a client during re-enactment. One of my initial research questions that has since been excluded was intending to understand the function and importance of containing mechanisms so as to

avoid triggering clients. After thorough discussions with my supervisor and reviewing the results, it is clear that while containing through mechanisms such as distancing or projective techniques can be important, one can also not discount the value of emotional arousal in therapy. De Witte et al. (2021), in fact, refer to emotional arousal as a therapeutic factor in experiential therapies such as drama therapy. In order for re-enactments to possibly facilitate the processes of abreaction and catharsis, it may in fact be necessary to evoke emotions in order for this emotions to subsequently be released or processed. This research has thus allowed me to reframe my thinking of emotionally evocative work as not necessarily re-traumatising, but possibly a helpful or even desirable aspect towards healing. The balancing act between containing and evoking of course cannot be prescriptive, and may differ between each clients and their needs.

11. Conclusion

At the close of this research, I am confident in making the following concluding remarks. Firstly, I conclude that re-enactment could be a useful in processing past trauma, including childhood trauma, in drama therapy. Drawing on compelling evidence and case examples, the literature points to the merits of using re-enactment within drama therapy as a means to desensitise clients to their past trauma through exposure. Secondly, re-enactment work could similarly be appropriate in assisting clients with BPD to process their past trauma. If, as the literature suggests, BPD could be partly caused by childhood trauma, this approach may be valuable in reinstating a sense of safety in the present while processing the past. Thirdly, this research has strongly pointed to the value of a strong therapeutic alliance to support re-enactment work. This alliance appears to be a particularly important factor in conceptualising this work with BPD clients.

Alongside the above statements, it remains important to state that re-enactment should be facilitated in a gentle and gradual manner. Re-enactment work should not be attempted before the therapist and the client together decide that the client may be ready to re-face their past trauma. A prescriptive timeline cannot be placed on this, but needs to be determined on a case-by-case basis. Gradual exposure may not be a linear journey, but may involve alternating between distanced and under-distanced work according to the clients' needs.

12. Implications for Future Research

It is my belief that further research should be carried out to practically explore the use of re-enactment in working with childhood trauma within the therapy space. Bringing human participants into this research may be important in order to understand how this approach may work on an embodied level with clients.

Additionally, there appeared to be a paucity in the literature in discussing the function or value of embodiment within re-enactment work. Noting the importance of working with the body to process trauma, as well as the fact that re-enactment largely occurs through the body, there is a need for further research to be conducted in order to deepen this understanding from the field and perspective of drama therapy.

13. Challenges and Limitations of Study

Conducting an integrative literature review in the time of the COVID-19 pandemic presented a challenge to the research. I found that much of the relevant literature that I identified when gathering sources existed in books rather than in journal articles. This was particularly true for drama therapy-related literature. My departmental and university libraries were either closed or difficult to access due to COVID-19 safety protocols, and I therefore found it difficult to access all of the information that I would have ideally preferred. However, I believe that a sufficient amount of literature was gathered to adequately address my research questions.

A limitation to this research, which could be argued to be a limitation for many literature-based studies, was that my research questions were not tested practically with research participants. While I believe that conducting a desktop review was important and necessary to upholding a high ethical standard in my work, it nonetheless remains a possible limitation. Working with participants may have afforded this research data that was more specific to the research questions. Additionally, this may have allowed me to foreground participants' voices more in my research. Most of the literature that I reviewed presented the participants' experiences through the voices of the therapist, rather than emphasising the participants' voices. While the therapist's voice and analysis is vitally important, I believe that a platform should also be given to the client's voices for a more accurate portrayal of the therapy experience.

Reference List

Allsopp, K., Read, J., Corcoran, R. & Kinderman, P. (2019). Heterogeneity in psychiatric diagnostic classification. *Psychiatry research*, *279*, pp.15-22.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*. 5th edition. Washington D.C.: American Psychiatric Publishing.

American Psychological Association. (2017). *What Is Exposure Therapy?* [Online]. Available: https://www.apa.org/ptsd-guideline/patients-and-families/exposure-therapy. [Accessed: January 2022].

American Psychological Association. (2020). *APA Dictionary of Psychology Abreaction*. [Online]. Available: https://dictionary.apa.org/abreaction. [Accessed: July 2021].

American Psychological Association. (n.d.). *Trauma*. [Online]. Available: https://www.apa.org/topics/trauma. [Accessed: August 2021].

Avalon Malibu. (2017). *Why Borderline Personality Disorder is Considered the Most "Difficult" to Treat*. [Online]. Available: https://www.avalonmalibu.com/blog/why-borderline-personality-disorder-is-considered-the-most-difficult-to-treat/. [Accessed: June 2021].

Barbato, L. (1945). Drama therapy. *Sociometry*, *8*(3/4), pp.158-160.

Bentall, R.P., de Sousa, P., Varese, F., Wickham, S., Sitko, K., Haarmans, M., & Read, J. (2014). From adversity to psychosis: pathways and mechanisms from specific adversities to specific symptoms. *Social psychiatry and psychiatric epidemiology*, 49(7), pp.1011-1022.

Bentall, R.P., Wickham, S., Shevlin, M., & Varese, F. (2012) Do Specific Early-Life Adversities Lead to Specific Symptoms of Psychosis? A Study from the 2007 The Adult Psychiatric Morbidity Survey. *Schizophrenia Bulletin*, 38(4), pp.734–740.

Bloomberg. (2021). *South African Unemployment Rate Rises to Highest In The World*. [Online]. Available: https://www.bloomberg.com/news/articles/2021-08-24/south-african-unemployment-rate-rises-to-highest-in-the-world. [Accessed: January 2022].

Boals, A. (2018). Trauma in the eye of the beholder: Objective and subjective definitions of trauma. *Journal of Psychotherapy Integration, 28*(1), 77–89.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), pp.77–101.

Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys*. Mahwah, N.J.: The Analytic Press.

Cooper, M.G., & Leeser, J.G. (2011). *Clinical social work practice an integrated approach*. 4th ed. Boston, MA: Allyn & Bacon.

Creswell, J.W. (2009). Research design: Qualitative, quantitative, and mixed methods approaches. 3rd edition. Los Angeles, London, New Delhi, Singapore: SAGE Publications.

Darwin, C. (1998). *The expression of the emotions in man and animals*. London, U.K.: Oxford University press, 1998).

De Witte, M., Orkibi, H., Zarate, R., Karkou, V., Sajnani, N., Malhotra, B., Ho, R.T.H., Kaimal, G., Baker, F.A. & Koch, S.C. (2021). From therapeutic factors to mechanisms of change in the creative arts therapies: A scoping review. *Frontiers in Psychology*, p.2525.

Dingfelder, S.F. (2004). *Treatment for the 'untreatable'*. [Online]. Available: https://www.apa.org/monitor/mar04/treatment. [Accessed: June 2021].

Duffy, B. (2014). *Facilitating Embodied Instruction: Classroom Teachers' Experiences with Drama-based Pedagogy*. PhD Dissertation, University of South Carolina.

Dunlop, I. (1977) *Edvard Munch*. London, U.K.: Thames and Hudson.

Erikson, E.H. (1963). Childhood and Society. New York, U.S.A.: W.W. Norton.

Etikan, I., Musa, S.A. & Alkassim, R.S. (2016). Comparison of convenience sampling and purposive sampling. *American journal of theoretical and applied statistics*, *5*(1), pp.1-4.

Farber, T. (2020). *Shocking stats on gender-based violence during lockdown revealed*. [Online]. Available: https://www.timeslive.co.za/news/south-africa/2020-09-01-shocking-stats-on-gender-based-violence-during-lockdown-revealed/. [Accessed: November 2021].

Foa, E. B. & Rothbaum, B. O. (1998). Treating the Trauma of Rape. New York, U.S.A.: Guilford Press.

Foa, E.B., Keane, T.M., Friedman, M.J. & Cohen, J.A. (eds.). (2010). Effective treatments for PTSD: practice guidelines from the International Society for Traumatic Stress Studies. New York, U.S.A.: Guilford Press.

Giacomucci S. (2021). *Essentials of Psychodrama Practice. In: Social Work, Sociometry, and Psychodrama. Psychodrama in Counselling, Coaching and Education*. Vol 1. Singapore: Springer.

Glass, J. (2006). Working Towards Aesthetic Distance. In: Carey, L. (ed). *Expressive and creative arts methods for trauma survivors*. London: Jessica Kingsley Publishers.

Gunderson, J.G., Shea, M.T., Skodol, A.E., McGlashan, T.H., Morey, L.C., Stout, R.L., Zanarini, M.C., Grilo, C.M., Oldham, J.M. & Keller, M.B. (2000). The Collaborative Longitudinal Personality Disorders Study: development, aims, design, and sample characteristics. *Journal of personality disorders*, 14(4), pp.300-315.

Gupta, S. (2021). *What Is Experiential Therapy*? [Online]. Available: https://www.verywellmind.com/experiential-therapy-definition-techniques-and-efficacy-5198815 [Accessed: February 2022].

Gupta, S. (2021). *What Is Exposure Therapy?* [Online]. Available: https://www.verywellmind.com/exposure-therapy-definition-techniques-and-efficacy-5190514. [Accessed: January 2022].

Haen, C. (2007). Fear to tread: play and drama therapy in the treatment of boys who have been sexually abused. In: Brooke, S.L. (ed.) *The use of the creative therapies with sexual abuse survivors*. Illinois: Charles C Thomas Publisher.

Handcock, M.S. & Gile, K.J. (2011). Comment: On the concept of snowball sampling. *Sociological Methodology*, 41(1), pp.367-371.

Hartfield, K. (2019). *A Brief Introduction to Jungian Sandplay Therapy*. [Online]. Available: https://cgjungsarasota.org/2019/11/a-brief-introduction-to-jungian-sandplay-therapy/. [Accessed: July 2021].

Herman, J.L., Perry, J.C. & Van der Kolk, B.A. (1989). Childhood trauma in borderline personality disorder. *The American journal of psychiatry*. 146(4), pp.490-5.

Hoosain, S. (2018). Decolonising social work research with families experiencing intergenerational trauma. *Southern African Journal of Social Work and Social Development*, 30(1), pp.1-18.

Irwin, E.C. (1977). Play, fantasy, and symbols: Drama with emotionally disturbed children. *American Journal of Psychotherapy*, *31*(3), pp.426-436.

James, M. & Read Johnson, D. (1997). Drama therapy in the treatment of combat-related post-traumatic stress disorder. The Arts in Psychotherapy, 23(5), pp.383-395.

Jencius, M. & Duba, J.D. (2003). Searching for the Ideal Parents: An Interview With Al Pesso and Diane Boyden. *The Family Journal*, 11(1), pp.89-97.

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

Kaminer, D. & Eagle, G. (2010). *Traumatic Stress in South Africa*. Johannesburg, S.A.: Wits University Press.

Kellermann, P.F. (1994). Role reversal in psychodrama. *Psychodrama since Moreno: Innovations in theory and practice*, pp.263-279.

Kiger, M.E. & Varpio, L. (2020). Thematic analysis of qualitative data: AMEE Guide No. 131. *Medical teacher*, 42(8), pp.846-854.

Kipper, D.A. & Ritchie, T.D. (2003). The effectiveness of psychodramatic techniques: A meta-analysis. *Group Dynamics: Theory, Research, and Practice*, *7*(1), p.13.

Kolaitis, G. & Olff, M. (2017). Psychotraumatology in Greece. *European Journal of Psychotraumatology*, 8:sup4, 135175.

Lancaster, L., Gould, C., Vetten, L. & Sigsworth, R. (2015). *FACTSHEET: South Africa's 2014/15 assault and sexual crime statistics*. [Online]. Available: https://africacheck.org/factsheets/factsheet-south-africas-201415-assault-and-sexual-crime-statistics/. [Accessed: January 2022].

Landy, R.J. (1994). *Drama therapy: Concepts, theories and practices*. Illinois: Charles C Thomas Publisher.

Landy, R.J., (1991). Role as the primary bridge between theatre and drama therapy. *Dramatherapy*, 13(2), pp.4-11.

Langhoff, C., Baer, T., Zubraegel, D. & Linden, M. (2008). Therapist–patient alliance, patient–therapist alliance, mutual therapeutic alliance, therapist–patient concordance, and outcome of CBT in GAD. *Journal of Cognitive Psychotherapy*, 22(1), pp.68-79.

Marcow Speiser, V. & Speiser, P. (2021). The heart of the matter: Arts-based reflections, writings and responses during COVID-19. *Journal of Applied Arts & Health*, *12*(3), pp.305-317.

Maromo, J. (2019). *Black citizens bear brunt of unemployment, inequality in SA – StatsSA*. [Online]. Available: https://www.iol.co.za/news/south-africa/black-citizens-bear-brunt-of-unemployment-inequality-in-sa-statssa-37212798. [Accessed: January 2022].

Maté, G. (2021). *Discovering the Wisdom of Trauma*. [Online]. Available: https://drgabormate.com/event/discovering-the-wisdom-of-trauma/. [Accessed: November 2021].

Merriam-Webster. (2021). *Definition of trauma*. [Online]. Available: https://www.merriam-webster.com/dictionary/trauma. [Accessed: August 2021].

Minisini, V. (2021). South Africa's Secondary Pandemic: A Crisis of Gender Based Violence. [Online]. Available: https://globalriskinsights.com/2021/03/south-africas-secondary-pandemic-a-crisis-of-gender-based-violence/. [Accessed: November 2021].

Moodley, K. & Kling, S. (2015). Dual loyalties, human rights violations, and physician complicity in apartheid South Africa. *AMA journal of ethics*, 17(10), pp. 966-972.

Morris, N. (2018). *Dramatherapy for borderline personality disorder*. New York: Routledge.

National Collaborating Centre for Mental Health (UK). (2009). *Borderline Personality Disorder: Treatment and Management.* British Psychological Society.

National Health Service (NHS). (2019). *Causes - Borderline personality disorder*. [Online]. Available: https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/causes/. [Accessed: July 2021].

National Health Service. (2019). *Treatment – Borderline Personality Disorder*. [Online]. Available: https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/treatment/. [Accessed: July 2021].

Ogden, P. (2009). *Modulation, mindfulness, and movement in the treatment of trauma-related depression*. [Online]. Available: http://www.bemindful.org/articles/ogdenart.pdf. [Accessed: January 2022].

Padgett, D.K. (2017). Choosing the right qualitative approach(es). *Qualitative methods in social work research*, pp.31-56.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2013). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method

Implementation Research. *Administration Policy in Mental Health and Mental Health Services*, 42(5), 533-544.

Palmier-Claus, J., Berry, K., Bucci, S., Mansell, W., & Varese, F. (2016). Relationship between childhood adversity and bipolar affective disorder: Systematic review and meta-analysis. *British Journal of Psychiatry*, *209*(6), 454-459.

Pesso Boyden Training UK. (2021). *Pesso Boyden System of Psychotherapy: A 10 minute Introduction*. [Video file]. Available: https://www.youtube.com/watch?v=mVEziCmX8QU. [Accessed: January 2022].

Pitre, R., Sajnani, N. & Read Johnson, D. (2015). Trauma-centered developmental transformations as exposure treatment for young children. *Drama Therapy Review*, *1*(1), pp.41-55.

Porges, S.W. (2009). The polyvagal theory: new insights into adaptive reactions of the autonomic nervous system. *Cleveland Clinic journal of medicine*, *76*(Suppl 2), p.S86.

Ramafoko, L. (2020). *Gender-Based Violence*. [Online]. Available: https://mg.co.za/special-reports/2020-12-04-gender-based-violence/. [Accessed: November 2021].

Rodriguez, T. (2016). *Therapists' Fear of Borderline Personality Disorder Persists*. [Online]. Available: https://www.psychiatryadvisor.com/home/topics/personality-disorders/therapists-fear-of-borderline-personality-disorder-persists/. [Accessed: June 2021].

Rubin, D. C., Boals, A., & Berntsen, D. (2008). Memory in posttraumatic stress disorder: Properties of voluntary and involuntary, traumatic and nontraumatic autobiographical memories in people with and without posttraumatic stress disorder symptoms. *Journal of Experimental Psychology*: General, 137, pp. 591–614.

saferspaces. (2022). *Gender-based violence in South Africa*. [Online]. Available: https://www.saferspaces.org.za/understand/entry/gender-based-violence-in-south-africa. [Accessed: January 2022].

Safran, J.D., Muran, J.C. & Rothman, M. (2006). The therapeutic alliance: Cultivating and negotiating the therapeutic relationship. In *Clinical strategies for becoming a master psychotherapist* (pp. 37-54). Academic Press.

Sajnani, N. & Read Johnson, D. (2014). *Trauma-Informed Drama Therapy*. Illinois: Charles C. Thomas Publisher Ltd.

Salters-Pedneault, K. (2020). *Borderline Personality Disorder Treatment*. [Online]. Available: https://www.verywellmind.com/borderline-personality-disorder-treatment-425451. [Accessed: July 2021].

Salters-Pedneault, K. (2020). *The Relationship Between Child Abuse and BPD*. [Online]. Available: https://www.verywellmind.com/the-relationship-between-child-abuse-and-bpd-425153. [Accessed: June 2021].

Schaefer, C. E., & Drewes, A. A. (2009). The therapeutic powers of play and play therapy. In A. A. Drewes (Ed.), *Blending play therapy with cognitive behavioral therapy: Evidence-based and other effective treatments and techniques* (pp. 3–15). U.S.A.: John Wiley & Sons, Inc.

Schaefer, C.E. (1999). Curative factors in play therapy. *The Journal for the Professional Counselor*, 14, 1, 7–16.

Schermer, V.L. (2004). Group interventions for treatment of psychological trauma-module 9: Identification and management of masked trauma reactions in groups. New York, NY: American Group Psychotherapy Association.

Schimelpfening, N. (2020). *How Abreaction Relates to Dissociation and Trauma*. [Online]. Available: https://www.verywellmind.com/understanding-abreaction-1065382. [Accessed: July 2021].

Siegal, E. (1984). *Dance Movement Therapy: Mirror of Ourselves*. New York, U.S.A.: Human Sciences Press.

Smit, S. (2021). *Covid kills a decade of employment growth in SA*. [Online]. Available: https://mg.co.za/business/2021-05-08-covid-kills-a-decade-of-employment-growth-in-sa/. [Accessed: January 2022].

stats sa. (2021). *Quarterly Labour Force Survey (QLFS) – Q3:2021*. [Online]. Available: http://www.statssa.gov.za/?p=14957. [Accessed: January 2022].

Stupiggia, M. (2019). Traumatic Dis-Embodiment: Effects of trauma on body perception and body image. In *The Routledge International Handbook of Embodied Perspectives in Psychotherapy* (pp. 389-396). Oxfordshire, U.K.: Routledge.

Svrakic, D.M., Draganic, S., Hill, K., Bayon, C., Przybeck, T.R. & Cloninger, C.R. (2002). Temperament, character, and personality disorders: etiologic, diagnostic, treatment issues. *Acta Psychiatrica Scandinavica*, *106*(3), pp.189-195.

Tantia, J.F. (2019). Toward a somatically-informed paradigm in embodied research. *Inter national Body Psychotherapy Journal: The Art and Science of Somatic Praxis*, *18*(2), pp.134-145.

The University of Manchester. (2019). *Borderline Personality Disorder has strongest link to childhood trauma*. [Online]. Available:

https://www.manchester.ac.uk/discover/news/borderline-personality-disorder-has-strongest-link-to-childhood-trauma/. [Accessed: June 2021].

The Wisdom of Trauma [film]. (2021). U.S.A.: Science and Nonduality.

Thobejane, T.D. (2013). History of apartheid education and the problems of reconstruction in South Africa. *Sociology Study*, 3(1), pp.1-12.

Torraco, R. J. (2005). Writing Integrative Literature Reviews: Guidelines and Examples. *Human Resource Development Review*, 4(3), pp.356–367.

Toscani, F. (1998). Sandrama: Psychodramatic sandtray with a trauma survivor. *The Arts in psychotherapy*, 25(1), pp.21-29.

Tull, M. (2020). *How Exposure Therapy Can Treat PTSD*. [Online]. Available: https://www.verywellmind.com/exposure-therapy-for-ptsd-2797654. [Accessed: July 2020].

Van der Kolk, B. (1994). The body keeps the score: memory and the evolving psychobiology of posttraumatic stress. *Harv Rev Psychiatry*, 1(5):253-65.

Van der Kolk, B. (2014). *The Body Keep the Score: Brain, Mind and Body in the Healing of Trauma.* New York, U.S.A.: Penguin.

Van der Kolk, B.A., Hostetler, A., Herron, N. & Fisler, R.E. (1994). Trauma and the development of borderline personality disorder. *Psychiatric Clinics of North America*, *17*(4), pp.715-730.

Van der Kolk, B.A., McFarlane, A.C. & Weisaeth, L. (eds.). (2012). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York, U.S.A.: Guilford Press.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, R., Van Os, J., & Bentall, R.P. (2012) Childhood Adversities Increase the Risk of Psychosis: A Meta-analysis of Patient-Control, Prospective- and Cross-sectional Cohort Studies, *Schizophrenia Bulletin*, 38(4) pp.661–671.

Waelder, R. (1933). The psychoanalytic theory of play. *The Psychoanalytic Quarterly*, 2(2), pp.208-224.

Wilkinson, K. (2016). *GUIDE: Rape statistics in South Africa.* [Online]. Available: https://africacheck.org/factsheets/guide-rape-statistics-in-south-africa/. [Accessed: January 2022].

World Bank. (2021). *Unemployment, total (% of total labor force) (modeled ILO estimate)*. [Online]. Available: https://data.worldbank.org/indicator/SL.UEM.TOTL.ZS?locations=ZA-1W&most_recent_value_desc=true. [Accessed: January 2022].

Yalom, I.D. (1985). The Theory and Practice of Group Psychotherapy. 3rd edition. New York, U.S.A.: Basic

Yalom, I.D. (1989). *Love's executioner and other tales of psychotherapy*. New York: BasicBooks.

Yeomans, F.E., Gutfreund, J., Selzer, M.A., Clarkin, J.F., Hull, J.W. & Smith, T.E. (1994). Factors related to drop-outs by borderline patients: Treatment contract and therapeutic alliance. *The Journal of psychotherapy practice and research*, 3(1), p.16.