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Embodied Creative Arts Therapy Interventions with Trauma: A Qualitative Study

Brian Timothy Harris
Lesley University

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Brian T. Harris

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS

ADHD............Attention Deficit Hyperactivity Disorder

AMT...............Analytical Music Therapy

APA ....American Psychiatric Association

CBT................Cognitive Behavioral Therapy

C-PTSD..........Complex Post Traumatic Stress Disorder

DID ....Dissociative Identity Disorder

DSM...............Diagnostic and Statistical Manual of Mental Disorders

DVT ....Developmental Transformations

GIM................Guided Imagery in Music

MT..................Music Therapy

ND..................Normative Dissociation

PD ....Pathological Dissociation

PTSD..............Post Traumatic Stress Disorder

SE...................Somatic Experiencing

SP ....Sensorimotor Psychotherapy

ABSTRACT

With the primary purpose to extend therapists' knowledge base, open dialogue on treatment efficacy, and stimulate creative yet effective interventions, this two-phase qualitative study pursued the guiding research question, *How do creative arts therapists use embodied interventions in the treatment of psychological trauma?* Phase One of the study was conducted with music therapists who had extensive experience with trauma and reported on their experiences with and awareness of embodied trauma treatment through a broad spectrum of creative modalities. Phase Two was grounded in theories of body awareness and creative arts therapy applications and included therapists specializing in music, dance/movement, art, drama, or expressive therapies modalities. This dissertation focuses on a presentation of the data analyzed during the study's second phase. Seven creative arts therapists participated in Phase Two of the study. Participation entailed semi-structured, 45- to 60-minute interviews. Thematic qualitative data analysis revealed seven themes and nine subthemes, which are examined under the categories of factors in facilitation and interventions. Factors in facilitation include (1) a client-centered approach, (2) safety, (3) sociocultural factors, and (4) therapist resources. The themes categorized as interventions are (5) somatic awareness and interventions, (6) relational enactments, and (7) creative interventions. Themes of safety, sociocultural factors, and a client-centered approach pointed to participant support of a flexible, individualized approach to trauma work based on clients' specific needs. Participants noted the need for sufficient therapist resources when treating trauma, which led to subthemes of clinical supervision, personal therapy, and individual creative exploration. Participant awareness of clients' bodies as well as somatic countertransference led to somatic interventions. Participants also examined enactments

inside the therapeutic relationship and included multiple forms of creativity in the treatment

process. Outcomes may contribute to future research into multi-modal creative therapeutic

treatment, client-centered approaches, and embodied trauma interventions.

CHAPTER 1

Introduction

This qualitative research study examines the topic of embodied interventions for psychological trauma used in creative arts therapies. The study was conducted in two phases. Phase One of the study was conducted with music therapists who had extensive experience with trauma and reported on their experiences with and awareness of embodied trauma treatment through a broad spectrum of creative modalities. Phase Two aimed to expand the knowledge base of how creative arts therapists work with the body in relation to trauma. In doing so, the research aimed to fill research gaps in the literature and help build dialogue regarding trauma treatment across the different creative arts therapies specializations. Exploring various trauma treatment options can open dialogue on treatment efficacy and stimulate creative yet effective interventions. The guiding research question of the second phase of the study was, *How do creative arts therapists use embodied interventions in the treatment of psychological trauma?*

Psychological trauma can result from emotional, physical, or sexual abuse, natural disasters (e.g., hurricanes or earthquakes), armed conflict, or witnessing violent acts. Individuals who encounter these experiences can develop symptoms such as hyperarousal, depression, and dissociation that can lead to a diagnosis of posttraumatic stress disorder (PTSD). To illustrate, a survey conducted among U.S. military service members offered insight into war-based trauma and PTSD rates. The survey showed service members' reported experiences of PTSD symptoms increased by over 50% between 2005 and 2008 alone (Robbins, 2009), coinciding with increased deployments to combat zones.

Additionally, in 2012, the number of U.S. military suicides surpassed the number of combat deaths in Afghanistan. Suicide was at a record high, suggesting that the severity of the experience of trauma may have also increased (Chappell, 2013). The statistics for U.S. service members are consistent with PTSD and suicide rates in other countries, such as the United Kingdom ("UK soldier and veteran suicides," 2013). Although these statistics represent solely military traumas, the increase in trauma symptoms highlights the need for effective therapeutic treatments across populations and demographics. Thus, an exploration of various trauma treatments in use can serve to open dialogue on treatment efficacy and stimulate creative yet effective interventions.

Current trends in psychotherapeutic trauma treatment favor approaches such as cognitive behavioral therapy (CBT; Dalgleish et al., 2015) focused on changing patients' thinking or behavior patterns with the goal of changing the way they feel. However, some researchers have theorized that such cognitive and verbal-based therapy treatments may be ill equipped to address the complexity of mind and body symptoms associated with trauma (e.g., Bryant, 2010; Koch & Weidinger-von der Recke, 2009; van der Kolk, 2014). These theorists suggested techniques that focus on creating awareness of the body may be better equipped to treat trauma through an integrative look at the intricacies of symptom manifestation. However, there is currently a lack of adequate research to support these theories.

Psychological trauma may contribute to a variety of accompanying physiological symptoms including dissociation, somatization, and eating disorders (American Psychiatric Association, 2013). In the last ten to fifteen years, theorists began to focus on body

awareness in relation to PTSD and the trauma experience (P. A. Levine, 2010a; Ogden, Pain, Minton, & Fisher, 2005; Rothschild, 2000).

The concept of embodiment in psychotherapy traces to Willhelm Reich's early theories incorporating physical contact into traditional psychoanalysis (Boadella, 1997). Reich and Boadella proposed that the complex nature of trauma often manifests both cognitively and physiologically. Specifically, the human body *embodies*, or holds a memory of the trauma, and expresses it in body language, posture, and physical symptoms. Further, these trauma memories often disconnect from the brain's speech center and limit patient's ability to express the trauma verbally (van der Kolk, 2014). Therefore, theorists proposed that trauma is best treated by *somatic* or *embodied* approaches that seek to work with the relationship between the mind and the body. This understanding of trauma manifestation, or *body awareness*, leads to questions of how best to provide embodied treatment.

The term *embodiment* is commonly used in the modern practices of body psychotherapy and dance/movement therapy (e.g., Heller, 2012; Meekums, 2006). Appel-Opper (2010) described embodied interventions in this way: "In their ongoing nonverbal communication, therapist and client co-create an embodied field in which both relate with and refer to one another….Such resonances can be developed into embodied interventions" (p. 49). For purposes of this study, an *embodied trauma intervention* is defined as any clinical intervention that seeks to increase a client's awareness of the body (e.g., breath, posture, tension, movement, and sensation) as it may relate to psychological trauma.

Theorists have also explored the application of creative arts therapies in work with trauma (Malchiodi, 2008; Sutton, 2002; Talwar, 2007). In North America, *creative arts therapy* is defined as the use of "art, music, dance/movement, drama, and poetry/creative

writing, within the context of psychotherapy, counseling, rehabilitation, or health care" (Malchiodi, 2008, p. 2). The parameters of creative arts therapy can vary geographically. Further, each therapy field has specific and unique training and practice requirements. Because of these varying requirements, many publications on arts therapies and trauma are specific to only one art.

Nevertheless, preliminary research is promising in the area of creative arts therapies and trauma. Studies have indicated that music therapy, dance/movement therapy, and drama therapy may be effective in trauma treatment (Bensimon, Amir, & Wolf, 2008; Carr et al., 2011; Mackay, Gold, & Gold, 1987; Meekums, 1999). Unfortunately, many emerging quantitative studies included only small samples and lacked control groups. There have been few qualitative studies (e.g., Austin, 2004; Meekums, 1999), making it difficult to build solid theories. In addition, meta-analytic studies that could combine small-sample studies to increase generalizability are lacking.

Creative arts therapies are uniquely positioned to provide embodied treatment in part due to their focus on body-oriented elements such as music-creation, movement, art-making, and enacting (Koch & Fuchs, 2011). Creative arts therapies that use embodied trauma interventions may offer means to increase mind-body awareness and provide more thorough and effective means to access the trauma that traditional CBT or purely verbal therapies do not. With the aim of improving such theories, the qualitative research in this dissertation examined how creative arts therapists specializing in the modalities of music, dance/movement, art, drama, or expressive therapies use trauma interventions via their own reporting. The current study was conducted in two phases. Phase One sought to understand how music therapists used embodied practices in trauma work. In the first phase, three music

therapists, selected based on their experience working with clients with trauma histories, were interviewed in person for approximately one hour. Analysis of the transcribed and coded data revealed six themes and 11 subthemes. The first theme of the initial study phase showed that, regardless of duration in the field, participants continued to seek out ongoing opportunities to learn and grow as professionals through supervision, mentorship, and learning from their own experiences.

The second theme revealed that all participants had theoretical and training influences of analytic or psychodynamic philosophies in their approach to trauma work. In the third theme, the data revealed several creative interventions such as music and imagery were used in trauma treatment. Body awareness was the fourth theme, outlining that participants felt that trauma manifests in the body and therefore should be treated in the body. This theme also showed participants' beliefs that therapists should strive to have awareness of their own bodies in relation to clinical work with trauma. The fifth theme related to the importance of helping clients find appropriate resources, such as understanding the breath, "rewriting" old patterns, and "filling in" the metaphoric void left behind by ridding the psyche of negative material. In the final theme, participants discussed how their personal histories related to work with trauma and the recovery process.

Several themes from the first phase of this study, conducted with music therapists, may be present for other creative arts therapists as well. For example, the use of imagery was prominent in participant discussion of creative interventions. Art therapists such as Adduci (2008) have explored the usefulness of art-making as a resource in treating trauma. The first phase also highlighted the importance of body awareness. Researchers have examined the use of creative arts therapies in the treatment of body-based symptoms of

trauma including hypervigilance, somatization, and dissociation (Chapman, Morabito, Ladakakos, Schreier, & Knudson, 2001; Fagen & Wool, 1999; Gleadhill & Ferris, 2010; Volkman, 1993). Awareness of the body and client safety in relation to trauma has been discussed within the dance/movement therapy profession as well (Gray, 2001; Meekums, 1999; Mills & Daniluk, 2002). One study participant identified the concept of "re-writing" a traumatic experience through music-making and imagery. This mirrored the way narrative therapists have discussed the benefits of re-writing in a literal sense (e.g., Dimaggio, Salvatore, Azzara, & Catania, 2003) where clients are encouraged to retell their stories in written form. Participants in the first phase of the study were asked to speak about embodied *music therapy* for trauma treatment. However, the results revealed participants found links to embodied trauma treatment using additional creative modalities such as movement, imagery, and dramatic enactment. That is, initial inquiry in Phase One revealed these music therapists were using multiple creative arts therapy modalities in the embodied treatment of trauma. This raised questions regarding the possibility that other creative arts therapists may be using embodied interventions.

This dissertation focuses on a presentation of the data analyzed during Phase Two of the study. This phase was designed as a qualitative inquiry into the use of creative arts therapies as embodied psychotherapy treatment for trauma. The primary purpose of the second phase of the study was to understand better how creative arts therapists work with the body in relation to trauma. To address the question of how creative arts therapists use embodied interventions in the treatment of trauma, Phase Two compared and contrasted varying creative arts therapy approaches to embodied trauma treatment to help build dialogue across the different creative arts therapies regarding trauma treatment.

CHAPTER 2

Literature Review

This chapter provides a discussion of previous research pertaining to creative arts therapy and embodied approaches to trauma. The following aspects of trauma treatment are reviewed: (a) trauma terminology, (b) traditional trauma interventions, (c) the embodied nature of trauma, (d) embodied psychotherapy theories and research in trauma care, and (e) embodied creative arts therapy approaches. In addition, study designs, findings, and interventions are reviewed and critically examined.

Trauma Terminology

Due to the complex nature of trauma, a number of diagnoses exist under the umbrella term *trauma*.

Psychological trauma. Trauma-based diagnoses such as PTSD and dissociative identity disorder (DID) have a high risk of comorbidity and have been found to be associated with depression or anxiety (Campbell et al., 2007), eating disorders (Mitchell, Mazzeo, Schlesinger, Brewerton, & Smith, 2012), attention deficit hyperactivity disorder (ADHD; Harrington et al., 2012), substance abuse (Najavits & Walsh, 2012), and suicidal ideation (Calabrese et al., 2011). The following discussion examines several trauma-based diagnostic terms and related research.

PTSD. The American Psychiatric Association (APA) first included PTSD as a diagnosis in 1980, as part of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III)* (American Psychiatric Association, 1980; Breslau, 2009). The *Diagnostic and*

Statistical Manual of Mental Disorders (American Psychiatric Association, 2013, pp. 271-

273) uses the eight criteria identified in Table 1 to determine PTSD.

Table 1. *Diagnosis Criteria for PTSD according to APA*

	Criteria
1	Exposure to actual or threatened death, serious injury, or sexual violence
2	Presence of intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred
3	Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred
4	Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred
5	Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred
6	Duration of the disturbance is more than one month
7	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
8	The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition

A multidisciplinary organization known as the "PTSD Alliance" estimates that 8% of

adults living in the United States will develop PTSD during their lifetimes. Women are

nearly twice as likely as are men to develop PTSD (Post Traumatic Stress Disorder Fact

Sheet, n.d.). Although PTSD is the most common trauma-based diagnosis, there is

disagreement over whether the diagnosis is a sufficient umbrella term for the symptoms.

Complex PTSD. Some researchers and clinicians felt that the diagnosis of PTSD still does not accurately describe the experience of prolonged trauma over time or multiple forms of trauma exposures (e.g., Cloitre et al., 2011; Courtois, & Ford, 2009). Psychiatrist Judith Herman (1992) labeled such expanded phenomenon *complex PTSD* or *C-PTSD*. Whereas PTSD historically focused on single-event trauma, the term C-PTSD makes inclusions for multiple-event trauma and aspects of dissociation often correlated with PTSD. For example, instances of trauma such as physical and sexual abuse in childhood create a broader spectrum of issues related to developmental trauma. Proponents of the C-PTSD diagnosis stressed that it allows a fuller picture of the experience of trauma by including symptoms that often fall under other diagnoses, such as somatoform, dissociative, substance abuse, eating, mood, and borderline personality disorders (van der Kolk, 1996). Despite efforts to include aspects of developmental trauma and recurring traumas under the PTSD diagnosis in the *DSM-5* (American Psychiatric Association, 2013), some of the above concerns remained unaddressed.

Dissociation. According to the *DSM-5*, dissociation is characterized by a disruption in integrated functions of memory, consciousness, identity, or perception of the environment (American Psychiatric Association, 2013). Theorists have also included disruptions in somatosensory functions in their descriptions of dissociation (Nijenhuis, Spinhoven, Van Dyck, van der Hart, & Vanderlinden, 1996). As reported by van der Hart and Horst (1989), French psychologist Pierre Janet popularized the concept of dissociation in relation to psychological stress in 1887. Janet labeled the condition "posttraumatic hysteria" (p. 399) and noted that dissociation occurred in instances of high stress. Freud (1896/1994) also discussed the notion of hysteria, initially using a sampling of 18 patients to link childhood

sexual abuse to adult manifestations of mental illness. However, he reversed his theories on these links shortly thereafter, when he developed his seduction theory that suggested his patients did not experience memories, but rather imagined fantasies (Masson, 1985). Freud's problematic reinterpretation, which may have occurred due to cultural norms and pressure from his professional peers of the time, can shed light on the complicated politics of memory, trauma, and dissociation that persist today. After Janet's and Freud's initial discussions, few scholars referred to dissociation in the trauma literature until the late 1970s (e.g., Hilgard, 1977). However, Janet's early description provided a precursor to modern understanding of the relationship between dissociation and PTSD.

The impact of dissociation ranges from benign dissociation, such as daydreaming and "absent-mindedness," to severe dissociative experiences such as DID. Steinberg and Schnall (2001) characterized DID by five symptoms: amnesia or memory problems involving difficulty recalling personal information; depersonalization or a sense of detachment or disconnection from one's self; derealization or a sense of disconnection from familiar people or one's surroundings; identity confusion or inner struggle about one's sense of self/identity; and identity alteration or a sense of acting like a different person.

Studies have found dissociation to correlate highly with PTSD. Carlson, Dalenberg, and McDade-Montez (2012) conducted a meta-analytic study reviewing 25 years of research (1986 to 2011) on the relationship between traumatic stress and dissociation. They found evidence that indicated a relationship among dissociation, traumatic stress, and PTSD. Their study included the following five findings: dissociation is moderately related to trauma exposure and severity; dissociation symptoms rise sharply immediately after trauma exposure, then gradually decline for most but stay severe for some; dissociation is clearly,

consistently, and very strongly related to the presence and severity of DSM–IV PTSD symptoms; the presence of high dissociation raises the probability of the presence and high levels of PTSD symptoms; and dissociative symptoms relate as strongly to the three PTSD symptom clusters as they do to one another (p. 486). Their study demonstrated the importance of including dissociation in the discussion and research of PTSD and other trauma diagnoses.

Further inquiry into dissociation examined aspects of dissociation and C-PTSD in participants ($N = 65$) receiving treatment for conflict-related trauma (Dorahy et al., 2013). Researchers found that participants with clinical levels of dissociation ($n = 27$) also showed significantly more severe symptoms of C-PTSD, as well as shame, guilt, and withdrawal, when compared with participants with subclinical dissociation levels ($n = 38$). Additionally, the study found that C-PTSD had an impact on the patient's ability to sustain intimate relationships. Although the sample size was small and homogenous (all in Northern Ireland), the findings supported the theories of Herman (1992), who made a case for a broader understanding of symptoms such as guilt, shame, and impaired intimacy in relation to trauma.

Whereas dissociation is often described as a negative side effect of trauma, several studies examined the complexities of altered states of consciousness in relation to movement (Becker-Blease, 2004; Thomson & Jaque, 2012). Thomson and Jaque studied dissociation and flow in 74 dancers. They broke down altered states into three categories: normative dissociation (ND), pathological dissociation (PD), and flow. Examples of ND include daydreaming, night dreaming, fantasy, and absorption in tasks at hand (Butler, 2006). Similarly, PD is exemplified in diagnoses such as PTSD (American Psychiatric Association,

2013), whereas *flow*, a concept originated by Csikszentmihályi (1990), is defined as a state of optimal focus on a given task. Flow involves spontaneous experiences of joy and a lack of depressive or anxious feelings. The outcomes of Thomson and Jaque's (2012) quantitative study indicated that pathological dissociation may negatively affect the experience of flow. This study also included a small sample size and lacked a control group, and a key limitation was that its findings have not yet been replicated in other settings. Additionally, the study did not clearly demonstrate the differences between ND and flow. On the other hand, the study outcomes led to the question of whether positive altered states such as flow may have a relationship with the absence of clinical dissociation. An expansion of this study could explore whether the presence of flow, often found in artistic endeavors, can prevent or inhibit instances of pathological dissociation. As concepts related to flow are incorporated into theories on clinical music improvisation (Forinash, 1992) as well as Laban movement analysis (Stone, 2006), further exploration could have direct implications for creative arts therapists.

Transference and Countertransference. Sigmund Freud used the term *transference* to describe the way patients transfer feelings and assumptions onto their therapist, and psychoanalysis specifically encourages transference as a way for both patient and therapist to observe the patients' formative dynamics.

Early definitions of *countertransference* highlighted how therapists can transfer their own feelings and assumptions to the patient. Although Freud believed countertransference could interfere with therapy, other theorists believed it could be useful in exploring the patient's unconscious and embodied messages and provocations.

Countertransference theories have shifted over time. More recent theories stated that countertransference builds on the therapist's unconscious reactions to the client's material (Racker, 1968/2012). Pearlman and Saakvitne (1995) outlined how a therapist can move this awareness into consciousness in a way that benefits the therapeutic process. They stated, "Therapists' awareness of attunement to these [countertransference] processes will inform their therapeutic interventions, enrich their work, and protect themselves and their clients" (p. ii).

Countertransference experienced in or related to the body may be defined as *somatic countertransference*. The extant research into somatic countertransference explored how it may manifest for therapists working with trauma. For example, Egan and Carr (2008) studied somatic countertransference experiences in female trauma therapists ($N = 58$) working for the National Counseling Service in Ireland. The researchers found over 70% of participants experienced five items of somatic countertransference: sleepiness, muscle tension, unexpected shift in body, yawning, and tearfulness. In addition, the authors noted an inverse relationship to the amount of somatic countertransference experienced by the clinician and the frequency with which the clinician received clinical supervision. This, they suggested, may demonstrate that supervision buffers the experience of empathetic physical responses to clients.

Traditional Trauma Interventions

CBT. Review of the literature showed CBT to be one of the most researched methods for trauma treatment (e.g., Cohen, Mannarino, Perel, & Staron, 2007; Dorrepaal, Thomaes, Smit, & van Balkom, 2010; Frank et al., 1988; Muesser et al., 2008). One reason for this may be the degree to which CBT-based methodologies can be easily replicated. The

U.S. Department of Veterans Affairs stated that CBT "is the most effective treatment for PTSD" (National Center for PTSD, 2011). However, not all researchers and theorists found CBT treatment sufficiently effective in treating trauma. Bryant (2010) addressed limitations with CBT-based treatments, stating, "A cautionary note about the general applicability of CBT has been that it may not adequately address the nature and breadth of psychological difficulties experienced by patients with more emotionally complex PTSD" (p. 879). Bryant presented a case to include emotional regulation techniques in traditional CBT treatment. Koch and Weidinger-von der Recke (2009) noted, "Many [trauma] symptoms have strong somatic features and for this reason nonverbal therapies are an important complement to traditional verbal therapies" (p. 295). These theories indicate that traditional verbal therapeutic approaches such as CBT have not addressed the complete trauma picture. They also support the need for further research into creative and somatic or embodied techniques that may be better positioned to address the complexities of trauma.

Integrating CBT with creative methods. Some researchers began to focus on the inclusion of more creative methods with CBT practices. For example, Rademaker, Vermetten, and Kleber (2009) performed a retrospective evaluation of a "multimodal, exposure-based group treatment program for PTSD and associated symptoms" (p. 482) in peacekeeping veterans ($N = 22$). One noteworthy aspect of this study is the breadth of treatment forms included in a military program. Specifically, the treatment took place one day each week for approximately 21 weeks and consisted of exposure-based CBT, psycho-education, creative arts therapy, psychomotor therapy, socio-therapy, and case management. The researchers used four assessment scales: the Self-Rating Inventory for PTSD, Symptom Checklist, Utrecht Coping Scale; and Minnesota Multiphasic Personality Inventory. A

comparison of the pre- and post-treatment scores showed a statistically significant decrease in depressive, anxiety, and somatic symptoms post-treatment. Although the lack of a control group and relatively small sample size affected the ability to validate this study, the study represented an important step in considering creative and embodied treatments for PTSD alongside more traditional, recognized methods. Expansions on this study could attempt to separate out treatment methods and compare the efficacy of each method internally and across methods.

Other researchers also found that CBT treatment alone may not be enough to address the complexity of body-based trauma symptoms such as eating disorders. A 10-week study ($N = 20$) of the effects of group CBT on anorexia nervosa found that CBT methods alone ineffectively reduced symptoms (Leung, Waller, & Thomas, 1999). The researchers suggested that CBT is "insufficient to induce changes, due to its failure to address some process issues central to anorexia nervosa (such as poor motivation, lack of insight, and ambivalence towards treatment)" (p. 351). They further hypothesized that CBT may be ineffective due to its lack of focus on the complex physical symptoms associated with anorexia. This study supported the need to expand the realm of research on trauma-related diagnoses to include broader-based treatment models.

Although research on CBT and trauma remains prevalent, critics of pure CBT methods of trauma treatment have noted its lack of focus on the body, which may prevent the mind-body integration necessary for recovery (e.g., P. A. Levine, 2010a; Ogden et al., 2005). Koch and Weidinger-von der Recke (2009) stressed, "Conventional verbal psychotherapies are suited to address cognitive and emotional elements of trauma: however, they do not address the trauma directly on a body level" (p. 294). Thus, theories and research around the

use of creative and embodied practices have begun focusing on the complexities of trauma that practices such as CBT alone may not adequately address.

Embodied Nature of Trauma

Rene Descartes' 17th century philosophies supported the notion of *dualism*, in which the mind and body act as two separate but related entities. Cartesian dualism assumes the mind to be nonphysical and consciousness separate from the body (Williams, 1996). Philosophers such as Heidegger (1927/1996) and Merleau-Ponty (1962) challenged these theories, viewing the body less as an object and more as a condition of experience—and their philosophies helped define the concept of *embodiment* found throughout numerous modern disciplines such as education (Dadds, 2008), sociology (Ignatow, 2007), and linguistics (Lakoff & Johnson, 1999). Further, theorists such as Reich, Janet, and Mathias Alexander addressed the specific ways in which the body can hold records of emotional experiences. For example, they proposed that changes in body posture and sensations correlatively affect emotional states. Creative arts therapists have noted the role embodiment plays in fostering empathy in the client-therapist dyad (Meekums, 2012). These theorists helped build the modern therapeutic concept of embodiment that views cognitive, emotional, and physical experiences as interrelated.

Psychotherapists may be able to use this concept of embodiment to increase client and therapist body awareness in relation to emotions and cognition. Creative arts therapists differ from verbal psychotherapists in that they are trained to help clients enact that body awareness through creative engagement such as movement, art-making, music-making, and dramatic enactment. Bonnie Meekums (2012) explored how creativity related to embodied empathy in the client-therapist relationship, noting, "Creative collaboration may play a

crucial role in kinesthetic empathy" (p. 62). Koch and Fuchs (2011) suggested that dance/movement, art, and music therapists may be well positioned to use embodiment in practice and research due to these therapists' specialized training in embodied realms such as body movement, painting and sculpting, and rhythm. They stressed:

> Arts therapists need to take the opportunity to contribute their knowledge to refine the operationalizations of movement, rhythms, and strokes used by embodiment researchers since their knowledge of theories and operationalizations of movement and qualia exceeds the knowledge of the average interdisciplinary embodiment researcher. (p. 279)

Embodied Psychotherapy Theory and Research

In the last several decades, a growing number of theorists have highlighted the need for trauma work to focus on integrating psychology and physiology (e.g., Damasio, 1996; P. A. Levine, 2010a; Ogden & Minton, 2000; Porges, 2011; Rothschild, 2000; van der Kolk, 1994). These theories can be grouped under the category of *embodied psychotherapeutic approaches to trauma treatment*. Theorists such as P. A. Levine (2010a) and Ogden, Minton, and Pain (2006) have outlined theories for embodied psychotherapy practice. However, little research has been conducted to determine the efficacy and generalizability of their methods.

Theory. Peter A. Levine's (2008) work focused on a method called *Somatic Experiencing* (SE). The SE method builds on an understanding of how animals in the wild process trauma, noting that they are able to physically release their traumatic experiences. Levine theorized that humans store traumatic experiences in the body, and that healing comes through "the awareness of body sensations that contradict those of paralysis and helplessness,

and which restore resilience, equilibrium and wholeness" (P. A. Levine, 2009). Levine

offered a comparison to traditional psychotherapy treatments in trauma, stating:

> In distinction to cognitive and emotional based therapies ("top-down"
>
> approaches which focus on insight and emotions first and only secondarily
>
> focus on somatic responses to trauma), SE is a "bottom-up" approach. It
>
> focuses on the brain stem and its survival-based functions that are not under
>
> conscious or emotional control. Access to these instinctual action and arousal
>
> systems is through the vehicle of physical bodily sensations. Cognitions and
>
> emotions are included in SE practice but they are secondary or derivative from
>
> physical sensations through bottom-up processing. (P. A. Levine, 2010b)

Here Levine emphasized some of the possible limitations of traditional approaches to trauma,

wherein cognitive and emotional work may leave out the core physiological roots of how

trauma is stored.

Ogden et al. (2006) took a similar approach to P. A. Levine's trauma work, using a

method they called *sensorimotor psychotherapy* (SP). Ogden et al.'s approach expanded on

the difference between "top-down" and "bottom-up" processing in relation to trauma

treatment. "Top-down" processing is the approach traditionally used in verbal

psychotherapy, wherein cognition and emotions are explored through interactive verbal

dialogue. Narrative becomes the key component in the psychotherapeutic process. The

premise is that once the language has changed, physical or embodied changes in the client

may follow naturally. Thus, narrative is not considered an embodied approach, because work

with the body is not a primary focus and integration of the body with mental processes is

generally not a goal. In contrast, "bottom-up" processing focuses on identifying physical

responses. According to Ogden et al., the benefit of this method in trauma work is that "the client learns to observe and follow the sensorimotor reactions that were activated at the time of the trauma, as well as to mindfully execute physical actions that interrupt maladaptive tendencies" (p. 24).

Research supporting Ogden's and P. A. Levine's theories. Both Ogden's and P.A. Levine's theories argued for the notion of embodied work in trauma treatment. However, a review of the literature suggested there have been relatively few empirical studies to support their theories. One study based on Levine's SE philosophy was conducted in the Tamil Nadu region of southern India following the 2004 tsunami (Parker, Doctor, & Selvam, 2008). Participants ($N = 150$) were included based on a prescreening for trauma symptoms. Noteworthy, though unclear as to why, there were nearly three times as many women ($n = 110$) as men ($n = 40$) in the study. The mean age was 41.6 years. Each participant received "75 minutes of somatic therapy and training in affect modulation and self regulation" (p. 103). The three dependent variables were presenting post-tsunami symptoms, overall stress improvement, and impact of event scale—revised scores. Participants showed statistically significant improvements in trauma-based symptoms when comparing the pre- and post-treatment surveys. This study represented one of the first empirical studies using SE and Levine's theories. However, it was limited in that there was no control group. Therefore, the treatment cannot be reliably isolated as a factor in symptom improvement over time.

Another study used Ogden et al.'s (2006) theories to inform the treatment methods. Langmuir, Kirsh, and Classen (2011) conducted a quantitative research study at a trauma-based hospital in Toronto, Canada to determine the effectiveness of SP on reducing

symptoms related to trauma. Participants were 10 women ranging from 31 to 65 years of age, included in the group based on a history of childhood physical, sexual, or emotional abuse. Ten percent of participants experienced emotional abuse only, while 40% experienced emotional and sexual abuse, and 50% experienced physical, sexual, and emotional abuse in childhood. Treatment consisted of 20 weekly sessions of "SP-informed group therapy" (p. 214) co-led by a psychiatrist and a master-level psychotherapist, both trained in SP. Group members were given "basic tools to help them become comfortable with examining their somatic experience" (p. 219), with the assumption that increasing their body awareness would lead to a decrease in dissociation and other trauma-related symptoms. Data were collected using six questionnaires related to demographics, trauma history, and symptomatology and were analyzed using analysis of variance. The results revealed significant improvements in the areas of dissociation, body awareness, and the ability to be soothed. These results potentially provided an important starting point for future studies that focus on body-based treatment in trauma therapy. However, this pilot study's small sample size, lack of control group, and single-gender focus also hindered the study's validity and generalizability.

Further embodied therapies research. Researchers began to study embodied therapy theories such as Ogden et al.'s (2006) and P. A. Levine's (2008) just in the last decade. Other studies began to examine the effectiveness of increasing body-awareness skills. For example, a pilot study in post-war Kosovo examined the impact of mind-body skills on PTSD symptoms in adolescents. Gordon, Staples, Blyta, and Bytqi (2004) studied high school students ($N = 139$) in Drenica, Kosovo who participated in a six-week program that employed "meditation, biofeedback, drawings, autogenic training, guided imagery,

genograms, movement and breathing techniques" (p. 143). Students were divided into three groups that completed the program two months apart. Local high school teachers were trained by faculty from the Center for Mind-Body Medicine (based in Washington, DC) to conduct three-hour long weekly sessions over the course of the six weeks. All three groups showed decreased PTSD symptoms, but only two groups showed statistically significant reductions. This study contained no control group and was limited by the dual role of the therapeutic instructors as grade-assigning teachers. Although there were clear limitations to teachers providing therapeutic treatment to their students, this study demonstrated a creative approach to large-scale treatment in a post-war environment where mass trauma exposure is assumed (Harris et al., 2010).

Secondary trauma can be an area of concern for clinicians. Increasing clinician awareness of receptive traumatic responses might help prevent instances of secondary trauma. Raingruber and Kent (2003) conducted a phenomenological investigation at a United States university with nursing and social work faculty and students ($N = 47$). The study examined "how physical sensations and perceptions alert clinicians to reflect on human meanings associated with traumatic events" (p. 449). Participants were interviewed and asked to describe a traumatic event that took place in their practice or internship and their understandings of any physical sensations they may have experienced during those events. The data were qualitatively analyzed, and five areas emerged as precipitators to an embodied clinical response: the traumatic event itself, the significance of traumatic events for clients and family members, how participants would feel if they experienced something similar, how the traumatic event shaped their view of their profession, and the unpredictable nature of everyday life.

This type of qualitative examination allowed an in-depth look into clinicians' embodied self-awareness as it relates to trauma. The study seemed to describe body-based or *somatic* countertransference responses in healthcare professionals, although they do not use that specific terminology. These types of data could be useful in both examining the clinician's health and predicting the client's response. However, the study did not delve into the larger implications of these somatic or sympathetic physical responses. Further inquiry could examine the greater clinical and self-care implications of these types of awareness.

In addition to the above studies, researchers studied embodiment treatments such as mindfulness (Bernstein, Tanay, & Vujanovic, 2011) and yoga breathing (Descilo et al., 2012) as they relate to trauma. This growing body of research into embodied treatment approaches has been promising and supported the premise that increased body awareness in trauma treatment is beneficial. However, many quantitative studies showed limitations in their lack of control group or small sample sizes.

Embodied Creative Arts Therapy Approaches

Embodied psychotherapy approaches exist in the field of creative arts therapy as well. One example can be found in Diane Austin's (2008) theories that focused on the use of the voice in therapy, or *vocal psychotherapy*. Austin proposed that the voice can be used as a means to access "numbed-off areas in the body that hold traumatic experiences" (p. 22). She emphasized the use of the voice in conjunction with the breath, noting, "Recovering one's true voice requires re-inhabiting the body. The first step in reconnecting to the body-self is learning to breathe deeply" (p. 26). Austin's dissertation used qualitative methods to establish grounded theory related to her approach. The three female participants in the study were clients chosen from Austin's private practice and ranged in age from 20 to 50 years.

Data in addition to field logs and recorded transcripts were analyzed recursively using creative methods. Austin received peer and member feedback on her data analyses to increase credibility and validity. Austin's research provided rich descriptions of the inner workings of her methods.

Recently, Austin's approach has been examined quantitatively as well. Austin's theories informed the research intervention of a mixed-methods pilot study centering on grief (Iliya, 2015). The intervention used participants singing of an "imaginal dialogue" to grieving loved ones. In this way, participants were encouraged to embody the emotions of grief using the voice, as well as embody their loved ones through Gestalt-based role-play. The quantitative portion of the study included 10 adults with mental illness and complicated grief and took place over a 10-week period. Participants were randomly assigned to treatment or control groups and received eight to ten 45-minute treatment sessions. Members of the control group received standard treatment while those in the experimental group received music therapy. Pre- and post-test standardized grief questionnaires were administered and data analyzed using descriptive statistics as well as a nonparametric test. Results were encouraging because they demonstrated that those who received the music therapy reported greater improvement in grief symptoms compared to those who received only standard treatment. This study was well designed and stood out among music therapy research in that it used a randomized control group. However, because it was a pilot study, the sample size was small. Additionally, the study was limited due to the researcher's dual role as the participants' clinician.

Analytical music therapy (AMT). Embodied interventions are also a part of AMT training. Mary Priestley (1974) first developed the AMT approach wherein the therapist and client improvise together and collectively seek meaning in what they create (Eschen, 2002). Pedersen (2002) outlined an embodied training methodology called *psychodynamic movement* created by Priestley as an aspect of AMT. Pedersen identified one goal in psychodynamic movement as "making the body of the future music therapist sensitive in such a way that he/she can count on personal body sensations and body awareness as a pathway to knowledge and transference/countertransference in the therapist-client relationship" (p. 14). She also noted, "In psychodynamic movements it is most important that those feelings and expressions are connected with and recognized through body sensations." These AMT aspects emphasized how clinicians can use their own bodies to connect with the experience of the client, and these methodologies in training can help inform an understanding of embodied interventions. Qualitative methods for AMT research have been outlined (e.g., Langenberg, Frommer, & Tress, 1993) and recently, research conducted into Priestley's techniques (Cooper, 2013). However, a review of the literature indicated no research conducted on the clinical impact of AMT. Nevertheless, AMT's philosophies and interventions related to embodiment may offer potential and clinical research could prove particularly valuable in evaluating embodied music therapy techniques with clients with trauma histories.

Other creative arts therapy and trauma research. Creative arts therapy studies have addressed the use of the creative arts in trauma work. These include studies in music therapy (Bensimon et al., 2008; Carr et al., 2011), expressive writing (Brown & Heimberg, 2001; Hoyt & Yeater, 2011; Koopman et al., 2005), art therapy (Lyshak-Stelzer, Singer, St. John, & Chemtob, 2007; Morgan & Johnson, 1995), psychodrama (Carbonell & Parteleno-Barehmi, 1999; Hudgins, Drucker, & Metcalf, 2000), and dance (Meekums, 2008; Thomson & Jaque, 2012).

Studies have demonstrated creative arts therapies as effective in decreasing trauma-related symptoms such as hypervigilance, somatization, and dissociation (Chapman et al., 2001; Fagen & Wool, 1999; Gleadhill & Ferris, 2010; Volkman, 1993). Greenberg and van der Kolk (1987) claimed that the creative process can be used to bypass neural pathways developed through traumatic experiences and to allow clients to "rewrite" their responses. However, research is needed to support this claim.

Psychodrama. Scholars have explored psychodrama for its effectiveness in treating traumatic stress. Carbonell and Parteleno-Barehmi (1999) conducted a mixed-methods study to examine the effects of group psychodrama techniques with girls coping with trauma. Participants ($N = 26$) were sixth-grade girls identified by teachers, parents, or themselves as having traumatic responses to stressors. The treatment group ($n = 12$) received 20 weeks of psychodrama group treatment while the control group ($n = 14$) stayed on a waiting list until completion of the study. The treatment group format consisted of three phases: "(a) warm-up, (b) action, and (c) sharing" (p. 291). All participants completed pre- and post-test self-report surveys. A qualitative component was used to examine further the impact the group had on participants. The study results indicated the treatment group experienced significant

changes in withdrawn behaviors and anxiety or depression—two key components in traumatic stress. The control group showed no significant changes. Although the sample size was small and homogeneous in age and gender, this study indicated that actively engaging with peers in a creative process might reduce trauma-related symptoms.

Music therapy. In one music-therapy study, Bensimon, Amir, and Wolf (2008) explored themes of meaning in group drumming for men ($N = 6$) aged 20 to 23 years diagnosed with chronic PTSD after returning from Israeli military service. Data were collected from three sources: (a) digital cameras used to film the sessions, (b) open-ended interviews, and (c) therapist self-reports. In addition to individual verbal psychotherapy, study participants received 16 weekly group music-therapy sessions where they engaged in group drumming. Data were analyzed using content analysis, rhythmic transcription and categorization, and examination of the time and quality spent on each music instrument. The overall themes found in the study were that participants experienced "loneliness verses togetherness," "non-intimidating access to traumatic memories," "drumming out the rage," and "regaining a sense of control" (p. 37). Peer debriefing, triangulation, multiple observations of videos, and analyzing recorded data sequentially enhanced the study validity. Although this study represented an important beginning in exploration of music therapy applications in trauma, it is limited in that it studied only one technique (drumming) and one gender (male) and did not directly address certain key symptoms of PTSD such as hypervigilance and dissociation.

Carr et al. (2011) attempted to expand on the existing music therapy and trauma research by conducting a mixed-methods study in London, United Kingdom to examine the impact of group music therapy on PTSD symptoms and depression. Study participants

($N = 17$), who ranged in age from 18 to 65 years and were previously nonresponsive to CBT, were randomly placed in treatment ($n = 9$) and control ($n = 8$) groups. Participants received no other psychotherapy during the study. Treatment group participants were interviewed after 10 weeks of group music therapy, but control group participants were eligible for treatment only after completion of the study. Both groups were assessed at the beginning and end of the study using the Impact of Events Scale-Revised and Beck Depression Inventory II. Study results showed statistically significant improvement in PTSD symptoms in the treatment group 10 weeks after baseline, and significantly more improvement when compared with the control group. Emergent themes from the qualitative analysis were (a) "engagement with music therapy," (b) "establishment of safety and trust," (c) "identification and expression of emotion," and (d) "capacity to tolerate particular sound qualities of instruments" (pp. 196-197). Limitations in this study, including its small sample size and the researchers' dual roles as music therapists, may have affected the validity of the outcomes. However, this study was well designed: it was the first music-therapy and trauma study to use a randomized control trial to demonstrate effectiveness of alternate treatments in cases where CBT had proven ineffective.

Art therapy. Lyshak-Stelzer, Singer, St. John, and Chemtob (2007) examined the effectiveness of a trauma-focused art therapy intervention with 13- to 18-year-old girls ($N = 82$) in two greater New York City area inpatient psychiatric facilities. Participants were randomly selected for inclusion in either the treatment or the control (treatment as usual) group. Treatment consisted of 16 group art-therapy sessions each with two to five participants. An evaluation of pre- and post-treatment scores indicated a statistically significant reduction of PTSD-related symptoms in treatment-group members compared with

control-group members. Although this was a pilot study and therefore limited in scale, it was

well designed in its use of a control group and randomized selection.

 Dance/Movement therapy. In 2015, a series of studies was conducted in an effort to

create a "body-oriented intervention manual for social workers to use when working with

trauma and PTSD" (B. Levine, 2015). Participants in the quantitative (and final) portion of

the research ($N = 98$) were practicing dance/movement therapists who completed a

25-question survey to determine intervention strategies among other factors. Questions used

a 5-point Likert scale to determine clinicians' frequency and timing of interventions such as

breathing, grounding, and guided movements during a session. The results indicated that

dance/movement therapists working with clients with trauma histories frequently used

breathing exercises at the end of sessions, movement guidance in the middle of sessions, and

grounding techniques throughout the sessions. This study helped identify the interventions

dance/movement therapists use in trauma work and set the groundwork to make body-

oriented recommendations for verbal-psychotherapists to use. Whereas the researcher was

careful to note that the data presentation was not intended to make verbal psychotherapists

into dance/movement therapists, specific precautions and ethical limitations should be

addressed when the interventions are included in the intended manual to clarify how these

ideas may be used by non-dance/movement therapists. Additionally, it would be useful to

follow up this study with an evaluation of the efficacy of the identified interventions.

 Other perspectives. The majority of extant research supported the relationship

between creativity and resolution of trauma symptoms. However, one study conducted by

Knezevic and Osvenik (2002) took a different perspective. The researchers examined

creativity in children living in the post-war town of Mostar, Bosnia and Herzegovina and

asked, "Can creativity in conditions of war trauma be a danger to personal development?" (p. 1139). Study participants ($N = 425$) ranged in age from 8 to 17 years, came from both the western ($n = 261$) and eastern ($n = 164$) sides of the deeply divided town, and had been identified by their teachers as creative students. Participants were surveyed and analyzed using a "classic psycho trauma-scale" (p. 1148) and the Torrence Test of Creative Thinking. The researchers claimed that the results indicated a correlation between creativity and oppositional behaviors and suggested that children prone to being more oppositional following the war would be "pushed deeper into social conflicts" (p. 1151). However, there were several key limitations to this study. First, the test used to determine *oppositionality* (p. 1151) did not appear to be a validated measurement tool. Second, the researchers did not sufficiently support the hypothesized link between oppositional behavior and poor quality of life. Further research into the topic should use validated measurement tools and might examine more of the complexity of oppositional behavior and creativity in a post-war environment.

Summary

Trauma-based diagnoses such as PTSD, C-PTSD, and dissociation require therapeutic approaches that can address their complexities. Although CBT remains the predominant approach in trauma treatment and research, theorists have noted limitations in the approach, particularly because it does not address the body-based nature of trauma. A review of the literature on embodied and creative psychotherapeutic approaches such as creative arts therapies demonstrated the potential of these approaches to address the complexities of trauma. However, research in these areas remained limited, and most empirical studies represented preliminary inquiries. Many quantitative studies lacked a control group and had

small sample sizes, which negatively affected study validation. Several factors may contribute to these study limitations. For example, resources are often limited in areas of mass trauma or mental health facilities, and it can be difficult to allocate a researcher who is not also performing a clinical function. In addition, in areas where the trauma may be ongoing, such as conflict sites, there are challenges in establishing safe and ethical control groups. Existing qualitative research tended to focus on single modalities or even methodologies (e.g., Austin, 2008.). Although the extant studies provided rich insights into their specific focus areas, a broader qualitative examination may help outline the commonalities and differences among the creative arts therapy approaches to trauma work. Additional research is clearly needed to expand the breadth and depth of awareness, as well as to increase the validity of preliminary findings.

Theories related to embodied psychotherapies and trauma (P. A. Levine, 2010a; Ogden & Minton, 2000; Porges, 2011) and creative arts therapies and trauma (Malchiodi, 2008; Sutton, 2002; Talwar, 2007) have been expanding. Still, adequate research to support these theories is missing from the literature. Furthering this research will not only help close the gap in the field's research base, but also help better inform clinicians working with trauma. This dissertation's qualitative inquiry into the experience of creative arts therapists who use embodied interventions in work with trauma is designed to help establish parameters and direction for continued research.

This study was designed in two phases. The initial phase explored how music therapists use embodied interventions when working with trauma. Inquiry into the topic prior to the study determined a gap in the theory and research literature related to the use of embodied techniques in the creative arts therapies. A re-examination of the literature

following completion of Phase One demonstrated a gap in qualitative research that considered trauma interventions across creative therapeutic modalities. Based on these identified gaps, the researcher determined that it would be beneficial to incorporate a broader base of therapeutic perspectives when qualitatively examining creative, embodied interventions with trauma. The following sections focus on the data analyzed during Phase Two of the study.

CHAPTER 3

Method

This qualitative study was designed in two phases using the same methodologies. This dissertation focuses on the second phase of the study, which examined how creative arts therapists specializing in the modalities of art, dance/movement, drama, expressive, or music therapy use embodied interventions in the treatment of clients with histories of trauma. Specifically, the researcher interviewed seven creative arts therapists working with clients who had experienced trauma, in order to explore their use of embodied interventions. This study was philosophically rooted in a constructivist approach, which seeks to understand an experience through the viewpoint of the selected participants (Creswell, 2012). Qualitative constructivist research uses broad questions to gain varied meanings of a complex experience. In line with the constructivist approach, the open-ended interview format was selected to provide for rich and varied responses to the core research question. The data were analyzed qualitatively using ATLAS.ti software. Forinash and Grocke's (2005) and Braun and Clarke's (2006) analysis suggestions informed the following steps for thematic analysis: (1) familiarize yourself with the data, (2) generate initial codes, (3) search for themes, (4) review themes, (5) define and name themes, and (6) create a narrative using themes.

Participant Sample

Purposive sampling was used to help recruit study participants who would be well suited to providing rich answers to the interview questions (Creswell, 2012). Preliminary recruitment used word of mouth to gather information on potential participants. Snowball sampling was also used to assist the researcher in finding qualified participants outside the

realm of his expertise (Vogt, 1993), such as art therapists. The researcher's 20-year experience specializing in music therapy and trauma work in conjunction with his affiliations with several academic institutions aided access to key informants. Inclusion was based on the potential participant being a creative arts therapist and maintaining a clinical, educational, or theoretical specialization in the area of trauma. The researcher made initial contact with participants via e-mail to invite participation in the research and share relevant participation information. All seven prospective participants who were contacted agreed to take part in the study. The three music therapy participants in the study were interviewed during the first phase of the study. Data analysis was first conducted internally and across interviews of music therapists. This analysis process was repeated with the initial three interviews during the second phase in order to analyze the data in the context of the additional four interviews. The researcher was acquainted with five of the seven participants prior to beginning research, through educational or professional relationships. The potential implications of these relationships is explored in the discussion section.

Informed Consent

Lesley University's Institutional Review Board approved this study. Before the start of the research, each participant signed an informed consent form (Appendix A) for participation in the research. The participants were informed about the nature, purpose, and procedures involved in participating in the study via the consent form and verbally by the researcher. The participants were invited to ask questions and express doubts, and were provided answers. They were advised of the option to leave the study any time without consequences and were assured full anonymity and confidentiality. Specifically, only the researcher would know their identities and their names, and identifying information would be

excluded from publication. Instead, their identities would appear using pseudonyms in the dissertation or other publications.

Demographics

As shown in Table 2, the seven participants varied in gender, sexual orientation, race/ethnicity, nation of birth and residence, age, and years in the creative arts therapy field. Six participants were female and one male. Six (86%) identified as straight/heterosexual and one as bisexual. In order to allow for the complexity of identity, participants were asked how they identified in terms of race/ethnicity in an intentionally open manner. Three (43%) identified as Caucasian while two (29%) identified as mixed race/ethnicity. One participant identified as part Native American, one as "of Pakistani descent," and one as Jewish Israeli. Three (43%) participants were born outside of the United States but six (86%) participants currently resided in the United States. The number of years in the field of creative arts therapy ranged from 14 to 37. Interestingly, while the mean was 24 years, the median was 16 years due to two groupings at either end of the sample. All participants taught, published, and presented in their respective fields in addition to providing clinical treatment. Participants reviewed and approved the individual demographic descriptions presented in the following chapter.

Data Collection: Interviews

To obtain sample demographics and to understand better how creative arts therapists used embodied techniques, the study was designed using a verbal interview format. The researcher initially contacted participants by telephone or email and asked them to participate in the study. The researcher conducted each interview, lasting between 45 and 60 minutes. In-person interviews were conducted when possible due to the increased level of comfort and

intimacy provided. However, due to geographic constraints, this was not possible for all interviews. Three interviews were conducted in person at various locations in the New York City metropolitan area and four were conducted via video-teleconference. Two digital audio-recording devices were used for all interviews, to safeguard in case of technological failure. The interviews consisted of 10 semi-structured questions (Appendix B) designed to explore the use of embodied interventions in work with clients who have trauma histories. Each interview was transcribed and placed in a password-protected computer file. In order to insure accuracy of wording and intent, interview transcripts were then sent to the participants for review. Five participants made changes to their interviews, including changing wording or clarifying responses. While reviewing the documents may have allowed participants to self-censor, some participants may have found it difficult to articulate their responses in verbal interview format.

Bias

The researcher acknowledges a motivation to pursue this topic related in part to a familial and personal history with embodied trauma and recovery. With this in mind, the researcher took several steps to reduce bias during the analysis process. First, the bracketing process (Gearing, 2004) was used to help identify how the researcher's perspective may have influenced the data collection and analysis. The researcher kept a journal to record thoughts and feelings that would arise in relation to the interviews and re-examined the journals prior to analysis to help contextualize his viewpoint. Additionally, the researcher maintained regular personal therapy and clinical supervision. These spaces proved useful in processing responses emerging from the interviews. Finally, an Austrian graduate student studying dance/movement therapy in Germany read the interview transcripts and independently

determined codes and themes. Because the research participants varied in cultural

backgrounds as well as modalities, the peer reviewer was selected from a cultural

background and modality different from the researcher's in order to reduce bias in the

analysis process.

Table 2. *Sample Demographics*

Demographic	*n*
Gender	
Female	6
Male	1
Sexual Orientation	
Straight/Heterosexual	6
Bisexual	1
Race/Ethnicity	
Caucasian/White	3
Mixed race/ethnicity	2
Native American	1
"Pakistani descent"	1
Jewish Israeli	1
Nation of birth	
United States	4
Outside the United States	3
Residence	
In the United States	6
Outside the United States	1
Years in profession	14-37[a]

Note. N = 7.

[a]*M* = 24, *Mdn* = 16

Data Analysis

In efforts to become familiar with the participant's responses, the researcher listened to all recorded interviews a minimum of two times and read each transcript twice prior to beginning coding. During the two initial reviews of the interviews, the researcher took notes in a separate Word document. These notes included abstract thoughts or associations such as noting a feeling of lightheadedness while listening to a participant's response. During the coding process, the interviews were first coded individually. Next, the codes were compared across interviews and adjusted to reflect commonalities and differences. The researcher found 74 codes through this analysis. These codes were then placed into preliminary groupings that were reworked multiple times to examine various possible interpretations. Prior to determining themes, the peer reviewer was provided with full un-coded transcripts of participant interviews to assure impartial analysis. In addition to sharing independent codes and theme clusters, the peer reviewer offered rich comments and insights on the interviews. For example, upon each interview, the peer reviewer noted main impressions as well as associations and comparisons with other interviews. This helped illuminate the peer reviewer's analysis *process*, in addition to her findings. A comparison of the independent analyses conducted by both the researcher and the peer reviewer showed many similarities and aided establishment of the themes and subthemes. The themes related to, for example, awareness of client's body, countertransference, the client-therapist relationship, a client-centered approach, therapist resources, and supervision.

The peer reviewer's analysis highlighted some additional areas of importance that the researcher chose to omit from the current thematic results due in part to their lack of prevalence across interviews. These concepts, including touch, spirituality, focus, and

attunement, were primarily concentrated in individual interviews and may be useful to explore in future research.

The results are presented in the next chapter as a discussion of the themes and subthemes that emerged from the data analysis and include exemplary quotations from the participants.

CHAPTER 4

Results

This study's second phase examined how creative arts therapists use embodied interventions and general body awareness when working with clients who have trauma histories. Seven creative arts therapists participated in semi-structured interviews with the researcher. Analysis of the interviews revealed 74 codes that were grouped and reduced to determine the seven emergent themes and nine subthemes presented in this chapter.

Participants

As summarized in Table 3, the following is a description of each study participant. Participant modality, educational background, professional interests, and general work location were highlighted to provide a richer picture when reading the data. All participant names were changed to support anonymity. Additionally, demographic information that may have compromised individual anonymity has been presented as general statistics in Table 2 in the Method chapter.

Alma trained in Europe in AMT and Bioenergetic Body psychotherapy. She has been practicing these techniques for more than three decades, providing music psychotherapy for clients with medical or psychological trauma. She has advanced degrees from two northern European universities. Alma has published numerous articles in the field and served as a tenured professor and adjunct professor at numerous universities in the United States and Europe.

Merlin is a drama therapy educator and clinician who has been in the field since 2001. She holds a PhD in interdisciplinary studies and coordinates a drama therapy program at a

North American university. Merlin has published and presented on topics including trauma, social justice, feminism, and improvisation, and specializes in the drama therapy method, *Developmental Transformations (DVT)*.

Heather is based in the United States but has worked in dozens of countries with survivors of mass trauma, torture, and violence. In addition to an MA degree in somatic psychotherapy and dance/movement therapy, she holds an MPH and a BA degree in international relations. Her career has spanned political science, public health, bodywork, and dance/movement therapy among others. Heather specializes in Continuum Movement practices and teaches workshops throughout the world.

Jeremy is a drama psychotherapist and adjunct faculty member at two east coast universities in the United States. He holds a PhD from a northeastern American university and has been in the field since 1999. Jeremy has edited several books and written numerous articles and book chapters related to trauma work. He is currently in full-time private practice. His trauma focuses include familial, interpersonal, developmental, and mass trauma.

Laura is a music therapist who specializes in Guided Imagery and Music (GIM) and was trained by GIM founder Helen Bonny. Laura received her PhD from a European university. She now directs an academic music-therapy program at an American university. Laura has published several books and presented around the world.

Melissa is a licensed mental health counselor, arts therapist, and expressive therapist who uses a cross-cultural focus in treating trauma. She has been in practice for 15 years. She completed her MA degree on the west coast of the United States but teaches at a

university in northeastern United States. She is currently pursuing doctoral studies in a

related field.

Sarah is a professor of music therapy who lives in the Middle East. She has a

doctorate in music therapy from an American East Coast university and has worked in the

field over 30 years. Sarah has published several research studies related specifically to music

therapy and trauma and numerous articles in closely related areas.

Table 3. *Individual Participant Descriptions*

Pseudonym	Highest education level/degree	Primary modality	Years in field[a]	Work location
Alma	MA	Music therapy: AMT; Bioenergetic body psychotherapy	30+	USA
Merlin	PhD	Drama therapy: DVT	14	USA
Heather	MA, MPH	Dance/movement therapy; Continuum movement	15	USA International
Jeremy	PhD	Drama therapy; Group psychotherapy	16	USA
Laura	PhD	Music therapy: GIM	30+	USA
Melissa	PhD student	Art therapy; Expressive therapy	15	USA
Sarah	DA	Music therapy	30+	Middle East

Note. N = 7.
[a]*M* = 24, *Mdn* = 16

The data consisted of transcribed interviews that the researcher analyzed and coded to determine emergent themes. The qualitative analysis, as described in the Method chapter, elicited seven themes and nine subthemes, which fell under the two categories of factors in facilitation and interventions. The primary themes under the category factors in facilitation are (1) a client-centered approach, (2) safety, (3) sociocultural factors, and (4) therapist resources. The themes categorized as interventions are (5) somatic awareness and interventions, (6) relational enactments, and (7) creative interventions.

Themes 1-4: Factors in Facilitation

The themes of a client centered approach, safety, sociocultural factors, and therapist resources emerged as factors in therapeutic facilitation. These are aspects related to clinical work with trauma that influence the trajectory or efficacy of the clinical work.

Theme 1: Client-centered approaches. Data analysis demonstrated that all participants chose interventions based, at least partly, on the needs of the client. At times, client needs led participants to move away from their preconceived notions of treatment. Thus, the participants explored how client-centered approaches meant that the therapist should be flexible in how they intervene, based on client needs.

Three (43%) participants addressed the notion that the client's needs should come before the therapist's need to use a specific intervention. These participants highlighted their opinion that "client-centered" also meant "seeking to do no harm." Melissa explained, "It's client-based. It's client-directed and competency-based, like 'what can I actually facilitate and hope to not do harm?'"

Participants also addressed providing clients with choices as a means to help them control their own processes. Jeremy said, "I just feel we want to be able to meet people

where they are, and that includes offering them a lot of options on how we are going to meet them."

The data indicated that participants who had specialized trainings still felt the need to be flexible when implementing interventions. Merlin, who uses a specific form of drama-therapy intervention known as DVT, described the choice to prioritize the needs of the client over the desire to use a specific intervention:

> There were some children and adults who wouldn't want to go near a space
>
> that was filled with ambiguity and that was less controllable. So it's not as
>
> though we would move into DVT immediately with everybody. It's always
>
> client before technique so were not imposing DVT or any creative process on
>
> anyone.

This flexibility was also addressed in relation to the clinician's theoretical framework. Although Laura described her work as informed by psychodynamic theory, she also acknowledged that this approach may not fit all of her clients. "Some clients aren't ready to go into the patterns. So, everybody doesn't do that kind of work."

The data showed that when participants focused on the needs of their clients, they sometimes had to make adjustments in their interventions.

> My clients kind of demanded it. I had an actor as one of my primary
>
> individual clients and a music therapist as one of my clients. It became very
>
> important to incorporate that, and I think even for the people that ended up
>
> being very comfortable with art therapy, we had to go through a process of
>
> paying attention to their somatic experience before they could really engage in
>
> a creative process. (Melissa)

The interplay between the identity of the therapist and the needs of the client emerged in three (43%) interviews. Jeremy discussed how imposing a methodology onto a client may be more harmful than reparative.

I feel like the longer I'm a clinician, the more integrative I'm becoming. In the sense that—I just feel like at a certain point, me being tied to one way of working is for me a level of arrogance. That, why do I impose that—"This is the way to work with this person who comes in the room," particularly those who have been interpersonally traumatized and have had people impose their way on them a lot?

According to participants, when working with trauma, clinicians should avoid prescriptive approaches and take time to understand the client's needs. Melissa stated, "It needs to be always client-directed rather than a preconceived notion of what the treatment should look like before you know the client."

Therapist flexibility and willingness to consider the client's needs over the therapist's predetermined methodology, modality, or training support client-centered approaches, according to participants. The data indicated that participants believed overall therapist adaptability to be a key component in maintaining a client-centered approach.

Theme 2: Safety. All participants addressed incorporating concepts of safety into clinical work with trauma. These concepts include control, trust, and pacing. Participants highlighted their belief in the necessity for therapist awareness of client's individualized safety needs.

One (14%) participant discussed the role of client self-disclosure in safety. Jeremy spoke about his outlook that client-led choices in self-disclosure contribute to a sense of control.

I think sometimes we have this notion that for therapy to be effective the client has to share everything with us, and for some of my patients, I just want them to go through the experience and they can choose when they want to share what's in their narrative. That's their choice.

Two (29%) participants expressed a belief that clients must feel safe in their bodies in order to deem the treatment safe. Melissa stated, "Unless the body feels safe, they aren't safe."

The data revealed the participant view that the pacing of treatment is a consideration in client safety. Jeremy discussed how trust and stability play into the timing of the move into an embodied approach:

I think the body is a really scary place for many of our patients. And that doesn't mean they don't need that work. I think that sometimes they need other work first. They need grounding and stability first. Or, they need to test the clinical relationship and your trust as the therapist.

Melissa furthered the notion of moving slowly into an embodied process. She described the importance of respecting the client's pace:

Pacing of the work with the body is essential….I just get really worried how fast people are trying to resolve trauma in this way that doesn't allow for honoring the embodied experience as the center of what the healing process for the client; what the client needs.

Participants explored the potential to harm clients by moving too quickly. Jeremy discussed becoming aware of "urgency" in clinical work:

I've also learned—when I have urgency around the clinical interventions, it's probably the wrong intervention for the patient. It's probably coming from something else and I need to pause. You know, I learned to distinguish between impulse and urgency. There have been times when I moved people too fast and we ended up playing out something that wasn't helpful for them, and really made it scary for them to come back to therapy.

Participants viewed safety as a key component to the treatment of trauma. Trust, control, and pacing emerged as pertinent factors in the establishment of safety.

Theme 3: Sociocultural factors. The data revealed that participants found sociocultural factors relevant to treatment and influential in their clinical interventions. These sociocultural factors included mental health history of the client's families and the client's country of origin, social systems, race, and economic status.

Sociocultural factors emerged in regards to the mental health of the client's family of origin. To illustrate, Alma stated that her intent was to help clients understand the role their sociocultural history plays in present day treatment.

I work with patients with bipolar disease, and some of them have experienced psychological trauma that can be traced back; their bipolar illness has been reinforced by some trauma in their early childhood. I work with identifying what happened and helping them to see now, give them tools to deal with whatever trauma they are experiencing now—like clients who have been raped; clients who have been living with parents who abandoned them or who

didn't see them, hear them, relate to them; clients that grew up with alcoholic parents, parents that were addicted.

Sociocultural elements such as rituals, social systems, and country of origin influenced how three (43%) participants approached treatment in their work with trauma. Melissa believed that cultural awareness is the direction trauma treatment should be heading, explaining, "The next level of professional development is figuring out what are the competencies of different cultures through their rituals and their practices in the communities."

Participants stressed an understanding of the client's social systems as a crucial component in the healing process. Merlin stated, "A person's social system in relationships is a major protective factor when it comes to trauma and moving into post-traumatic growth. It has a huge bearing."

Participants also discussed the client's cultural context as it relates to therapeutic decisions. For example, they considered touch in therapeutic treatment within the cultural context of the client. Heather said, "I think some cultures have continued to embody and allow for that through the life span much more eloquently than others. And so, a lot of my clients greet with a hug or three kisses on the cheek."

Clinical decisions around culture and touch may require experience to negotiate effectively, according to participant views. In the following example, Heather discussed the complexity of an early encounter with culture-based touch:

> I was brand new and I was thinking, "God, I just kissed my client's cheek I'm
> not supposed to do that." That level of contact, I think, that's how we honor
> and acknowledge a person, and I think that shows profound respect.

One participant identified cultural dilemmas related to touch. Heather spoke about a clinical intervention in which an African client placed Heather's hand over the client's scar. Heather outlined her experience of making clinical decisions amidst conflicting cultural standards:

> I really thought about that and I thought, if I had taken off my hand and if I
>
> had gone with the Western liability, I would have lost that relationship right
>
> there, and that ended up being the most profoundly healing relationship for
>
> both of us.

The data reflected participant beliefs that cultures of trauma can be broadly defined. Jeremy introduced the notion that clinical institutions can possess a culture of trauma, wherein staff attitudes and the physical environment can contribute to re-traumatizing clients. "I think there are so many ways in which well-intentioned organizations re-create those [trauma] dynamics for patients," he said.

Three (43%) participants highlighted the belief that sociocultural factors such as race and economic status can influence the trauma experience. For example, Merlin said, "[Trauma arises from] the toxic relentless trauma of poverty, ongoing racism." Awareness of culture should not be limited to the client's background, according to participants. Four (57%) participants spoke about their own sociocultural backgrounds as they related to treatment. Sarah discussed how she looked at the intergenerational impact of living and working in a culture steeped in trauma. "Almost my father's whole family was murdered by the Nazis, as well as my mother's father and youngest brother." She further explained how she felt her family trauma history paralleled the backgrounds of many of her client population:

Living in Israel, you cannot avoid it. I mean, almost every person who comes

to you for therapy either had trauma or PTSD. It's the second generation as

well as, of course, the holocaust survivors—and the third generation. So,

whoever you work with has some kind of trauma.

According to participants, the sociocultural elements in treatment ranged from

contextualizing the client's history to understanding the impact of factors such as poverty.

Participants believed that their own backgrounds, in addition to those of their clients, were

relevant to the treatment.

Theme 4: Therapist resources. Data analysis revealed participants beliefs that

therapist access to certain resources is a factor in treatment efficacy. These resources include

supervision, personal therapy, and individual creative exploration.

Subtheme 4a: Supervision. Five (71%) study participants discussed the role of

therapist supervision in the treatment of trauma. The data showed that participants felt

supervision was useful to process client material and identify therapeutic enactments.

However, they also noted the importance of finding a supervisor who met the therapist's

needs.

Three (43%) participants spoke about their views that supervision helps process the

material that therapists hold for their clients. Sarah explained, "I took supervision so I had a

place to digest and to deal with my feelings, my countertransference, my emotions, etcetera."

Supervision can play into helping a clinician identify therapeutic enactments as

discussed in the sixth theme, according to two (29%) participants.

Supervision is so crucial for somebody to say, "That doesn't seem consistent

to who you are," or "There's an odd feeling I get when you talk about this

case." Who can help us become more aware of what it is we're playing out,

because I really believe we will be playing it out and it's not a flaw of

therapy—but that is a function of therapy. (Jeremy)

As I sit back from that and get supervision on it and reflect on it, that's just

part of the treatment. My client is going to put me into the role of the

perpetrator, and my ability to tolerate that, to name it and sort of bring it into

consciousness is part of the work. (Merlin)

Whereas participants generally mentioned the presence of supervision as a positive

component, two (29%) participants also identified times when they felt the absence of a

supervisor negatively affected their work.

I was always on my own and I wasn't offered any supervision. I think I was

too young to know better and too, frankly, shell-shocked to be able to step out

of it and was just, I think, feeling so fortunate to be able to be doing all the

work—that it took me time to look back. (Jeremy)

The data also introduced the negative impact of lacking a supervisor for research

related to trauma-based clinical work. Sarah stated, "While doing research in Israel, I didn't

have a research supervisor. I was my own supervisor. And so, I did not have a place where I

could process my feelings, and that was missing."

Supervision was primarily identified as a helpful component to treatment. However,

two (29%) participants noted the importance of finding a supervisor philosophically aligned

with the therapists. For example, Jeremy stated:

When I was at my first job, I was doing all the really intense trauma work

with the kids in the inpatient unit and I did seek out supervision because I

wasn't happy with the person I had and found someone else in the
organization.

Subtheme 4b: Personal therapy. The data showed that personal therapy was a useful resource for the participants. They discussed it as a resource for coping with stress, working through personal traumatic material, and professional development. Three (43%) participants spoke about the benefits of therapy.

Alma spoke about the power of embodied psychotherapeutic work on her personal process, saying, "I want to say this, that I feel that the body psychotherapy was the most helpful for me—even more than the personal music therapy that I received, I would say."

Personal therapy was a means to work through trauma histories for three (43%) participants. Sarah explained, "It was stressful for me to have Holocaust survivors as clients. However, at that time I was in therapy myself," and Melissa stated, "As a contemporary therapist who can talk about this much more as a trauma survivor, I think I've gone through a lot of training through my own therapy."

Subtheme 4c: Individual creative exploration. Creativity was revealed as a tool to help participants find restoration, connect to spirituality, and increase self-awareness. Participants described using creativity throughout various stages of their professional and personal development. For example, Heather stated, "I've always used dance for my own restoration."

Whereas some participants explored creativity as a solo endeavor, others spoke about using peers and colleagues in creative explorations. In the following example, Sarah explored how group music improvisation helped her increase self-awareness:

I do have my improvisation group that I participate in. We are three people and we hope to have more. We meet once in three weeks and make music in my music room at home. We often talk about the body. We improvise and talk about it afterwards. We can comment on each other's bodies. For example, "Oh, did you notice how your body was moving when you played the saxophone?"

Participants noted creativity for its use in connecting them with what they termed "a higher power." Melissa described, "When I paint, it is connecting me to something larger and I think that's the healing. I don't think it's just about the creative process. I think for me it's very spiritual."

Participants also used creativity as a means to identify and connect to sociocultural elements of therapy. Melissa described how her own painting relates to her trauma history, saying, "The context of my painting is connecting with my ancestry. It's very strong and it's complicated emotionally and it is actually for me a trauma processing to be connecting with my ancestry since there's genocide in that context."

In addition to the numerous client resources outlined in the presentation of the data, analysis revealed that participants believed that *therapists* require resources to treat trauma effectively. They specifically related supervision, therapy, and creative outlets as personal resources they used as therapists.

Themes 5-7: Interventions

While the first four themes focused on factors that influence therapeutic treatment of trauma, the following themes focus primarily on the actions that take place inside the therapeutic setting. These themes are somatic awareness and interventions, relational enactments, and creative interventions.

Theme 5: Somatic awareness and interventions. Analysis of the data overwhelmingly revealed that participants believed somatic awareness and subsequent interventions to be significant components in the treatment of trauma. Two subthemes emerged in this category: awareness of client bodies and somatic countertransference.

Subtheme 5a: Awareness of client bodies. All study participants identified having an awareness of their client's bodies, such as in their unconscious movements and nonverbal communications, in clinical treatment. Participants explored their views that they could bring this awareness to the client's attention and incorporate it in therapeutic interventions.

Three (43%) participants spoke about becoming aware of their clients' bodies even when their clients remained unaware. Heather spoke about her belief that clients' unconscious movements hold information on their desires, saying, "I like to watch the movements that [my clients] are not aware of. An unconscious movement that somebody doesn't know they're doing is usually linked to a deep, unmet need."

Merlin explored increasing clients' awareness of their own bodies. She spoke about the ways in which the body unconsciously conveys emotional states: "I would draw attention to their physical expression of distress or the communication they were bringing into the room, and invite them to then bring their attention there too."

Sarah spoke about her awareness of her client's body as it paralleled her awareness of her client's music—nothing that shifts in the client's body happened in tandem with the shifts in her musical expression. "The sounds would change. Before, when her body was hunched over, the sounds she made were very, very quiet and had no rhythm. During the moments when she would sit up, her sounds were bigger."

In addition to noticing their clients' bodies, four (57%) participants believed it useful for therapists to communicate their observations to their clients. Merlin noted that in her experience, this dialogue around the body helped define client-therapist boundaries. "There's a lot more being shared when you're bringing the body into the conversation and one's boundaries are much more visible in that sort of embodied work."

Another participant outlined his experience guiding a client into an awareness of the client's own body so the client could understand how he physically held his emotional history.

> We go inside and look at somatic experience….He's beginning to understand
> the ways in which there's a lot on his shoulders, like when he's in that place
> of shame, how there's so much of that sort there, so much history that's
> loaded into that present moment. (Jeremy)

Although the data indicated that participants found body awareness helpful in clinical contexts, two (28%) participants also explored when it would be therapeutically appropriate to share their understanding of a client's body. Jeremy stated, "I would call [my client's] awareness to [his body] if I felt like he could tolerate it." Sarah expressed that awareness of clients' bodies does not always equate to a therapist's awareness of his or her own body. "I try to have a full awareness of my client's body…less of my own body [laughs]."

Subtheme 5: Somatic countertransference. The modern interpretation of *countertransference* builds on the notion that unconscious material between the client and the therapist can be useful in treatment. The data indicated that five (71%) participants found it therapeutically beneficial to be aware of their own bodies in relation to their clients' bodies. These five interviewees spoke about how the clinician's body can unconsciously hold information present in the client's body. This movement to conscious awareness of bodily held information in the clinician is known as *somatic countertransference* (Dosamantes-Beaudry, 2007).

According to four participants, somatic countertransference involved paying attention to the relationship between the therapist's body and the client's body. Sarah explained, "My awareness of my own body as well as my client's body is very much present in my therapy."

Three (43%) participants held the belief that the therapist's attunement to a client allows resonance of the client's material with the therapist. Alma used musical terms as a metaphor to explain this phenomenon:

I'm opening up my instrument so the client can play on me; play my strings as

well as I can resonate. I'm a big resonator for the client. And the client can

play me as well as I can see how the client is playing their own instrument or

not playing their own instrument.

Somatic countertransference can help therapists understand what roles they play for their clients, according to two interviewees. Merlin described the role of bringing conscious awareness to one's own body:

We're placing an intentional attention on the body. We're noticing shifts in

our clients' bodies but also shifts in our own, because shifts in our own give

us a lot of information. Some of that information might have to do with countertransferential phenomenon that's taking place, but it also gives us information about how we are being located in relationship to our client.

The discussion of four (57%) participants highlighted this relationship between unconscious and conscious awareness. The following quote demonstrated participant views that the therapist's awareness of the client's experience can come through the therapist's unconscious mirroring of the client's body.

> [I was] mirroring, but not in a conscious way. I would do it like picking it up from the unconscious. And then there would be other things that I would start to be aware of…so that I could connect with them bodily. Then I realized that sometimes the trauma has happened so early that it's pre-verbal and that it needs to be addressed in a bodily way. (Alma)

A client's communication of traumatic material can happen on an embodied level, according to two (29%) participants. Explained Jeremy, "There's so much that occurs at that level that I think we're not capable of picking up on because it doesn't have words; it's a body to body communication."

Two participants also noted how they began to understand their clients' emotional experiences through increasing conscious attention to their own bodies. They described how awareness of their own bodies informed their clinical intuition.

> There will be moments in therapy where I would sit hunched over and will "bring my body" to a sit-up position. While doing this, I can have a countertransferential insight: "I sat hunched over probably because I felt some kind of fear and needed to protect myself" (Sarah).

The data showed that four (57%) participants had to learn how to use embodied countertransference by increasing their own body awareness. One participant described this process of increasing awareness, noting the questions she learned to ask herself in order to improve her body awareness in relation to her clients' bodies.

How much tension do I have? Where do I have the tension? How do I release the tension? And how do I sit? Oh, I started noticing many things in my body. When I would sit like this [upright] and when I would sit like that [hunched over]; when I would play with my hands; when and where I would have an itch. (Sarah)

Three (43%) participants noted instances in which their increased body awareness led them to sense material that their clients had not yet revealed. These participants described how attunement to their own experiences informed their countertransference. Alma stated:

Maybe I'm working with a client that's a lot up in the head and "blah blah blah blah blah blah blah" and at a certain point I get cold hands or I get cold feet maybe. That tells me that something is cut off.

Sarah also explained:

I felt my stomach then and I feel it now. I knew that something terrible happened to her body. I was sure of it. We didn't talk about it at that time, but there is no question in my mind.

Therapists' awareness of their client's bodies can help the clients gain an understanding of their emotional worlds, according to four (57%) participants. These participants subscribed to the theory of countertransference, in which the emotions held in

their client's bodies influence the clinician's bodily responses. One participant explained how he believed this theory helped his client gain emotional insights.

> A lot of our work that was very instructive for me was me describing what went on in my body; asking him if it had meaning for him and returning it back to him symbolically. You know, "I'm feeling this compression in my hand right now and this nervous fluttering in my stomach. Does that makes sense to you?" and he would sit and try and sort of track himself and what was going on and, over time, we've started with…"yep, maybe I feel a little bit of that", and over time he was able to reclaim that and begin to develop his own language in doing that. (Jeremy)

The subthemes of *awareness of client's body* and *somatic countertransference* helped explore somatic awareness and interventions. The data indicated participant awareness of the body-informed decisions around clinical interventions.

Theme 6: Relational enactments. Two participants discussed how past conflicts become enacted in the client-therapist relationship and reflected on how these enactments can benefit the client. Merlin discussed the function of the client-enacting relationships that exist outside of the realm of therapy (such as family- or school-based relationships) with the therapist. "What's being worked at there is [my client's] capacity to project onto me whatever role he wants and to play out different versions of how he exists in relationship to other people." Merlin gave an example of enacting the role of perpetrator in a session where an adoptive mother was present with her son. Their play explored themes of trust and resistance.

The play with both of them involved my being able to take on the role of the

controlling one, and we can use the word "perpetrator" but, of course, every

time I say that in this context it's as play. I'm playing out this role of

"somebody's out to get them" or "out to get him." Then, his adoptive mother

would be the one to come to his aid and come to his rescue, and rather than

Joseph resisting that, Joseph would over time allow himself to be a little boy,

to be cared for by his mother.

Jeremy expressed a similar view related to the therapist actively engaging in client

enactments.

I believe very strongly in this concept of enactment; that we get lost in the

woods with our patients and we don't know that we're lost at the time that

we're lost until we wake up and figure it out.

Both participants described the role of these enactments as a means of repairing fractured

attachments related to traumatic experiences. Jeremy discussed how he viewed the

enactment in the context of a therapeutic relationship:

For treatment to work, it has to not just be experience in the air, but actually

be an experience. I work a lot from the attachment paradigm. So a therapy

relationship in which rupture and repair happens over and over is really

essential.

Merlin talked about learning to embrace enactments as a means of healing damaged

relationships to self and others.

I was surprised but this was a piece emerging for me around trauma work,

which had to do with our revisiting and repairing and readdressing the harm

that has been caused to our relationships, and relationship to self, and

relationship to other.

Participants viewed relational enactments in the context of the client-therapist relationship.

They noted how a therapist's willingness to step into and play out a past role for the client

could be used to repair historic harm.

Theme 7: Creative interventions. All participants discussed the use of creative

interventions involving art, music, dance/movement, or narrative components in embodied

treatment of trauma. Interestingly, the creative interventions did not strictly align with the

creative modalities participants had identified. That is, all seven participants referenced

using creative modalities other than their primary modalities. Additionally, as addressed in

the theme *client-centered approaches*, participants noted they used different modalities based

on their clients' needs. The data indicated four subthemes of creative interventions: art,

music, dance/movement, and narrative interventions.

Subtheme 7a: Art. Analysis showed participants used art in the treatment of trauma.

They discussed art as a kinesthetic tool, as well as a tool to elicit imagery and symbolism.

The use of art as a kinesthetic tool emerged as a subtheme, wherein participants discussed art

as a means to help regulate the mind and body. Melissa described her views on the role of

art-making as a physical act. "Whenever you're cutting something, you're sewing

something, you're gluing something, that's still a kinesthetic engagement—it's not just

sensory; it's not just a unidimensional experience."

In addition to the physical elements of art, the data also showed participant beliefs

that symbolism and imagery could be used in the treatment of trauma. According to Melissa,

"The art materials are engaging and they promote symbolizing. With the two- and three-dimensional arts, you are creating an image for a symbol for something."

Similar to symbolism, participants highlighted imagery as a useful tool to cope with challenging aspects of trauma recovery.

I do a lot of visualizations and imagery. And I know from my own experience

that it helps me a lot while dealing with difficult issues. I know that for some

of the clients it has been very helpful. (Sarah)

Another participant highlighted her belief in the connection between symbolism and imagery. Laura noted, "Your images all symbolize different parts of you."

Subtheme 7b: Music. Participant music therapists, as well as participants in all other modalities, explored the use of music as a clinical intervention. All participants believed that music-based interventions could be used in treating trauma. Participants spoke about music in regards to expression, fulfilling a basic need, and as a metaphoric parallel to understand the body.

Music was discussed as a tool for communication and connectivity. One participant noted that music helped children with visual impairments develop relationships with each other and acted as a compensatory tool in relation to their disabilities. According to Sarah, "Music was a wonderful way for them to communicate and express their feelings. They loved listening to each other play. It sure gave them a lot. It was a real compensation. They couldn't see, but they could play."

Sarah continued, describing music as more than just amusement or adjunctive treatment; instead, she noted music's ability to fulfill a primal need in some children. "For

some children, it was comforting and they enjoyed playing music; for others, it was like breathing air for them—they needed the music as much as they needed to breathe."

For clients with specific trauma histories, the participants articulated the belief that music can be used to help bring their traumas to light and begin the healing process. Sarah stated, "The music was such a powerful tool in helping my clients to expose their traumas and deal with it."

Four (57%) participants discussed the body in relation to music. This included references to the body as an instrument and the "musical elements" of the body. Alma described how she experiences this relationship as, "I feel there are so many parallels in terms of bodily descriptions. Bodily parameters that are the same as musical parameters: body tempo, body rhythms, body flow, and body tension."

Therapists in other modalities turned to pre-composed music and percussion as a means of therapeutic treatment. Jeremy noted using music for embodied enactment as well as for use in relationship building.

> I use music…less playing, although I have a drums and stuff in my office that some kids really gravitate towards. We have some conversations of matching my rhythm, you know going back and forth with them. But I also like a lot of my kids—you know that they bring in music and we play it and we talk about it.

Two participants described clinical interventions where client needs led them into a music-based exploration in treatment. "He grabbed the drums—two big Congo drums—they were beautiful and he played them," Melissa said. Heather noted, "We added one of his favorite songs and that piece probably took several months of weekly therapy."

Participants spoke about multimodal creative experiences involving music. Laura, for example, noted that music could evoke images that could be used to work toward therapeutic transformations. Laura reviewed her client's description of music that stimulated images, bringing her client into a transformation in his body. "Actually, it's a piece of his music. And the music filled him with lights. The music came into those places into his chest and into his head and filled them with light."

Subtheme 7c: Dance/Movement. All participants referenced using dance/movement interventions in relation to trauma work. The semiotic nature of movement was explained in the relationship between movement and dance. Heather noted, "Movement is a primary language, and the dance is the expressive aspect or face of that."

Movement was mentioned as a primary means to address and process stored trauma memories.

I said it was important. [I said,] "I think this is part of your body that is

remembering and actually trying to get you through this memory of this

trauma and the torture. So let's play with this movement and let's not talk and

just to do the movement." (Heather)

The data showed that participants—across modalities—used movement to support their clients' needs. In the following example, Laura encouraged the expressive movement to which her client felt drawn.

I was guiding her about the pain and I asked, "What needs to happen with

your fingers? What does that pain need to do?" And she came through the

pain in a way of saying, "My fingers need to dance." And so, her eyes were

closed and she just started moving her fingers, and it's like, "Oh, this feels

really good."

Participants learned to use other modalities based on their clients' needs. Below, a

music therapist described the necessity of learning to use a new modality:

> I realized that, with some of my clients, I was missing tools because they did
>
> not want to play, but they expressed themselves in movement. And they
>
> didn't want to talk in particular, but they expressed themselves in movement.
>
> (Alma)

Subtheme 7d: Narrative. Analysis of the data showed the emergence of the

subtheme of *narrative interventions*. Three (43%) participants addressed that written and

enacted narratives could be used to creatively explore traumatic client material.

Two participants spoke about the function of helping the client find a narrative for

their traumatic experience, in either the enacted or the written form of narratives. Jeremy

said, "I've had kids work on their trauma narrative that way….I would give them periods of

time to write pieces of their trauma narrative," and Merlin expressed, "Part of the treatment

involves finding a way to talk about, finding a way to put to language, what the story is so

that [my client] can start to use that."

Although the exploration of narrative is beneficial, the client should have control over

when they share their stories, according to one participant. Jeremy stated:

> I think sometimes we have this notion that for therapy to be effective, the
>
> client has to share everything with us, and I think for some of my patients I
>
> just want them to go through the experience and they can choose when they
>
> want to share what's in their narrative—that's their choice.

Whereas two (29%) participants identified narrative as a beneficial component, one (14%) participant expressed concern for the overemphasis on narrative in treatment modalities such as CBT. Melissa ventured, "The cognitive-behavioral models are really driving towards the processing of the narrative that's more on the cognitive-verbal level. I worry that it has been doing harm and almost enabling a dissociation."

However, the cognitive-behavioral approach to narrative may differ from the creative use of narrative, as outlined by one participant. Merlin described how she felt the therapist could use awareness and attention to the client's narrative to therapeutic ends:

He will naturally resurrect the same scene over and over again and, as a therapist, my job then is to play the scene but just a little bit differently; to alter myself just a little bit; to pause, to notice him a little bit more; to notice something different that he is doing. That's the key to having a conversation and listening to somebody. They're saying something and you're taking it into consideration rather than continuing along with your narrative. But it's happening at the level of body.

Participants believed that the needs of the client should lead the use of creativity. In addition, explorations of art, music, dance, movement, and narrative emerged across participant modality and further supported the theme of *client-centered approaches*.

Summary

Creative arts therapies were used by these participants in embodied ways to treat psychological trauma. Seven participants shared their beliefs and experiences in this realm. Analysis of the data revealed seven themes and nine subthemes related to how creative arts therapists use embodied interventions to treat trauma. These themes were presented in the

two categories of factors in facilitation, and interventions. Tables 4 and 5 summarize the themes and subthemes that emerged with exemplary quotes.

The themes emerged following analysis of the interviews. Factors in therapeutic facilitation included participant belief that the treatment should be flexible according the client's needs and that safety is a key component in the treatment of trauma. Sociocultural frameworks were relevant treatment factors according to the data. Participants also highlighted their experiences that therapists require resources such as supervision, personal therapy, and creative outlets to conduct successful therapeutic treatment of trauma. Participants spoke about the experience of being aware of the client's body, as well as aware of their own bodies to inform somatic countertransference and the movement of this awareness into somatic interventions. Finally, the data illustrated interventions related to enactment in the client-therapist relationship and richly described creative interventions using art, music, dance/movement, and narrative.

Table 4. *Results of Data Analysis: Themes, Subthemes, and Exemplary Quotes. Themes 1-5: Factors in Facilitation*

Theme	Subtheme	Exemplary quote
1. Client-centered approach		"We want to be able to meet people where they are and that includes offering them a lot of options on how we are going to meet them." (Jeremy)
2. Safety		"Unless the body feels safe, they aren't safe." (Melissa)
3. Sociocultural factors		"The next level of professional development is figuring out what are the competencies of different cultures through their rituals and their practices in the communities." (Melissa)
4. Therapist resources		
	4a. Supervision	"Supervision is so crucial for somebody to say, 'That doesn't seem consistent to who you are,' or 'There's an odd feeling I get when you talk about this case.'" (Jeremy)
	4b. Therapy	"The body psychotherapy was the most helpful for me—even more than the personal music therapy that I received." (Alma)
	4c. Creative outlets	"I've always used dance for my own restoration." (Heather)

Table 5. *Results of Data Analysis: Themes, Subthemes, and Exemplary Quotes. Themes 5-7: Interventions*

Theme	Subtheme	Exemplary quote
5. Somatic awareness and interventions	5a. Therapist's awareness of client's body	"I would draw attention to their physical expression of distress, or the communication they were bringing into the room and invite them to then bring their attention there too." (Merlin)
	5b. Somatic countertransference	"I felt my stomach then and I feel it now. I knew that something terrible happened to her body. I was sure of it. We didn't talk about it at that time. But there is no question in my mind." (Sarah)
6. Relational enactments		"I believe very strongly in this concept of enactment; that we get lost in the woods with our patients and we don't know that we're lost at the time that we're lost until we wake up and figure it out." (Jeremy)
7. Creative interventions	7a. Art interventions	"The art materials are engaging and they promote symbolizing. With the two- and three-dimensional arts, you are creating an image for a symbol for something." (Melissa)
	7b. Music interventions	"The music was such a powerful tool in helping my clients to expose their traumas and deal with it." (Sarah)
	7c. Dance and movement interventions	"Movement is a primary language, and the dance is the expressive aspect or face of that." (Heather)
	7d. Narrative	"I've had kids work on their trauma narrative that way.…I would give them periods of time to write pieces of their trauma narrative." (Jeremy)

CHAPTER 5

Discussion

This study qualitatively examined how seven creative arts therapists used embodied interventions in their work with clients who have history of trauma. Analysis of the data revealed the seven primary themes that fell into the two categories of factors in facilitation, and interventions. Factors in facilitation included the themes of client-centered approach, safety, sociocultural factors, and therapist resources. The category of interventions included the themes of somatic awareness and interventions, relational enactments, and creative interventions. Additionally, the nine subthemes are discussed below within the context of the primary themes.

This second phase of the research was designed to expand understandings gained from the initial phase that focused solely on the experience of music therapists using embodied interventions with trauma. Whereas Phase One of the study and the majority of previous research conducted into the use of creative arts therapies with trauma used a single modality (Bensimon et al., 2008; Carbonell & Parteleno-Barehmi, 1999; Lyshak-Stelzer et al., 2007), the results from Phase Two of this study could become part of a larger trend toward exploring interventions across modalities.

Findings and Conclusions

Themes 1-4: Factors in facilitation. The themes of a client-centered approach, safety, sociocultural factors, and therapist resources primarily centered around factors relevant to therapeutic facilitation. These themes may be viewed as aspects that contribute to the direction or effectiveness of trauma treatment.

Theme 1: Client-centered approaches. Participants discussed the importance of
therapist flexibility and willingness to consider the client's needs over the therapist's
predetermined methodology, modality, or training. The data indicated that participants
believed overall therapist adaptability to be a key component to maintain a safe and trusting
relationship with the client. Such therapist attunement to client needs reflects a client-
centered approach to therapy. Client-centered therapy, also known as *person-centered*
therapy, originated in the 1940s and 1950s and is a foundational component of humanistic
psychotherapy. Rogers's (1951) writings about his theories on client-centered approaches to
therapy helped set the stage for the development of humanistic psychotherapy. Rogers
advocated for a nondirective approach wherein the therapist uses empathy, clarification, and
reflection to empower clients to become experts in themselves. Although the creative arts
therapies were not as well defined during the time Rogers was developing his theories, he did
address applications of client-centered approaches related to play therapy. Practitioners of
(Freudian) psychoanalysis and (Skinnerian) behavioral psychotherapy, the predominant
approaches at the time, widely criticized Rogers' theories (Benjafield, 2010). These
practitioners believed that Roger's approach lacked the depth (psychoanalysts) and structure
(behaviorists) needed to be effective in therapeutic treatment. However, the data in this
current study suggest that the participants used a client-centered approach as part of a larger
framework that may provide both depth and structure dictated by client needs.

Although participant views appear consistent with a client-centered approach, other
interpretations are possible. Recent approaches such as integrative and eclectic
psychotherapy may also explain the data. An integrative approach looks for common threads
across theoretical frameworks in an effort to unite a client's affective, cognitive, behavioral,

and physiological systems (Norcross, 2005, p. 9). Similarly, eclectic psychotherapy is not bound by specific theories or methods, and practitioners are free to use "what they believe or feel or experience tells them will work best, either in general or suiting the often immediate needs of individual clients; and working within their own preferences and capabilities as practitioners" (Norcross & Goldfried, 2005, p. 3). In the context of trauma treatment, client-centered, integrative, and eclectic approaches all appear to emphasize therapist responsiveness to client needs as a means of increasing safety and empowerment.

  Theme 2: Safety. The data showed participants emphasized safety in relation to trauma work. This study addresses safety in terms of helping the client establish a sense of control over the treatment, and trust in the therapeutic relationship. Herman's (1992) seminal book *Trauma and Recovery* helped establish understanding that safety is a crucial component in treating psychological trauma. Herman's theories contributed to the development of a phase-oriented model in which the therapist seeks to help the client establish safety and reduce trauma symptoms prior to actively delving into traumatic memories. This relates to this study's participant concept that it is important to be mindful of pacing in trauma treatment. A premature exploration of the details of a client's traumatic history may prove counter therapeutic and harm the client. Meekums (1999) used the term *vector catalysts* to describe conditions that determine whether a therapeutic intervention is helpful or harmful (p. 252). In her study, Meekums found that "unless the required level of perceived safety was present for the client, certain interventions could be positively harmful" (p. 253). A recent report published in the *Journal of Traumatic Stress* indicated that 84% of expert clinicians endorsed a three-phase approach to working with trauma: Phase I—Stabilization and symptom reduction; Phase II—Treatment of traumatic memories; and Phase III—

Integration into everyday life (Cloitre et. al., 2011). The relevance of pacing, establishing

trust, and supporting control noted in the data are consistent with the phase-oriented

approach.

> ***Theme 3: Sociocultural factors.*** An additional factor in participants' understanding
of clients' needs was the examination of the sociocultural factors that relate to both the client

and the therapist. Heather spoke about a clinical decision involving the question of touch in

therapy with a client from another culture. She felt that her decision to touch the client was

based on the cultural context of the client—although it was perhaps at odds with professional

ethics set forth in her country of origin. Heather described her dilemma in this way: "If I had

taken off my hand and if I had gone with the Western liability, I would have lost that

relationship right there and that ended up being the most profoundly healing relationship for

both of us." Creative arts therapists have begun to explore cross-cultural considerations such

as Heather's in regards to trauma treatment (Gray, 2001; Lahad, Farhi, Leykin, & Kaplansky,

2010). These theorists noted the importance of developing an approach in the context of the

client's culture.

> In addition to culture of origin, sociocultural factors such as race, class, and gender
may be important to consider in the treatment of trauma. Participants discussed ways in

which their clients' backgrounds may have affected their experience of trauma. For example,

Merlin noted, "[Trauma arises from] the toxic relentless trauma of poverty, ongoing racism."

Bryant-Davis (2007) stressed that additional training may be necessary to prepare trauma

clinicians to address factors such as race in relation to trauma rooted in identity. This is also

consistent with participant views that therapists have a responsibility to examine their own

sociocultural backgrounds in relation to those of their clients. Failure to address identity

factors such as race, class, or sexual orientation in therapy can lead clients to decrease trust in the therapeutic relationship and overall sense of safety (Cardemil & Battle, 2003).

Theme 4: Therapist resources. The data indicated that participants felt it was important for therapists to have access to resources such as supervision, personal therapy, and actively creative endeavors. Therapists working with trauma are at increased risk of vicarious traumatization, compassion fatigue, and caregiver burnout (Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Because of this, appropriate resources may play a crucial role in therapists' health and longevity in the field as well as in treatment efficacy.

Continued supervision (subtheme 4a) may be viewed in the context of advanced competencies in the creative arts therapies. Bruscia (1986) introduced the idea of advanced competencies in music therapy and conducted a quantitative study (Maranto & Bruscia, 1989) that surveyed music therapy educators, supervisors, and clinicians ($N = 27$) regarding their perceptions of advanced practices. They found that participants viewed "clinical supervision" to be among the most important development areas for advanced clinicians. Participants in the current study also indicated supervision was useful in processing client material and identifying therapeutic enactments. Bruscia and Maranto's findings supported the notion that embodied creative arts therapy interventions may be most appropriate for advanced-level clinicians. In addition, findings of the American Music Therapy Association's task force compiled to determine advanced competencies in music therapy concurred that advanced clinical supervision was a key component of advanced practices (American Music Therapy Association, 2009). The final section of this chapter further discusses this notion.

Therapists and mental health workers have shown an increased likelihood to have personal trauma histories (e.g., Elliott & Guy, 1993), making the question of personal therapy (subtheme 4b) more crucial. Although this current study contained no interview questions specifically related to the topic of personal therapy, three (43%) participants chose to speak about their own trauma histories in relation to the work. As explored in the discussion of countertransference, psychotherapeutic approaches in creative arts therapies can involve a close examination of how a clinician's emotional material relates to that of the client. Therefore, the results of this study raise the question of whether it may be an ethical responsibility on the part of trauma therapists to pursue outlets in which to examine their own histories.

Therapists who pursue their own therapy experience both professional and personal benefits. According to a qualitative study by Macran, Stiles, and Smith (1999), personal therapy for therapists promotes separating their feelings from their clients', taking care of themselves, knowing their boundaries and limitations, working at a deeper level, and increased authenticity.

Personal therapy may also allow clinicians to gain insights into their clients' experiences through an increased awareness of their own histories. The concept of the wounded healer, first discussed in psychotherapeutic literature by Guggenbuhl-Craig (1971), outlines the need for therapists to understand their own histories with woundedness. The data in this study revealed that participants embraced the notion that their own emotional material and histories were useful in understanding their clients. Austin (2002) explored the concept of the wounded healer as it relates to music therapy work with trauma:

Any therapist working in-depth is using herself, as well as the music as an

"instrument." This human instrument needs the continued "fine tuning" that

personal psychotherapy and/or supervision provide in order to achieve the

self-knowledge and self-awareness necessary to recognize and work

effectively with transference, countertransference, and other unconscious

dynamics that emerge in a therapeutic relationship. (p. 241)

Austin's quote supports the participants' views that a key to understanding the

client's material lies in the clinicians understanding their own personal material. For

example, participant Alma spoke of the powerful influence of her own embodied

psychotherapy treatment, which allowed her to understand what it felt like to be held and

sung to "like a *father* to a baby." Sarah identified the influence of her family's intense

history with trauma as well as the impact of living in a country where many traumas have

taken place. Melissa stated simply, "I think I've gone through a lot of training through my

own therapy." The literature corroborates the clinical usefulness of these participants' brave

self-examinations.

Participants identified the importance of finding a personal creative outlet

(subtheme 4c) for restoration, personal insights, and spiritual growth. Scholars have written

about creative involvement in terms of personal music making for the music therapist

(Hesser, 2001) and active art-making for the art therapist (Allen, 1992). Both Hesser and

Allen believed that personal creative endeavors are crucial resources in the pursuit of

becoming and continuing to be an effective creative arts therapist. Allen cautioned against

what she called "clinification" (p. 28), a process in which a creative arts therapist loses sight

of the integral nature of creativity in his/her practice. A recent article on the use of personal

creativity for creative arts therapist (Iliya, 2014) also mirrored participant views. Iliya stressed that engaging in the creative process is crucial not only for individual therapists' wellbeing, but also for the field as a whole to thrive. She noted, "The field of creative arts therapy will neither survive nor progress if creative arts therapists are not habitually engaged in the practice of creativity and art-making themselves" (p. 110).

Although the role of personal creativity in supporting and maintaining the ability to practice is a crucial component to the field, perhaps it is both more human and more important to examine first the impact art making has on the clinician as a person. Brown (2008) conducted an arts-based inquiry into the relationship between therapeutic work and personal art making. In addition to the positive aspects of creativity such as containment, contemplation, connection, and spiritual depth, Brown found that clinicians who had lost a process of active personal creativity were at increased risk for aspects of burnout such as disconnection from self, anger, depletion, and apathy.

Study participants acknowledged ways in which their own creative explorations were a part of their self-growth and sustainability in the field. Similarly, psychologist Stephanie Harter (2007) advocated for therapists to use visual art making as a means of self-care. Harter, who worked with sex abuse survivors, noted that therapy is a "creative engagement" between the therapist and the client (p. 167). She also included samples of her own visual arts creations that she used for both personal and professional processes. Another preliminary study supported the participants' views that creative endeavors can help sustain their work over time. Bittman, Bruhn, Stevens, Westengard, and Umbach (2003) conducted a quantitative examination ($N = 111$) into the use of recreational music-making to reduce caregiver burnout in long-term care workers. They found a statistically significant reduction

in "multiple burnout and mood dimensions" in the treatment group when compared with the control group (p. 4). Due to the psychological stressors placed on therapists who work with trauma clients, Bittman et al.'s study helps support the importance of creative endeavors to relieve stress and promote longevity in the field as noted by participants.

Themes 5-7: Interventions. The following themes of somatic awareness and interventions, relational reenactments, and creative interventions fall under the broader category of interventions. While it should be noted that all participant discussion of interventions also involves an awareness, the following three themes focus primarily on decisions and actions that take place inside the therapeutic sessions.

Theme 5: Somatic awareness and interventions. All participants noted the importance of maintaining an awareness of the client's body (subtheme 5a)—identification of embodiment—in their trauma work, and four (57%) noted the significance of sharing this awareness with the client. These participants discussed how they used creative elements to raise body awareness as a component of mind-body integration. P. A. Levine (2009, 2010b) explained that the body can store traumatic experiences and stressed the need for interventions that increase body awareness to help contradict a sense of helplessness and paralysis and restore a sense of well being. This finding contrasts with purely verbal psychotherapy approaches that may be ill equipped to address trauma in the body. For example, Koch and Weidinger-von der Recke (2009) noted that such conventional psychotherapists may not have the training to address trauma held on a body level. In addition to the above theories, other research supported the participants' views that increased awareness of the body benefits the treatment of trauma (Langmuir, Kirsh, & Classen, 2011; Parker et al., 2008).

Participants expanded their discussions of body awareness to include countertransference (subtheme 5b). Egan and Carr's (2008) study of somatic countertransference noted an inverse relationship to the amount of somatic countertransference experienced by the clinician and the frequency with which the clinician received clinical supervision. This, they suggested, may demonstrate that supervision buffers the experience of empathetic physical responses to clients. These results support the participant belief in the current study that therapists can attune bodily to the experiences of the client and underscore the importance of clinical supervision (discussed later in this chapter). However, Egan and Carr appear to have viewed somatic countertransference as a potentially harmful experience related solely to mirroring negative feelings on the part of the client, whereas participants in this study noted many of the benefits of being aware of somatic countertransference.

Dosamantes-Beaudry (2007) offered the following description of somatic transference, which differs from Egan and Carr's:

> The totality of the patient's bodily-felt experience and enacted behavior
> (experienced as bodily-felt sensations and expressed via bodily-felt expressive
> movement and through kinesthetic and kinetic images) that function as
> transitional objects for the patient and provide critical relational
> psychodynamic meaning that at the outset of treatment is un- known to the
> patient. (p. 76)

This definition aligns with the participant view that somatic countertransference can help clinicians decipher information clients are not capable of verbalizing. As participant

Jeremy noted, "There's so much that occurs at that level that I think we're not capable of picking up on because it doesn't have words—it's a body-to-body communication."

Theme 6: Relational enactments. As noted in discussions of countertransference, theories on the client-therapist relationship evolved considerably since the early days of psychotherapy. In early psychoanalytic approaches, for example, the therapist was believed to be a blank slate onto which the client could project personal material (Mitchell, 1995). Theories have progressed to now include greater emphasis on human interactions both in and outside the therapeutic space. Object Relations theory, for example, supports the notion that human beings relate to others during adulthood based on how they related to their families in infancy (Klein, 1952). Attachment theory furthered this idea, focusing on how people develop and maintain trust in themselves and others through relationships with their caregivers.

In the 1980s, relational theorists examined the nonverbal communication between infants and caregivers. These theorists noticed the importance of genuine relationships between two partners leading to the idea of intersubjectivity, which focuses on the sharing of subjective states between a client and therapist (Stern, 2004). Benjamin's (1990) concept of *mutual recognition* connects the concept of intersubjectivity with theories on attachment. Benjamin explained that the process of differentiation happens as the client gradually recognizes the therapist's "subjectivity, developing the capacity for attunement and tolerance of difference" (p. 34). This development of relational theories leads to participant descriptions of enactments that take place in therapeutic relationships. Participants viewed the interaction of the client material with that of the therapist to be a key component to repairing historic fractures. As Merlin noted, "This trauma happens in relationships and

therefore needs to be repaired in relationships." The data also showed a prevalent participant belief that fostering this relationship was the groundwork for developing safe and productive goals and objectives. Lambert and Barley (2001) shared a similar view, noting that the relationship should come before the technique:

> This is not to say that therapists should not focus on improving therapeutic techniques. The major points to be made here are that therapists need to remember that the development and maintenance of the therapeutic relationship is a primary curative component of therapy and that the relationship provides the context in which specific techniques exert their influence. (p. 359)

Theme 7: Creative interventions. Theorists in each of the individual creative arts therapies have written about the power of creativity in use with trauma (Austin, 2008; Johnson, 1987; Malchioldi, 2008). Further, creative interventions have been shown to be effective in treating multiple aspects of trauma (Bensimon et al., 2008; Carbonell & Parteleno-Barehmi, 1999; Lyshak-Stelzer et al., 2007).

Participants in this research identified creativity as a primary tool in the treatment of trauma. Because an inclusion criterion for this study required participants be practicing creative arts therapists, it is perhaps not surprising that the role of creativity in interventions emerged as a theme. One might expect a music therapist, for example, to believe that music is a powerful tool in therapeutic treatment of trauma. However, the data uncovered rich descriptions of how participants used creative elements in embodied treatment of trauma. Additionally, it was surprising to find the degree to which creative arts therapists from individual modalities spoke about using creative tools from other identified modalities. For

example, Jeremy, a drama therapist, spoke about a client bringing in meaningful songs. Laura, a music therapist, spoke about the role of imagery and movement. This may be due in part to the fact that three study participants have affiliations with universities that offer either expressive therapies or creative arts therapy degrees where multimodal and intermodal approaches are more encouraged. Although one of these three identifies as an expressive therapist, all participant interviews—regardless of the participant's degrees, professional identity, or affiliations—exemplified the cross-modality phenomenon. Possessing a clinical awareness that multiple creative factors may be effective in treatment appears to relate to the notion of client-centered approaches previously discussed.

Study participants discussed art (subtheme 7a) in terms of symbolism—a tool to elicit imagery and promote kinesthetic regulation in clients with trauma. Symbolism and art have a long history in the realms of analytic and psychodynamic therapy. Jung's (1958/2012) legendary *Red Book* emphasized how creation of and reflection on art can contribute to a complex understanding of the psyche.

Previous researchers have studied art in the treatment of trauma in areas such as pediatric PTSD (Chapman et al., 2001). Although that study found no statistical difference in the reduction of specific PTSD symptoms when comparing the experimental and control groups, they found evidence that the art therapy intervention contributed to the reduction of acute stress symptoms.

Two participants in the current study noted that music (subtheme 7b) often works well in conjunction with imagery. Some GIM theorists agreed with the participants' beliefs that imagery in conjunction with music is useful in working with trauma and the body. Blake and Bishop (1994) outlined the impact of imagery and music in the treatment of PTSD. In

addition, a 2002 study of imagery found GIM effective with clients who had what researchers described as a "high portion of psychiatric complaints" (Körlin & Wrangsjö, 2002, p. 3).

Participants noted that music could be useful in working with the body and emotions and as a tool in therapeutic transformation. For example, Sarah noted, "The music was such a powerful tool in helping my clients to expose their traumas and deal with it." Other clinicians and researchers have found similar themes. Austin's (2008) theories and research examined the use of music and specifically the voice in relation to trauma work. Studies such as Iliya and Harris (2015) expanded on Austin's theories in an examination of singing and grief and demonstrated that the creative use of the voice may help support expression of difficult emotions.

As with music, all study participants addressed dance/movement interventions (subtheme 7c). One way they explored dance/movement was as a means to access memories stored in the clients' bodies. Dance/movement therapists also discussed how movement-based interventions can help move through stored traumatic memories (Gray, 2001; Mills & Daniluk, 2002). Participants also talked about encouraging an exploration of client movements even if movement were not the therapist's primary art form. Meekums (2000), a dance/movement therapist, explored an approach that incorporates multiple creative arts therapy modalities to work with survivors of child sexual abuse. Therapists in other modalities and even other fields such as social work may be able to use movement and body-based interventions, according to recent research. B. Levine (2015) conducted a series of studies designed for use in creating a body-oriented intervention manual for verbal psychotherapists to use when working with trauma. However, any creative intervention with

trauma should be used with caution and specifically implemented by a trained creative arts therapist of that modality. As the manual has not yet been published, it remains to be seen whether Levine will sufficiently contextualize the limitations of these interventions that were designed to be used by verbal psychotherapists.

Three (43%) participants in this study spoke about both development and enactment of the client narrative as a component in trauma therapy (subtheme 7d). They discussed narrative as both a written format and a narrative enactment. A small study conducted by Carbonell and Parteleno-Barehmi (1999) supported the notion that narrative enactment can reduce elements of traumatic stress. The mixed-methods study examined the effects of group psychodrama techniques with girls coping with trauma. Members of the treatment group showed significant improvement in withdrawn behaviors as well as anxiety or depression when compared with the control group.

Therapists have discussed the benefits of narrative in a written sense (e.g., Dimaggio et al., 2003) where clients are encouraged to retell their own stories in written form. In addition, preliminary research has been conducted on the benefits of this type of expressive re-writing (Hoyt & Yeater, 2011). Producing a trauma narrative is a component of many cognitive-behavioral forms of intervention (Cohen, Mannarino, & Deblinger, 2006; Rynearson, 2001). Further, an increasing number of clinical studies that use storytelling and narrative with trauma survivors have been published (Fry & Barker, 2002; Meyer-Weitz & Sliep, 2005; Reisner, 2003). One participant in the current study discussed the dangers of overreliance on verbal narrative format in the treatment of trauma. This cautioning may be best seen in light of the differences between traditional verbal narrative—which has been theorized to lack access to traumatized portions of the brain—and the creative exploration of

narrative that may access embodied experiences as discussed above (Koch & Weidinger-von der Recke, 2009; van der Kolk, 1996).

Despite six (86%) participants identifying as connected with a primary creative modality, all participants spoke about the use of multiple creative elements in embodied treatment of trauma. Whereas therapeutic approaches to trauma that use multiple forms of creativity have been theorized (Johnson, 1987), very few studies addressed more than one specific modality. One exception is Meekums' (2008) autoethnographic study. Her study used poetry she created and visual images (photographs) to examine her own identity as a "wounded dancer." Although the study was designed in part to examine Meekums's arrival at the role of "counseling trainer," it may provide a useful template for a form of qualitative research across modalities.

The categories of factors in facilitation, and interventions divide the seven emergent themes in Phase Two of this study. In this section, these seven themes and nine subthemes have been examined in the context of the existing literature and research.

Limitations

To increase the dependability of this study's outcomes, this section examines the potential biases and limitations of this study. Following this is a discussion of the possible contributions of the results to the field of creative arts therapy. Finally, recommendations are made for the direction of future research related to the current topic.

Due to the nature of a semi-structured interview process, at times these interviews became more akin to discussions. Although the researcher made efforts to remain neutral in the questions, he sometimes reflected or summarized how he viewed the participants' comments. The researcher was previously acquainted with several of the interviewees, and

these participants may have developed notions of the researcher's theoretical leanings based on prior professional encounters, which may have influenced the content of their answers. Additionally, the researcher selected participants based on their credentials as creative arts therapists and an understanding that their work was in some ways embodied. Therefore, an uncovering of themes related to body and creativity in the results may have been, in some ways, predetermined.

Including data from Phase One in the analysis during Phase Ttwo led a greater representation of music therapists (43%) than those from other modalities. The researcher's familiarity with five of the seven participants prior to the study may have influenced the data. Participants may have unconsciously tailored their answers based on their knowledge of the researcher's interests or passions. On the other hand, participants with existing relationships with the researcher may have been more forthcoming due to familiarity and an increased sense of comfort. Although the sample represented a diverse range of demographics, six of seven (86%) participants lived and worked in the United States. This weakness may have resulted in part from snowball sampling. Whereas snowball sampling is useful in identifying clusters of specific professionals, it also may provide less diverse demographic samples (Atkinson & Flint, 2001). Additionally, only one male was represented in the sample. However, this is consistent with the gender breakdown in many creative arts therapy fields (e.g., American Music Therapy Association, n.d., Membership). Despite possible limitations in diversity, the sample represents highly qualified key informants for this qualitative study due to their years of experience ($M = 24$ years), knowledge of trauma and extensive professional development.

The researcher acknowledges the extent to which his professional philosophies and personal history with embodied trauma may have influenced his interpretation of the data. For example, the researcher trained in AMT, an approach that focuses heavily on understanding countertransference in the therapeutic setting. Therefore, he may have placed increased emphasis on participant statements related to this theme. In addition, although the inclusion of the peer reviewer helped reduce bias because she was in a different modality and from a different culture, initial professional discussions showed that the peer reviewer and researcher may be closely aligned philosophically. On one hand, including a peer reviewer from a contrasting philosophy—for example, one who supports cognitive behavioral approaches—might have helped further reduce bias in the analysis process. However, exploration of this topic is still relatively recent. The specific experience and knowledge base of the researcher, combined with the related background of the peer reviewer, may have contributed to the richness of the data found.

Implications

The participants in this study had a mean of 24 years of experience in the creative arts therapies field. They all spoke about engaging in aspects of professional development such as supervision, training, writing, and presenting. Given their levels of experience, it may be unrealistic and perhaps unethical to expect an entry-level creative arts therapist to adequately approach embodied creative arts therapy work with trauma. For this reason, the researcher cautions against interpreting the findings of this study as a "how-to" manual for creative arts therapists working with trauma. More contextualization would be needed to know when to make such recommendations to clinicians. Furthermore—although not specifically addressed in the study—based on participant interviews, the researcher assumes most study

participants identify their work as psychotherapeutic in nature. This is not necessarily true for members of the general creative arts therapy communities. In music therapy, for example, therapeutic approaches may align more closely with other professions such as occupational therapy, physical therapy, speech therapy, or therapeutic recreation (American Music Therapy Association, n.d. What is music therapy?). Creative arts therapists' professional alignment with other fields can vary greatly based on the creative modality, geographic location, school, or training program. The outcomes of this study are perhaps most representative of master's level or higher creative arts therapists who practice in a psychotherapeutic manner.

Recommendations

When examined in the context of clinical practice, the results of this study may contribute to the larger framework including supervision, advanced training, and personal therapy that may help prepare clinicians to engage in embodied creative psychotherapy interventions.

The seven themes and nine subthemes examined the areas of factors in facilitation and interventions and help present a rich exploration of the uses of embodied creative arts therapy interventions in trauma work. The study demonstrates many similarities across creative modalities and finds that all participants chose to include multiple forms of creativity in their interventions. Additionally, the themes of sociocultural factors, safety, and client-centered approach all point to the idea that participants support a flexible and individualized approach to trauma work based on the specific needs of the client.

The hope is that this study can serve as a basis to increase both dialogue and research related to multimodal approaches in trauma treatment. Although some theorists have

discussed the implications of multimodal creative arts therapy treatments in trauma (Johnson, 1987; Perry, 2014), very little trauma research exists with interventions using more than one creative modality. Future research might examine the effectiveness of a multimodal creative intervention on trauma.

Additionally, the study was designed to contribute to the literature on embodied and somatic interventions with trauma. Creative arts therapists have researched some aspects of embodiment (Chapman et al., 2001; Fagen & Wool, 1999; Gleadhill & Ferris, 2010; Volkman, 1993). These studies have demonstrated the capacity for creativity to be used with embodied symptoms, but there is still insufficient literature as to how this may be used effectively to treat trauma. Future research can continue to expand the knowledge base of embodied, creative interventions used in the treatment of trauma.

The qualitative nature of this study was designed to deepen an understanding of how creative arts therapists use embodied interventions with trauma. Upon comparison of the findings to the existing literature, several factors in the discussion section stand out as particularly relevant to the current exploration of embodied trauma treatment. Based on the findings of this study, the researcher recommends continued research into the idea that flexibility and individualized approaches may help increase the client's sense of safety in treatment. For creative arts therapists, this may mean opening to the possibility of using multiple creative modalities to meet the client's emerging needs. Therapists may use an increased awareness of the client's body, as well as somatic countertransference, to deepen an understanding of the client's process. Finally, therapists providing embodied trauma treatment may benefit from resources such as supervision, personal therapy, and creative outlets. The findings of this study increase understanding of the above areas of creative

embodied treatment as experienced by the seven creative arts therapy participants. It is

hoped that the study outcomes will contribute to future research into multi-modal creative

therapeutic treatment, client-centered approaches, and embodied trauma interventions.

APPENDIX A

INFORMED CONSENT FOR DOCTORAL RESEARCH

LESLEY
UNIVERSITY

29 Everett St., Cambridge, MA 02138

Doctoral Research Informed Consent

You are invited to participate in the research project titled "Embodied Interventions in The Creative Arts Therapy Treatment of Trauma." The intent of this research study is to examine the experience of creative arts therapists who use embodied treatment interventions with clients with trauma histories.

Your participation will entail being interviewed for up to one hour and a half, in person, via phone or video conferencing. Follow-ups to interviews may be needed to clarify or deepen understanding of initial interview responses.

In addition

- You are free to choose not to participate in the research and to discontinue your participation in the research at any time.

- Identifying details will be kept confidential by the researcher. Data collected will be coded with a pseudonym, the participant's identity will never be revealed by the researcher, and only the researcher will have access to the data collected.

- Any and all of your questions will be answered at any time and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation.

- Participation in this research poses minimal risk to the participants. The probability and magnitude of harm or discomfort anticipated in the research are no greater in and of themselves than those ordinarily encountered in daily life.

- If any problem in connection to the research arises, you can contact the researcher Brian Harris at 646-671-4865 and by email at bharris7@lesley.edu or Lesley University sponsoring faculty Dr. Michele Forinash at 617-349-8166, forinasm@lesley.edu. You may also contact the Lesley University IRB at irb@lesley.edu or through the IRB co-chairs, Robyn Cruz (rcruz@lesley.edu) or Terry Keeney (tkeeney@lesley.edu).

- The researcher may present the outcomes of this study for academic purposes (i.e., articles, teaching, conference presentations, supervision etc.)

My agreement to participate has been given of my own free will and that I understand all of the stated above. In addition, I will receive a copy of this consent form.

_____ __ _____ _____ _____

Participant's signature   Date   Researcher's signature   Date

APPENDIX B

SEMI-STRUCTURED INTERVIEW QUESTIONS

1. How long have you been a (dance/movement therapist, art therapist, music therapist, drama therapist and/or expressive therapist)?

2. Where did you study/train?

3. What kinds of psychological trauma have you worked with?

4. What kind of training or experience do you have in working with clients with trauma?

5. What are your treatment approaches when working with trauma?

6. Could you describe a situation in which you used an embodied intervention with a client who had a history of trauma?

7. What impact, if any, did you observe this intervention had on the client?

8. Do you employ creative elements outside your primary modality in the treatment of trauma?

9. What do you feel is the relationship between creativity and embodiment?

10. Is there anything else you would like to add that I haven't already asked you?

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