Spring 5-22-2021

The Need for School-Based Trauma-Informed Drama Therapy Interventions: A Literature Review

Nicole Ventura
nventura@lesley.edu

The Need for School-Based Trauma-Informed Drama Therapy Interventions:

A Literature Review

Capstone Thesis

Lesley University

Nicole Ventura

April 7, 2021

Nicole Ventura

Mental Health Counseling with a specialization in Drama Therapy

Tim Reagan, PhD, RDT, APTT

Abstract

In this capstone thesis, the author explores the availability and accessibility of school-based trauma-informed drama therapy interventions as a means to address the impact of adverse childhood experiences (ACEs). A significant amount of research exploring the impact of ACEs is focused on the long-term negative effects they have on adults, reflecting back on how the adverse childhood experiences impacted their continued development (Brown et al., 2009; Chapman et al., 2004). However, less attention has been paid to the impact of such experiences on children during their childhood. Rather than waiting for ACEs to turn into lifelong physical and mental health problems, programs that address these experiences and stressors need to be implemented at the school-age level. This gap in research reflects a lack of urgency in providing early intervention programing. Even less research has been conducted on the use of dramatic embodied play as a stress-reduction intervention with school-aged children. Through my research, this writer has learned that there are school-based social-emotional learning programs, school-based trauma-informed programs, and school-based drama therapy programs, but only one that combines all three components. This paper concludes with a discussion advocating for the wide-spread adoption of The Miss Kendra Programs as a school-based, trauma-informed, social-emotional learning program that is rooted in the drama therapy technique of DvT.

Keywords: adverse childhood experiences (ACEs), drama therapy, developmental transformations (DvT), embodiment, play, school-based intervention, trauma-informed, social-emotional learning (SEL)

The Need for School-Based Trauma-Informed Drama Therapy Interventions

Introduction

This thesis will identify and explore the availability and accessibility of school-based support programs and argue the need for school-based trauma-informed drama therapy intervention programs. The topics under consideration are adverse childhood experiences (ACEs) and the efficacy of school-based social-emotional support programs, trauma-informed programs, and drama therapy programs. Finally, this literature review will argue why the Miss Kendra Programs are the most effective school-based program in addressing ACEs and toxic stress. Racial and locational considerations and inequities will also be discussed.

ACEs are broadly defined as stressful or traumatic events that people experience early in life, and include all forms of physical and emotional maltreatment, sexual abuse, neglect, and exploitation, as well as experiences such as witnessing domestic violence, parental divorce or incarceration, and caregiver alcohol or drug or substance abuse disorders (Felitti et al., 1998). A significant amount of research exploring the impact of ACEs is focused on the long-term negative effects they have on adults, reflecting back on how the adverse childhood experiences impacted their continued development (Brown et al., 2009; Chapman et al., 2004; Westermair et al., 2018). However, less attention has been paid to the impact of such experiences on children during their childhood. Rather than waiting for ACEs to turn into lifelong physical and mental health problems, programs that address these experiences and stressors need to be implemented at the school-age level. This gap in research reflects a lack of urgency in providing early intervention programing. Even less research has been conducted on the use of dramatic embodied play as a stress-reduction intervention with school-aged children. This niche is where the bulk of my research lies.

Adverse childhood experiences are unfortunately prevalent for today's youth, even more so with the various restrictions in place due to the COVID-19 pandemic (Bryant, Oo, & Damian, 2020). ACEs impact the social, emotional, behavioral, mental, and academic development of a person. In a September 2020 interview, Dr. Nadine Harris Burke said, "Educators can deliver the daily doses of healing interactions that truly are the antidote to toxic stress" (Merrill, 2020). Drama therapy, especially the approach of developmental transformations (DvT), is grounded in embodiment, encounter, relationships, and play. This type of communication is age appropriate for school-aged children and often more accessible than verbal communication. Therefore, it is my belief that all school districts should adopt trauma-informed drama therapy interventions.

This writer has learned that there are school-based social-emotional learning programs, school-based trauma-informed programs, and school-based drama therapy programs, but only one that combines all three components. The Miss Kendra Programs is a school-based, trauma-informed, social-emotional learning program that is rooted in the drama therapy technique of DvT. Over the past year, this writer has had the privilege of interning at the flagship location of the Miss Kendra Programs and have seen the efficacy of the interventions firsthand.

Children communicate differently than adults, and verbal communication can be complicated, especially for younger students.

> Many of our kids have been told that they are the problem. Helping them to understand that what’s going on in their bodies is actually a normal response to the abnormal circumstance that they find themselves in, giving them tools to understand how to calm themselves down, how to keep themselves safe, how to connect with nurturing relationships—I’ve seen it be life-changing and life-saving. (Merrill, 2020)

Using embodied practices as stress reduction techniques, such as recess, mindful meditation, yoga, progressive muscle relaxations and release therapy have been found to be helpful in alleviating tension caused by ACEs in children (Pitre, Mayor, & Johnson, 2016). However, these techniques do not address traumatic events or experiences head-on. Drama therapy has historical success with this population, especially when it comes to the alleviation of stress (North American Drama Therapy Association, n.d.). The use of drama therapy, specifically a trauma-informed approach such as DvT, allows for children to express themselves through embodiment, enactment, and interpersonal play.

As stated above, the need for early intervention in the addressing of ACEs is crucial to the healthy development of a child. This research is relevant to the field of mental health and drama therapy because early school-based interventions could dramatically decrease the number of untreated childhood mental health difficulties which would in turn decrease the number of mental health difficulties in adults. Implementing an accessible and playful approach to mental health and trauma will allow children to develop the language necessary to communicate their complications and worries while also helping them develop healthy coping skills and resilience. The information and data compiled in this literature review will hopefully inspire school districts to adopt an early intervention trauma-informed, social-emotional learning program that implements drama therapy as the primary means of communication and growth. The Miss Kendra Programs are the most effective of such programs, incorporating all components of the topics above.

The following literature review is divided into five sections expanding on the topics under consideration. Those sections will explore adverse childhood experiences, drama therapy and embodied play, various school-based support programs, Miss Kendra Programs, and

multicultural considerations that will summarize any discrepancies in care and support due to location, race and/or ethnicity.

Literature Review

Adverse Childhood Experiences

Impact on Adults

Unaddressed adverse experiences in childhood have lifelong repercussions. Extensive research on these impacts has been well documented, but full exploration of the topic is out of the scope of this literature review. This writer will highlight the findings of Chapman et al. (2004), Brown et al. (2009), and Westermair et al. (2018) to briefly summarize the mental, physical, and behavioral effects adverse childhood experiences (ACEs) could have on adults.

Chapman et al. (2004) write about how childhood experiences of witnessed or firsthand abuse, neglect, and other household dysfunction can attribute to the development of several psychiatric disorders including posttraumatic stress disorder (PTSD), borderline personality disorder (BPD), dissociative disorders, and depressive disorders. The researchers surveyed 9,460 adult members of the Kaiser Health Plan, with a median age of 57. The survey specifically asked participants to report on adversities experienced in their first 18 years of life covering topics of emotional abuse, physical abuse, sexual abuse, domestic violence, household substance abuse, parental separation or divorce, criminal household members, and mental illness in the household (Chapman et al., 2004). The data supported a strong correlation between ACEs and lifetime and current psychiatric disorders, specifically depressive disorders. Chapman et al. (2004) conclude, “Prevention of ACEs and early treatment of persons affected by them will likely substantially decrease the serious burden of depressive disorders” (p. 223-224).

Brown et al. (2009) examine the relationship between ACEs and premature mortality. Similar to the Chapman et al. (2004) study, Brown et al. (2009) use data collected from a pool of 17,337 adult members of the Kaiser Health Plan. The initial data were collected between 1995-1997 and follow-ups were conducted in 2006. The baseline data were then compared with data from the National Death Index (NDI). Heart disease and stroke, cancer, diseases of the nervous system, diseases of the respiratory system, and diseases of the digestive system were responsible for 90% of all deaths among the study participants. Overall, 1,539 participants died during the follow-up process "with an average YLL [years of life lost] of 10.4 years per death" (Brown et al., 2009, p. 393). Astoundingly, individuals who experience six or more adverse childhood experiences died nearly 20 years earlier than individuals without ACE exposure.

Westermair et al. (2018) also look at the physical impact ACEs have on a person, while also exploring the correlation between toxic stress and the increase of high-risk and/or maladaptive behaviors. Data were collected from 396 psychiatric in-patients via an ACEs questionnaire. Childhood household dysfunction was connected to higher rates of smoking, alcohol dependency, obesity, self-harm or suicide, eating disorders, and difficulty with emotional regulation. Childhood maltreatment resulted in higher rates of social phobia, contributing to isolation, dysregulation of bodily sensations, and underdeveloped interpersonal skills.

Impact on Children

As stated and presented above, a significant amount of research exploring adverse childhood experiences is focused on the long-term negative effects they have on adults. Bethell et al. (2014) specifically address the impact ACEs have on children while still in childhood and assess the impact those experiences have on development, school success and engagement. They also focus on the importance of building resilience as a means to manage and improve the effects

of ACEs. In their study, Bethell et al. (2014) use data from the 2011-12 National Survey of Children's Health, which collected information on over 95,000 children between the ages of zero and 17 regarding exposure to nine adverse childhood experiences listed in Table 1. Their findings, derived from the statical evaluation of the prevalence of ACEs compared to various health-related variables, show that the negative impact of adverse childhood experiences does, indeed, begin in childhood. In fact, "forty-eight percent of US children have had at least one of the nine key adverse childhood experiences evaluated in the NSCH. This translates into an estimated 34,825,978 children nationwide" (Bethell et al., 2014, p. 2109). The data suggests that the alleviation of immediate stressors brought on by exposure to ACEs can ultimately yield long-term developmental benefits.

Table 1

ACEs Examined

Adverse Childhood Experience
1. Experience of extreme economic hardship
2. Parental divorce or separation
3. Living with someone with an alcohol or drug problem
4. Witnessing or being the victim of neighborhood violence
5. Living with someone who was mentally ill or suicidal
6. Witnessing domestic violence
7. Having a parent serve time in jail
8. Being treated or judged unfairly due to race or ethnicity
9. Death of a parent or primary caregiver

Note. Nine ACE exposures examined against data from the 2011-12 National Survey of Children's Health (Bethell et al., 2014).

Blodgett and Lanigan (2018) also collected data specific to children's experiences of ACEs by employing school staff and personnel as reporting agents. Staff reported results from a

10-item ACEs questionnaire for a sample of 2,101 children, ranging from kindergarten through sixth grade, across ten schools. Staff was given training on how to administer the survey and how to handle varying degrees of disclosure. Based on the data, tables were created to compare the reported ACEs to (a) school performance, (b) academic failure, (c) attendance concerns, and (d) behavioral concerns. "Burke and colleagues (2011) found that as ACE exposure increased, learning and behavior problems in schools also increased" (Blodgett & Lanigan, 2018, p. 138). More specific data regarding demographic and ACEs exposure were also collected, showing a higher prevalence of adversities for non-white student. These findings will be further discussed in the Multicultural Considerations section of this literature review. Overall, the study confirmed that ACEs exposure "within the general elementary school population is very common" (Blodgett & Lanigan, 2018, p. 145).

Zeng et al. (2019) examined the impact of ACEs on a population even younger than elementary school-aged children: preschool. These authors compare preschool suspension and expulsion rates to parent-reported ACEs exposure in conjunction with the 2016 National Survey of Children's Health. "Children with early suspension and expulsion experiences are more likely to encounter academic failure and grade retention, hold negative school attitudes, dropout of high school, and be involved in juvenile justice systems" (Zeng et al., 2019, p. 2). In addition to these future repercussions, preschool children who are suspended or expelled are also being removed from crucial early developmental social and emotional interactions which could result in future behavioral and interpersonal complications.

Given the data supporting the prevalence and exposure of adverse childhood experiences on children of all ages, society should be working on providing accessible, trauma-informed school-based programming that increases social and emotional learning to help those children

build resilience and coping skills before they develop lifelong mental or physical problems. It is important to implement a cultural norm of open conversation surrounding mental health and ACEs in order to decrease feelings of shame and/or guilt. Based on the above research, early identification and supportive intervention of ACEs is extremely important in improving the academic success and overall health of children who have experienced traumatic events (Bethell et al, 2014; Blodgett & Lanigan, 2018; Zeng et al., 2019).

Impact of the COVID-19 Pandemic

At the time this literature review was written, the COVID-19 pandemic was still very active. Schools across the nation have been operating either fully in-person, in a hybrid or cohort model, or remain completely remote and virtual. Bryant et al. (2020) present a speculative argument for the increase of ACEs exposure due to the coronavirus pandemic. "According to the Administration for Children and Families more than 78% of child abuse and neglect is perpetrated by the children's parents; the same parents they are now in social isolation with" (Bryant et al., 2020, p. S193). In addition to being victims, these children might also be subject to witnessing abuse or neglect on other members of their household. On a broader scale, the economic impact and the increased levels of toxic stress could also contribute to higher rates of ACEs. Future research must be conducted to track the prevalence of these potential adversities. For now, it is crucial to provide all children with accessible, trauma-informed, and embodied care before these exposures lead to lifelong social, emotional, behavioral, and mental complications.

Drama Therapy and Embodied Play

The North American Drama Therapy Association (NADTA; 2021) defines drama therapy as "the intentional use of drama and/or theater processes to achieve therapeutic goals. … an

embodied practice that is active and experiential" (para. 1). Drama therapy in the United States was established in 1979, but is still relatively underrepresented in the overall field of psychotherapy. It serves all populations, addressing a wide range of clinical disturbances, and has various approaches that focus on different core principles. The commonalities between the various approaches are the ideas of embodiment, play, and interpersonal relationality. Drama therapy is a rehearsal of life, wherein clients can rewrite past experiences, gain new insight or perspectives in the here and now, and explore future possibilities.

Jones (2007) states, "Embodiment in dramatherapy involves the way the self is realized by and through the body. The body is often described as the primary means by which communication occurs between self and other" (p. 113). Drama therapy differs from talk therapy by engaging the entire body. Gross and fine motor skill development are among the first major milestones for infants (Broderick & Blewitt, 2014). We learn to communicate with our bodies before we are able to articulate our needs and wants through language. "Drama therapy provides a developmentally appropriate means of processing events with children and adolescents for whom verbal methods alone may be insufficient" (NADTA, n.d.).

Developmental Transformations

Developmental transformations (DvT) is an approach of drama therapy that was gradually created by David Read Johnson and colleagues between 1974 and 1992. It is based on the principle that life is unstable. Instead of trying to fix the instability, DvT aims to help the client become more comfortable with and tolerable of said instability. This is attained by the development of coping skills and resilience through improvisational play and embodied encounter. As people, we exist in relationship to others. Even those who have been abandoned or choose to live in isolation have been abandoned *by* someone or are isolating *from* someone.

Within DvT, the therapist, or playor, is an active participant within the therapeutic relationship and enters the imaginal world of the mutually agreed-upon playspace with the client, or player. "The client has nothing to play with except the therapist" (Johnson, 2009, p. 96), making the encounter highly relational and extremely intimate. The playspace is the "container of the entire therapeutic action" (Johnson, 2009, p. 93) that defines the discrepancy between real and representational or imaginal interaction and encounter. DvT can be practiced with an individual client, within a group setting, and with a community at large to address collective trauma. A skilled playor picks up on emergent images and themes within the playful encounter, notices and names any trends they see, and creatively challenges the player to expand their comfortability and role repertoire.

In 2016, Pitre, Mayor, and Johnson wrote about the efficacy of short-form developmental transformations as a trauma-informed, school-based stress reduction technique. For this drama therapy intervention, students are removed from their classrooms for a period of roughly 15-20 minutes in order to "play" with a trained drama therapist. The drama therapist aims to raise the anxiety of the student by presenting a series of behaviors such as "approaching, avoiding/ignoring, insults/criticism, attempts to control, being ill/drunk, being dependent or being sly/manipulative/seductive" (Pitre, Mayor, & Johnson, 2016, p. 173). Activations and reactions to the stimuli are then noted and the play is deepened surrounding the specific behavior. As stated earlier, less complex stress reduction approaches such as recess, mindful meditation, yoga, progressive muscle relaxations and release therapy are discussed as a means of comparison, but do not utilize a trauma-informed lens (Pitre, Mayor, & Johnson, 2016).

At the 2019 NADTA conference, Pitre, Davis, and Johnson expanded on the 2016 stress reduction study by turning their focus to using a distinct six-role sequence, presented in Table 2,

to screen for toxic stress and possible ACEs exposure. Again, these play assessments would happen during the school day, lasting roughly 20-30 minutes. Prior to the play, the drama therapist conducts a brief verbal inquiry regarding the child's home life (ex. who they live with, who does not live with them, if anyone in the house is sick or unwell, etc.). Even if the child does not explicitly disclose their victimhood or witnessing of physical, emotional, or sexual maltreatment, neglect, or other household dysfunction, their body will produce a subconscious response (ex. fight, flight, freeze, fawn) to the roles presented in the sequence within the play. That activation will signal to the drama therapist that the child has been exposed to the relating key stressor(s). It is critical to establish a playspace to help the child differentiate between reality and play. Follow-up verbal inquiry with the child, their caregiver(s), or the school can then be used to gather further details of the child's specific situation and address any reportable offenses. Future play sessions would then use imaginal exposure within the dramatic frame to help the child find comfortability within their instability through the development of coping skills.

Table 2

Six Roles in the Sequence

Role	Key Stressor
Injured person	Exposure to someone who has been harmed
Needy and demanding person	Being asked to fulfill the needs of another person
Neglectful person	Exposure to emotional neglect and lack of care
Intoxicated person	Exposure to the unpredictability of an adult under the influence
Seductive/manipulative person	Exposure to an untrustworthy/unsafe person
Threatening person	Exposure to physical harm or verbal abuse

Note. Sequence of six roles to assess for toxic stress and possible ACEs exposure (Pitre, Davis, Johnson, 2019).

The *Developmental Transformations Text for Practitioners: Number Two* (Johnson, 2013) outlines the training requirements and expectations for those who intend to practice DvT. There are two levels of training. Level One takes roughly a year to complete and consists of 10 monthly trainings, of which a minimum of eight are required. Training happens under the guidance of a DvT supervisor and students are expected to achieve a "solid familiarity with DvT methods and theories, and be able to lead individual and group sessions with supervision" (Johnson, 2013, p. 97). Experiential training, both as a playor and player, assists in the understanding of the main competencies. In order to graduate to Level Two, students must pass the Level One test and submit a written report of an individual session and a group session that documents the student's knowledge of DvT concepts and methods as well as personal reflections. "The aim of Level Two training is to achieve proficiency in individual and group work, in teaching and supervising DvT, and achieving the maximum benefit from personal work in the practice" (Johnson, 2013, p. 98). This level takes roughly two years to complete, involving a minimum of 16 training sessions, involvement in personal DvT therapy, and two written papers that demonstrate a deep understanding of DvT practice. As Sajnani (2014) notes, "training focuses on one's abilities to use themselves and their capacity to communicate in subtle ways, through their own bodily movement, speech, sounds, gaze, and personality" (para. 3).

School-Based Support Programs

> An understanding of ACE risk is not only useful for the most vulnerable children but may also be productively used to understand and respond to children who struggle with academic success as a critical developmental process but who may never be formally diagnosed or referred for services. (Blodgett & Lanigan, 2018, p. 141)

Children spend the majority of their time in schools, so in terms of accessibility, it would make most sense to implement a school-based support program to help address any ACEs, traumatic events, or other stressors that might impact a child. “Specific barriers to services such as transportation and stigma can be reduced, and required parent participation is kept to a minimum” (Langley et al., 2015, p. 869). School social workers and teachers play an important role in creating supportive and safe-enough school environments. Having properly trained mental health and trauma-informed personnel in schools can decrease behavioral issues and increase academic performance across the student body. School social workers have the unique opportunity to act as a supportive bridge that connects the student to resources both inside and outside a school environment. They are advocates who "engage students by viewing their behaviors as contextual to their home and school environments" (Cuellar & Mason, 2019, p. 25). In an attempt to account for the voices and opinions of school social workers with regard to school safety, Cuellar and Mason (2019) used an ethnographic approach via an anonymous electronic questionnaire. In additional to addressing their thoughts on safety, participants highlighted the importance of "mental health and trauma-informed training and services that include trauma reduction-informed services in the schools and for local community partnerships to address school safety" (Cuellar & Mason, 2019, p. 28). Participants also advocated for all school personnel to be trained in mental health and wellness interventions to increase overall safety and to combat the current 1:1,500 student-to-social workers ratio (Cuellar & Mason, 2019).

Lindo et al. (2014) explore the use of teacher-child relationship building (TCRB) and child-centered play therapy (CCPT) as methods of addressing the mental health needs of school-aged children. TCRB aims to alleviate stress from individual school social workers and guidance

counselors who are traditionally already overwhelmed by the number of students they need to support. CCPT is a particularly helpful approach as "children use play as their natural form of communication and express their thoughts, feelings and experiences" (Lindo et al., 2014, p. 285). Lindo et al. (2014) used a phenomenological approach to access teacher perceptions regarding the effectiveness of TCRB. Eighteen pre-kindergarten teachers from an early learning academy in the southern United States each conducted four 30-minute individual sessions with a struggling student. Data were collected via a post-intervention interview and concluded that teachers believe a strong teacher-child relationship and the use of play minimizes social, emotional, behavioral, and academic difficulties within the classroom. School-based interventions have a positive impact on a student's social, emotional, behavioral, and academic success, yet many schools rely on a single social worker or counselor instead of engaging teachers or outside specialists. More schools need to implement such supportive programs.

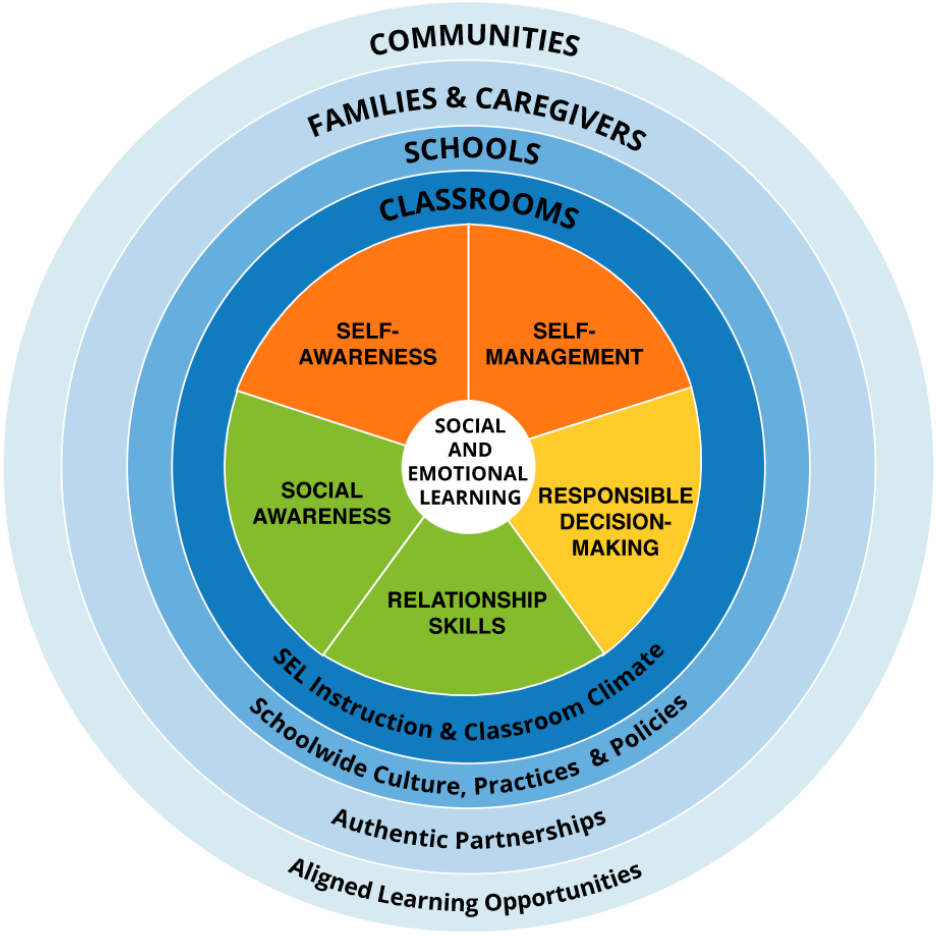
Social-Emotional Learning (SEL) Programs

More often than not, children struggling with toxic stress and ACEs exposure have behavioral difficulties and are labeled as being disruptive or a handful. By acknowledging the stressors that take place outside of school within a school-based program, mental health and school-based professionals can begin to holistically address the needs of the student. That is where social-emotional learning programs come into play. The Collaborative for Academic, Social, and Emotional Learning (CASEL) seeks to provide support and resources to educators working with students from preschool through high school. However, development does not happen within a vacuum. “We believe it is most beneficial to integrate SEL throughout the school’s academic curricula and culture, across the broader contexts of schoolwide practices and policies, and through ongoing collaboration with families and community organizations”

(CASEL, 2021, para. 6). The CASEL Wheel, shown in Figure 1, outlines the four key settings and the five main competencies of social-emotional learning. Integrating the concepts of self-awareness, self-management, social awareness, relationship skills, and responsible decision-making into the everyday curriculum will give students the tools for "academic success, school and civic engagement, health and wellness, and fulfilling careers" (CASEL, 2021, para. 4).

Figure 1

CASEL Wheel



Note. CASEL Wheel covering the five main social-emotional learning (SEL) competencies and the four key settings (CASEL, 2021).

Trauma-Informed Programs

The National Child Traumatic Stress Network (NCTSN) advocates for school systems as a whole to adopt a trauma-informed framework to better support students, employees, and the community at large. This type of framework requires constant collaboration and communication between all parties to ensure that the students have mental and emotional supports in addition to the traditional academic assistance. The NCTSN (2017) defines a trauma-informed school as, "one in which all administrators, staff, students, families, and community members recognize and respond to the potentially negative behavioral, relational, and academic impact of traumatic stress on those within the school system including children, caregivers, teachers, other school staff, as well as on the system itself" (p. 4). As previously mentioned, development does not take place in a vacuum, and the correlation between exposure to traumatic events and the level of academic achievement is clear. Trauma-informed schools provide an arena for children to openly share their struggles and traumatic exposures, receive convenient support within the school system at no cost, and gain psychoeducation on the normative emotional and behavioral reactions trauma has on the brain and body to better understand why they feel or act a certain way. Meeting the child where they are, rather than enforcing blind disciplinary action, will give them the opportunity to gain a better understanding of self and give them the vocabulary to articulate exactly what it is that is blocking them from academic and social achievement.

Bounce Back is one such trauma-informed program (Langley et al., 2015). Bounce Back takes on a trauma-focused cognitive behavioral (TF-CBT) approach, implementing the Cognitive Behavioral Intervention for Trauma in the Schools (CBITS). In a study conducted by Langley et al. (2015), 74 children ranging from first to fifth grade participated in 10 TI-CBT group sessions, two to three individual sessions, and one to three parent education sessions. All sessions took

place within the school day. Data were collected via parent and child reports to assess symptoms of posttraumatic stress, anxiety, and depression at baseline, three months, and six months. Interventions included, "psychoeducation, relaxation training, cognitive restructuring, social problem solving, positive activities, and trauma-focused intervention strategies, including gradual approach of anxiety-provoking situations and trauma narrative" (Langley et al., 2015, p. 858). The data showed a significant reduction in symptoms, further supporting the need for trauma-informed school-based programming.

Drama Therapy Programs

School-based drama therapy (SBDT) has been used across all grade levels serving various populations. Mayor and Frydman (2019) explored the prevalence and practice of SBDT programs across North America and found "there is a clear research focus on the detrimental impact of trauma on both child development and academic success, and the potential for drama therapy to help students process and express their experiences of harm and re-engage in the school" (Mayor & Frydman, 2019, p. 9). In order to understand the scope and scale of SBDT, a web-based survey composed of a maximum of 70 questions was sent to NADTA members between February and July of 2018. Data were collected on demographics, employment, organizational information, perceived impact of SBDT, individual practice, and challenges in service delivery (Mayor & Frydman, 2019). The bulk of students being serviced were enrolled in elementary, middle, and high schools, with some participation within preschools and colleges. This scope of engagement proves the versatility and flexibility drama therapy offers in addressing the various developmental needs of students.

Sajnani et al. (2019) use collaborative discourse analysis to compare three school-based drama therapy interventions: ENACT, Creative Alternatives of New York (CANY), and

Animating Learning by Integrating and Validating Experience (ALIVE). ENACT, based in New York City and Los Angeles, utilizes a trauma-informed and strengths-based approach, and practitioners act on the assumption that all participants have experienced some form of trauma. Teaching artists, often paired with a drama therapist, perform relatable scenes that act as a springboard to spark conversation with the students. It is important to note that the teaching artists are "purposefully matched to schools by ethnicity, culture and neighbourhood in order for students to see themselves reflected within the scenes" (Sajnani et al., 2019, p. 30). The scenes typically present a conflict and conclude at the climax, inviting students to then engage and make a choice as to how the scene should proceed. A post-scene discussion helps the students process the witnessed enactment. CANY, originally founded at Mt. Sinai Hospital in New York, is a trauma-informed drama therapy program grounded in the following principles: "metaphor as healing tool, group as therapeutic agent, and creativity as health" (Sajnani, et al., 2019, p. 33). Operations ceased in 2017, but the model continues to be taught and practiced. The work is based in projection and collaborative story creation. "CANY works from the assumption that creativity is an indication of mental well-being. Through creation, new roles, relationships and behaviours are imagined, allowing for a shift in how the individual experiences self and others" (Sajnani et al., 2019, p. 33). ALIVE, now known as the Miss Kendra Program, began in New Haven, CT and is now being implemented in multiple cities across 10 states in the USA, with an additional four states in program development. Also trauma-informed, this approach is designed to help the school community at large, addressing the ripple effect trauma and toxic stress can have on a student. Programming is implemented in small classroom groups and through individual student pull-outs. "Too often, systems wait until children begin acting out before referring them to get support. ALIVE is a preventative approach that focuses on attending to

students' stresses before they exhibit distressing symptoms and behaviours, in order to facilitate their ability to learn" (Sajnani et al., 2019, p. 36). The classroom-based interventions focus on the Legend of Miss Kendra and address a specific list of traumatic situations children could possibly be exposed to. Counselors explicitly engage the students in these difficult conversations and provide them with language and appropriate coping skills. The individual play sessions use short-form DvT as a stress reduction technique (Pitre et al., 2016). The majority of SBDT practitioners (39%) reported using developmental transformation as their primary drama therapy approach. Only 4% of respondents use ENACT and 2% of respondents use CANY (Mayor & Frydman, 2019, p. 17).

Miss Kendra Programs

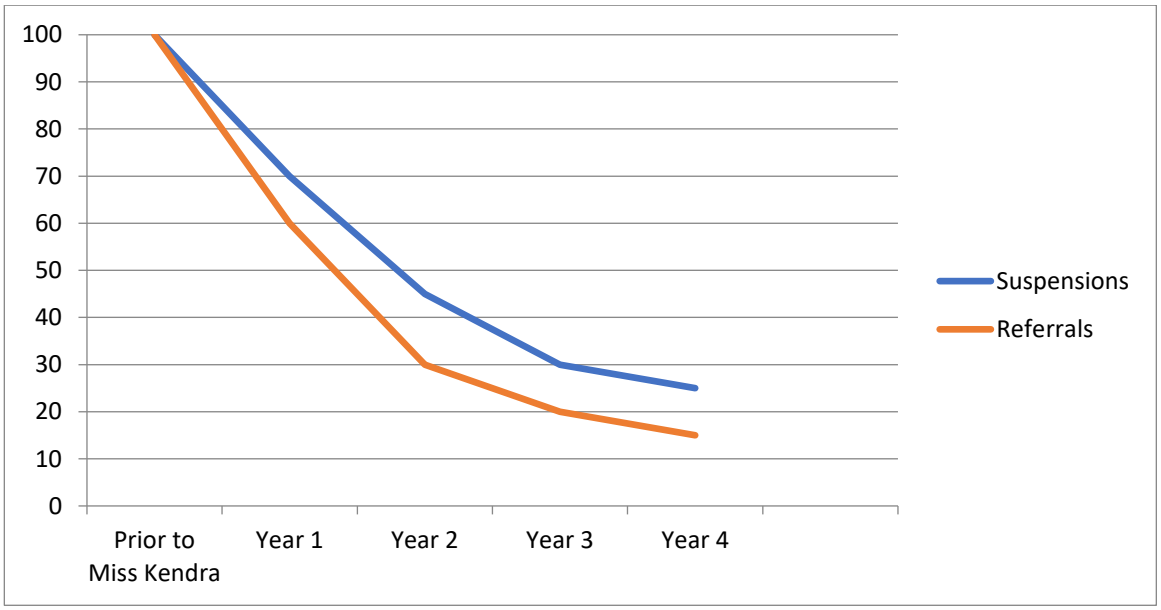
The Miss Kendra Programs is the non-profit arm of the Post Traumatic Stress Center (PTSC) in New Haven, CT. The program began in an underprivileged and low socioeconomic district where adverse childhood experiences were extremely prevalent. The academic performance and emotional/behavioral regulation of the students were suffering. Stress levels of the students were high, making it difficult for them to focus. Internal evidence collection was done through observation and intervention with the students, while external evidence was collected from other peer-reviewed sources who were exploring the impact of ACEs and school-based interventions. The evidence was assessed and conversations with students and school administration helped track responses to the interventions. Schools reported fewer office referrals and classroom disturbances and an increase in engagement and open conversation. These trends can be traced at each school the program is implemented in, as shown in Figure 2.

"Throughout all of ALIVE's programming, the goal is to shift cultural norms of avoidance towards open conversation around trauma, provide a variety of opportunities for

students to express their stress and anxiety, and bolster the students' innate sense of strength and resiliency" (Sajnani, 2019, p. 36). Far too often, students are silenced or discouraged to share their trauma. Without a healthy release, students will act out in a number of ways. "School environments that do not recognize when externalizing behaviors and emotional dysregulation of a student are a result of trauma and loss may respond in a punitive and potentially harmful way" (NCTSN, 2017, p. 3). Giving students opportunities to release air from their metaphorical stress balloons will allow them to ground themselves and focus on the academic tasks in front of them without being weighed down by the impact of external ACEs and toxic stress. This is done through individual sessions, classroom lessons, and letters written to "Miss Kendra" for children to discretely communicate any worries they might be experiencing.

Figure 2

Aggregate of 12 Schools Implementing Miss Kendra Programs



Note. Percent reduction in suspensions and office referrals compared to length of Miss Kendra Programs implementation. Aggregated data collected from 12 school (PTSC, 2020).

While the program is very cost-effective, it still requires a funding source for implementation in the schools, and funding is usually only guaranteed for a single school year (Bruckerhoff, 2015). During the first year of implementation, the Miss Kendra Program costs roughly $25,000, depending on the school size, averaging out to be about $50 per child in a school of 500 students. Further implementation years cost only $5,000 per year, averaging about $10 per student. “A 2015 study by the Center for Benefit-Cost Studies of Education at Columbia University’s Teachers College found that every dollar schools spend on SEL programs returns an average of $11 of economic benefits to society” (Miss Kendra Programs, 2021, p. 4).

Implementation models

The Miss Kendra Programs can be implemented via outside specialists or in-district teachers. Specialists, or Miss Kendra’s helpers, are typically trained drama therapists who act as independent contractors. They enter the school and offer classroom activities as well as individual pull-outs. They have a strong knowledge of trauma-informed care, drama therapy interventions, and operate under a culturally competent lens. Depending on the needs of the school, specialists are in the building, or available online, for a minimum of four hours on a single day. Consultations with teachers and administrators are conducted on an as-needed basis.

School teachers, support staff, and administrative staff undergo intensive training covering trauma-informed care, cultural humility, and classroom activities. This training can take place either in-person or online by experienced Miss Kendra trainers. Miss Kendra staff members supervise the implementing district through ongoing phone coaching and follow-up visits in order to advise and monitor the success of the program. Schools also receive official Miss Kendra materials, “including worry boards, mailboxes, stationery, training manuals, posters, and stamps” (Miss Kendra Programs, 2021, p. 5).

COVID-19 curriculum

Due to the COVID-19 pandemic, practitioners have had limited access to in-person implementation. In an effort to offer continued engagement, specialists at the New Haven location created a YouTube series entitled “Miss Kendra’s Mailbox: 19 Worries for COVID-19” (Miss Kendra Time!, n. d.). The series is made up of 24 videos addressing topics such as the Legend of Miss Kendra, wearing masks, social distancing, missing loved ones, loss and grief, getting tested, boredom and disengagement, resource scarcity, conflict at home, cyberbullying, and more. Practitioners share the video, invite the students to engage in the topic being addressed, and use age appropriate expressive interventions. Individual disclosures are monitored for possible risk and appropriately followed-up on.

Multicultural Considerations

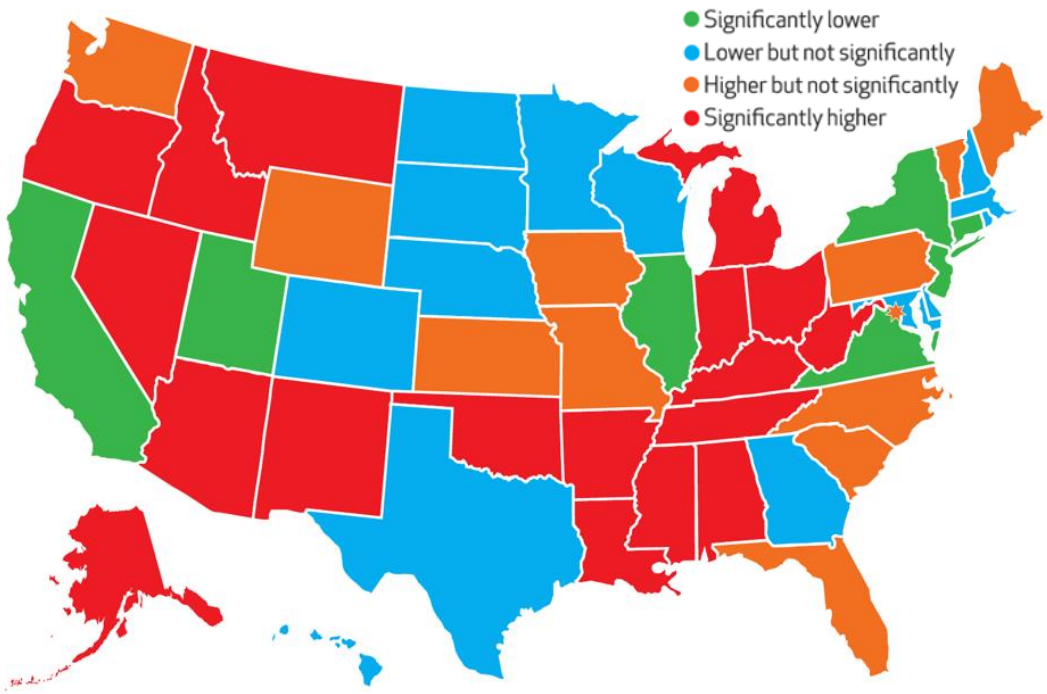
Accessibility to these programs based on race and ethnicity are all important factors to consider. Assari (2020) states, "Race and socioeconomic status (SES) closely correlate with each other as well as with exposure to childhood trauma" (p. 58). School-based practitioners need to be aware of how their intersectionality and the student’s intersectionality can impact their experiences. While programs like ENACT go out of their way to make sure practitioners reflect the culture and ethnicity of the population being served, that is not always a possibility. It is worth noting that an overwhelming number of school-based drama therapy practitioners identify as female (86.1%) and Caucasian/White (72.2%), with 47.6% practicing in the Eastern USA (Mayor & Frydman, 2019). More often than not, practitioners will not mirror the complex identities of their students. “Inequities based on race, ethnicity, class, language, gender identity, sexual orientation, and other factors are deeply ingrained in the vast majority of these systems and impact young people and adult social, emotional, and academic learning” (CASEL, 2021,

para. 7). Due to these inequities, it is crucial for practitioners to locate themselves within the helping relationship. Dee Watts-Jones (2010) speaks to the importance of naming similarities and differences between the helping professional and client served in key identities, such as "race, ethnicity, gender, class, sexual orientation, and religion" (p. 405). By engaging in this type of open discussion, underlying ideological, institutional, and interpersonal oppression and privilege can be brought to the forefront of the conversation instead of being ignored. Pretending that these identifiers do not directly impact a helping relationship is not only irresponsible, but harmful and unethical.

Geographical location also plays an important role in terms of accessibility to services. Figure 3 illustrates the prevalence of children ages zero to 17 who have experienced two or more adverse childhood experiences compared to the national average. "Nationwide, 22.6% of children experienced two or more of the nine adverse childhood experiences. The state with the lowest percentage of such children was New Jersey (16.3%) and the state with the highest percentage was Oklahoma (32.9%)" (Bethell et al., 2014, p. 2109). State to state comparisons aside, it is important to note that nearly a quarter of youth in the United States have been exposed to two or more adverse experiences. As previously stated, the implementation of school-based supports allows for students and families to access no-cost care without having to worry about transportation or parental supervision. While school-based interventions will not completely circumvent the inequities in accessing these services, they can certainly minimize the stress a family and community might feel. Regardless of race, ethnicity, socioeconomic status, or location, children should have access to proper mental health resources, social-emotional training, and trauma-informed care.

Figure 3

Prevalence of Children Ages Zero to 17 Who Have Experienced Two or More ACEs



Note. Data evaluated in the 2011-12 National Survey of Children's Health. The map shows prevalence in each state compared to the US average. In the key, "lower" indicates better performance (Bethell et al., 2014, p. 2109).

Discussion

Adverse childhood experiences (ACEs) are extremely prevalent for today's youth, and school-based support programs provide equitable accessibility to the student body. Through this literature review, this writer identified school-based social-emotional learning programs, school-based trauma-informed programs, and school-based drama therapy programs. However, the Miss Kendra Programs is the only program that combines the school-based, social-emotional, trauma-informed, and drama therapy components that provides support through classroom activities and individual sessions. Developmental transformations (DvT), the approach used by Miss Kendra's

helpers, is the primary drama therapy approach used by school-based practitioners, and short-form DvT has been proven to be effective as a stress reduction technique.

Drama therapy, specifically DvT, provides an age appropriate means of expression that removes the pressure of explicit verbal communication. As previously stated, DvT is based on the principle that life is unstable. Instead of trying to fix the instability, DvT aims to help the client withstand life's instability by developing coping skills and resilience. Using play and embodiment in a dramatic, intimate encounter with a trusted adult allows children to give voice to the struggles they might be experiencing. Having a trained drama therapist or DvT practitioner integrated into a school system allows for communication and collaboration with school administrative staff, parents and caregivers, and the community at large. Identifying common adverse childhood experiences in the area could lead to ideological and legislative change.

Over the past year, this writer has implemented the Miss Kendra Programs both in person and virtually across several New England school districts serving students from pre-K to fourth grade and has seen the efficacy of the interventions firsthand. These experiences, paired with the literature reviewed, inspired the writer to create several arts-based responses that captured the emotional journey of this process. The culminating arts-based response, shown in Figure 4, captures the dichotomy between despair and hope. The darker imagery represents the claustrophobic frustration and despair felt by this writer and her students regarding the prevalence of childhood ACE exposure and the limited supportive programing available. The bright, fractured imagery within the figure represent the multidimensional joy and hope that witnessing and reading about the success and espousal of school-based, trauma-informed, drama therapy interventions has brought this writer. This writer used oil pastels and chalk pastels, and the color pallet was inspired by student artwork created over the course of the year.

Figure 4

Kaleidoscopic Resilience

Note. This writer's culminating arts-based response capturing the emotional and intellectual journey of this capstone thesis experience. Oil pastel and soft pastel.

The widespread adoption of the Miss Kendra Programs could conceivably reduce suspension rates and office referrals nationwide simply by addressing the impact ACEs have on the developing body and brain. Further research should be conducted on attainable funding options for school districts and accessible training options for prospective DvT practitioners to encourage a more diverse and multicultural cohort. It is imperative that students are viewed through a multiculturally competent lens and have their experiences acknowledged and validated. By socially, emotionally, behaviorally, mentally, academically, and creatively supporting our children today, we will provide them with a strong foundation as adults tomorrow.

References

Assari, S. (2020). Family socioeconomic status and exposure to childhood trauma: Racial differences. *Children, 7*(6), 57-70. http://dx.doi.org/10.3390/children7060057

Bethell, C. D., Newacheck, P., Hawes, E., & Halfon, N. (2014). Adverse childhood experiences: Assessing the impact on health and school engagement and the mitigating role of resilience. *Health Affairs, 33*(12), 2106-2115. http://doi.org/10.1377/hlthaff.2014.0914

Blodgett, C., & Lanigan, J. D. (2018). The association between adverse childhood experience (ACE) and school success in elementary school children. *School Psychology Quarterly, 33*(1), 137–146. https://doi.org/10.1037/spq0000256

Broderick, P.C., & Blewitt, P. (2014). *The lifespan: Human development for helping professionals* (4th ed.). Pearson.

Brown, D. W., Anda, R. F., Tiemeier, H., Felitti, V. J., Edwards, V. J., Croft, J. B., & Giles, W. H. (2009). Adverse childhood experiences and the risk of premature mortality. *American Journal of Preventative Medicine. 37*(5), 389-396. https://doi.org/10.1016/j.amepre.2009.06.021

Bruckerhoff, T. F. S. (2015). External evaluation report: Animating learning by integrating and validating experiences (ALIVE). *Curriculum Research and Evaluation, Inc.*

Bryant, D. J., Oo, M., & Damian, A. J. (2020). The rise of adverse childhood experiences during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(S1), S193–S194. https://doi.org/10.1037/tra0000711

Collaborative for Academic, Social, and Emotional Learning. (2021). *SEL: What are the core competence areas and where are they promoted?* CASEL. https://casel.org/sel-framework/

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risks of depressive disorders in adulthood. *Journal of Affective Disorders. 82,* 217-225. https://doi.org/10.1016/j.jad.2003.12.013

Cuellar, M. J., & Mason, S. E. (2019). School social worker views on the current state of safety in U.S. schools: A qualitative study. *Children & Schools*, *41*(1), 25–34. https://doi.org/10.1093/cs/cdy028

Dee Watts-Jones, T. (2010). Location of self: Opening the door to dialogue on intersectionality in the therapy process. *Family Process. 49*(3), 405-420. https://doi.org/10.1111/j.1545-5300.2010.01330.x

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8.

Johnson, D. J. (2009). Developmental transformations. In D. R. Johnson & R. Emunah (Eds.), *Current Approaches in drama therapy.* (pp. 89-116). Charles C Thomas.

Johnson, D. J. (2013). *Developmental transformations text for practitioners: Number two* [Unpublished manuscript].

Jones, P. (2007). *Drama as therapy: Theory, practice, and research.* Routledge.

Langley, A. K., Gonzalez, A., Sugar, C. A., Solis, D., & Jaycox, L. (2015). Bounce back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. *J Consult Clin Psychol. 83*(5), 853-865. doi:10.1037/ccp0000051

Lindo, N. A., Dillman Taylor, D., Meany-Walen, K. K., Purswell, K., Jayne, K., Gonzales, T., & Jones, L. (2014). Teachers as therapeutic agents: Perceptions of a school-based mental health initiative. *British Journal of Guidance & Counselling*, *42*(3), 284–296. https://doi.org/10.1080/03069885.2014.896452

Mayor, C. & Frydman, J. S. (2019). The prevalence and practice of drama therapy in the North American school system: A descriptive report of contemporary service delivery. *Drama Therapy Review, 5*(1), 7-25. doi: 10.1386/dtr.5.1.7_1

Merrill, S. (2020, September 11). *Trauma is 'written into our bodies'—but educators can help.* Edutopia. https://www.edutopia.org/article/trauma-written-our-bodies-educators-can-help

Miss Kendra Programs. (2021). *Miss Kendra Program Connecticut* [Info sheet]. https://misskendraprograms.org/wp-content/uploads/2021/02/Miss-Kendra-Connecticut-5p.pdf

Miss Kendra Time! (n. d.). Miss Kendra's mailbox: 19 worries for COVID-19 [Unlisted YouTube Channel].

National Child Traumatic Stress Network. (2017). *Creating, supporting, and sustaining trauma-informed schools: A system framework*. National Center for Child Traumatic Stress.

North American Drama Therapy Association. (2021). *What is drama therapy?* NADTA. https://www.nadta.org/what-is-drama-therapy.html

North American Drama Therapy Association. (n.d.) *Drama therapy with children and adolescents* [Fact sheet]. https://www.nadta.org/assets/documents/children-adolescent-fact-sheet.pdf

Pitre, R., Davis, C., & Johnson, D. R. (2019). *Screening for toxic stress* [Conference handout]. NADTA40: Philadelphia, PA.

Pitre, R., Mayor, C., & Johnson, D. R. (2016). Developmental transformations short-form as a stress reduction method for children. *Drama Therapy Review, 2*, 167-181. http://dx.doi.org/10.1386/dtr.2.2.167_1

Post Traumatic Stress Center (2020). *Outcome data for the Miss Kendra Programs from various schools.* [Unpublished data set].

Sajnani, N. (2014). *About*. Developmental transformations. https://primediscrepancy.wixsite.com/dvt40/about

Sajnani, N., Mayor, C., Burch, D., Feldman, D., Davis, C., Kelly, J., Landis, H., & McAdam, L. (2019). Collaborative discourse analysis on the use of drama therapy to treat trauma in schools. *Drama Therapy Review, 1*, 27-47.

Westermair, A. L., Stoll, A. M., Greggersen, W., Kahl, K. G., Hüppe, M., & Schweiger, U. (2018). All unhappy childhoods are unhappy in their own way—Differential impact of dimensions of adverse childhood experiences on adult mental health and health behavior. *Frontiers in Psychiatry, 9*, 1-11. https://doi.org/10.3389/fpsyt.2018.00198

Zeng, S., Corr, C. P., O'Grady, C. & Guan Y. (2019). Adverse childhood experiences and preschool suspension expulsion: A population study. *Child Abuse & Neglect, 97*, 1-9. https://doi.org/10.1016/j.chiabu.2019.104149

THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Drama Therapy, MA

Student's Name: Nicole Ventura

Type of Project: Thesis

Title: The Need for School-Based Trauma-Informed Drama Therapy Interventions: A Literature Review

Date of Graduation: May 22, 2021

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Tim Reagan, PhD, RDT