



Australian Counselling  
Research Journal

Vol 13  
Issue 1

Special Issue on  
Expressive Therapies

2019

# Editorial

**Volume 13, Issue 1 - 2019. Dr Tarquam McKenna**

This edition of The Australian Counselling Research Journal is fundamentally an excellent guide to the literature that traverses the field of expressive therapy. The first paper, “Indigenous Trauma Healing: A Modern Model.”

As an exception to the five literature reviews that follow this is an exciting endeavour and presents a model from Indigenous perspectives on trauma and healing with practical suggestions for social work practice. First Nations people are considered in this paper and not unlike the Moreno Psychodrama literature review later in the journal the authors build on and refer to the holistic worldview honouring the interconnection of all beings. The authors use what they refer to as a “...common tool across cultures”, or the medicine wheel is explored and is a metaphor for a life journey.

The second paper by Mitchell and Benkendorff explores and presents a model describing the causes of and healing of trauma. The field of evidence-base for child-centred play therapy (CCPT) and nature-based therapies is along with two critical analysis of contemporary studies which utilised nature-based child centred play-based therapies NBCCPT.

“Frangible Emotion Becomes Tangible Expression: Poetry as Therapy with Adolescents” addressed the engagement of poetic forms and reflected on how poetry can be applied to the therapeutic world of liminality as childhood is left behind and the realm of the adult is considered. The notion of poetry for ‘adolescents is deliberated on as a transitional device, and the strengths of this paper are not only on its capacity to beguiled a sense of self but to used personal writing (and I assume “rap” to make the poetry therapy relevant and purposeful to the young person. The three authors (Allen, Carter and Pearson) note that “a major strength of PT is the positive effect it can have on group cohesion, as where a sense of safety, comfort and belonging exists, then commitment can emerge.”

Non-verbal therapeutic activities are counterposed in “Sandplay Therapy: A Safe, Creative Space for Trauma Recovery” (Pearson and Wilson). The use of woods is not required so explicitly in sandplay therapy, and this discussion is cohesive and addressed especially the literature around trauma-informed practice. The author reminds us that trauma has “.... the potential to overwhelm human adaptations and “generally involve threats to life or bodily integrity, or a close encounter with violence and death” (Herman, 1992, p.33).” Sandplay Therapy offers the traumatised clients access to memories that are stored implicitly as sensory-based experiences. The authors contend that expressive therapies can provide these therapeutic experiences, and besides, support the development of the therapeutic alliance with “a caring adult who provides opportunities to create and communicate” (Malchioldi, 2008, p. 153).

## Editors

**Dr Tarquam McKenna**  
Deakin University  
**Dr Ann Moir-Bussy**  
University of Sunshine Coast

We stay in the space of soma in “Dance Movement Therapy for the Treatment of Depression” (Fletcher and Gerschwitz). In this paper, we are looking at the literature around a rationale for the inclusion of Dance Movement Therapies in training of counsellors to treat depression. The authors contend that DMT offers therapists and clients an additional, creative, non-verbal treatment method to pharmacological, psychosocial or psychological interventions optimally delivered in a group format, providing meaningful and safe social interactions for people with depression. The paper recognises the field of DMT has been overlooked, and it is noteworthy that the University of Melbourne is readying to offer the first somatic (DMT) based MA in this field.

The final paper “Psychodrama: Conception, Evolution, Evidence and Application.” (Rogers & Kosowicz) addresses the century of psychodrama and is a survey of notions that are central to the work of Jacob Moreno. The authors are alert us to how other forms of role-based therapies have adopted his teachings. The work stands resolutely with the overview of Moreno’s role theory. As with the first opening article, this paper emphasises a little known aspect of Moreno’s philosophy. The author writes “role theory states that all people are interconnected...”. This sense of interconnectedness is often lost in the therapeutic field.

Except for the first paper these five papers come from MA counselling graduates. The students are now practitioners in their fields. It is noteworthy that the University of Sunshine Coast Postgraduate MA was established with a commitment to creative arts and expressive arts therapies by the original community of scholars. The first paper aside the move to other ways of knowing is central to all papers. The first paper is the core paper of this edition in the sense that it positions First Peoples First.

The legacies of our Aboriginal and the Torres Strait Islander people take in to account the mystery of interconnected in life. The medicine in the first paper is leading the community member or patient in their individual and collective exploration of the journey of life.

The following student literature reviews papers strongly illustrate how each of us as members of the global community is a unique human being. Each of us react in a different way depending upon the environment in which they find themselves at a given moment. The use of dance, poetry, psychodrama, sandplay and other art forms is critical as we counsellors and psychotherapists too frequently sit only alongside the cusp of knowing that is only verbal. The human condition is to know in many ways and this collection of therapeutic discussions and materials serve to illustrate literature and practice in the artistic field and its relevance to counselling and psychotherapies.

Professor Tarquam McKenna, has been active in arts-based therapies delivery for more than 30 years. He is currently Head of Research at IKE, Deakin University where he is Chair in Indigenous Knowledges (Research)

Tarquam McKenna  
Editor

## Editors

**Dr Tarquam McKenna**  
Deakin University  
**Dr Ann Moir-Bussy**  
University of Sunshine Coast

# Table of Contents

Volume 13, Issue 1 - 2019

<b>Indigenous Trauma Healing: A Modern Model</b>	<b>1</b>
Valerie Cloudclearer Ringland.	
<b>It's good to go outside: A Review of nature-based child-centred play therapy</b>	<b>8</b>
Alexis Mitchell and Natasha Benkendorff.	
<b>Frangible Emotion becomes tangible expression: Poetry as therapy with adolescents</b>	<b>14</b>
John D. Allen, Karen Carter & M. Pearson.	
<b>Sandplay Therapy: A safe creative space for trauma recovery</b>	<b>20</b>
Mark Pearson & Helen Wilson.	
<b>Dance Movement therapy for the treatment of depression</b>	<b>25</b>
Rachel Fletcher & Heidi Gerschwitz.	
<b>Psychodrama: Conception, Evolution, Evidence and Applications</b>	<b>30</b>
Carolyn A. Rogers & Diana Koswicz.	

## Editors

**Dr Tarquam McKenna**  
Deakin University  
**Dr Ann Moir-Bussy**  
University of Sunshine Coast

# Indigenous Trauma Healing: A Modern Model

Valerie Cloudclearer Ringland

Although Australian professional counselling services are well-established, a unified vision of what defines professional counselling identity in Australia remains elusively absent. Self-regulation within the Australian counselling profession contributes greatly to the strong development of professional training, ethics, and practice principles, yet a clear understanding of what constitutes professional counselling identity remains undefined. This paper proposes that, in order to develop awareness of what comprises professional counselling identity in Australia, the views of Australian counselling professionals are necessary. This paper offers a preliminary investigation of Australian professional counsellors' views of what defines professional counselling identity.

**Keywords:** *trauma, healing, indigenous, community social work, spirituality*

Decolonisation in social research and professional practice is a means to "redress the constructs used by academics and governments" (Sherwood 2010, p. 121). Within a decolonisation framework lies indigenous theory, the word "indigenous" is used to describe specific people whose beliefs, traditions and ways of living originate within a cultural group and place, or more broadly as a view of the world as a web of life that is inherently inter-connected and operates in cycles (Cervantes & McNeill, 2008). Indigenous theory is a philosophy of an innate wholeness in nature and an understanding that humans need to live in respectful relationship with all beings, and is reflected in numerous indigenous cultures around the world. In this paper, the term "Western" refers to a culture principally based on Judeo-Christian and scientific thinking that is mainstream in the Australia today.

## The Medicine Wheel

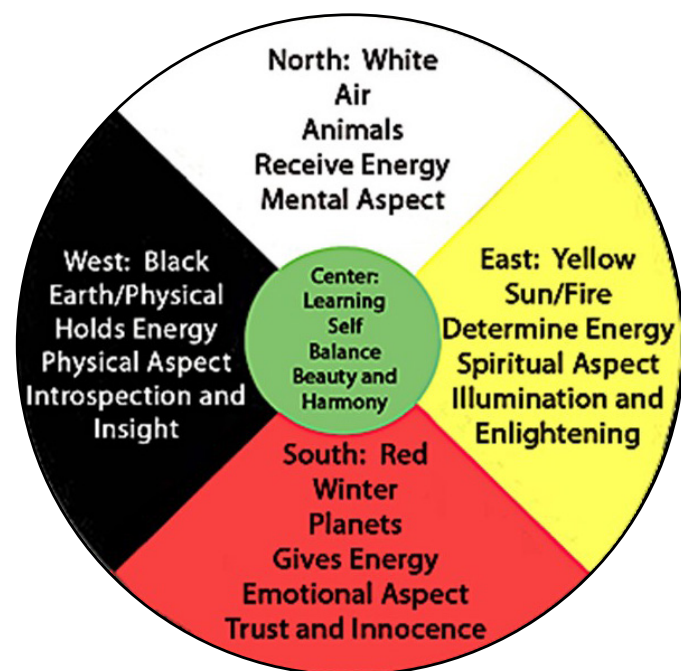
The medicine wheel is the "essential metaphor for all that is" (Rael, 1998, p. 35). Walking the medicine wheel is a life path, and the medicine wheel in a physical form is a tool for humans to learn, grow and maintain life balance (Dapice, 2006). There is no "right" or "wrong" way of using a medicine wheel (Bell, 2014). The practice of a talking circle, where people sit openly

with no physical object between them and take turns listening and speaking, is a metaphorical representation of the medicine wheel, the circle of life. A two-dimensional representation of a medicine wheel tends to be symbolised by a circle divided into four parts. There are numerous metaphorical perspectives on the four parts of the circle, including: the four directions of north, east, south and west; the four seasons of winter, spring, summer and fall; the four times of day of morning, afternoon, evening and night; the four stages of life of infant, child, adult and elder; the four elements of earth, air, water and fire; and four aspects of being of physical, spiritual, emotional and mental (See e.g. Bell, 2014; Charbonneau-Dahlen, 2015; Dapice, 2006; Rael, 2015). To see the wheel in three dimensions, consider a central point below the ground, a point in the center representing the heart that unites all beings, and a point above the ground. The portion of the medicine wheel above the ground, commonly referred to as Father Sky, represents the visible aspects of life, and the lower half of the medicine wheel, commonly referred to as Mother Earth, represents the invisible aspects of life below the ground. The invisible world below the ground is experienced through feeling, intuition and mystery, a metaphor for the darkness of Mother Earth's womb that sustains and nourishes the world we see and experience in physical form. The medicine wheel is a symbolic embodiment of our spherical planet Earth. All directions need to be in balance to live in wellness and be centered in our hearts. An example from the Hopi tribe of North America is shown in Figure 1 (Medicine Wheel, n.d.).

Corresponding Author: Valerie Cloudclearer Ringland  
Email: valerie.ringland@gmail.com

Australian Counselling Research Journal ISSN1832-1135

Figure 1. Hopi Medicine Wheel (Medicine Wheel, n.d.)



What is outside the boundary of the circle is undefined, space without form, the unknown or shadow. Inside the circle are known aspects of a culture or individual's world (Rael, 1998). Energy is constantly cycling in and out of the medicine wheel. In the Hopi medicine wheel in Figure 1, an aspect of the unknown enters in the North, the mental, and gives us an idea. Then it moves into the East, the spiritual, where we give meaning to the idea. Next it moves to the South, the emotional, generating feelings inside of us. Those feelings spur us into taking some sort of physical action in the West, and by expressing the energy physically, we move to the center of the circle, the Heart. It is in our hearts that we reconcile unknown energy, experiencing it in three dimensions by connecting the Earth below and the Sky above through our bodies like human lightning rods. This idea of a human as a three-dimensional sphere is expressed in Leonardo da Vinci's famous drawing of the Vitruvian man (Figure 2).

Figure 2. Leonardo da Vinci's Vitruvian Man



### Causes of trauma

Disease and trauma are caused by natural and supernatural forces, where natural forces include causes such as cold air, germs or impurities in food and water, and supernatural forces include upset social relations between people, upset relations with ancestors, or upset relations with other beings, such as spirits of a particular land or place (Sussman, 2004). One scholar has connected the Western perspective of unconscious or subconscious drives with indigenous concepts of spiritual forces with independent will and behavior (Holliday, 2008). Western systems tend to use a Father Sky, visible world-based "seeing is believing" hypothesis-testing approach, whereas indigenous systems use a Mother Earth, invisible world-based trusting "feeling is believing" approach. Since we are rooted in the Earth, the indigenous perspective is that we ought to focus the majority of our energy on cultivating a healthy invisible foundation based on values of acceptance, compassion and empathy. When our collective invisible soil is healthy and fertile, identities and behaviors that emerge will benefit all life forms.

Indigenous scholars see colonialism as "a violation of the psychological womb, a great rupture with the Mother [Earth], and a spiritual depression and moral suicide resulting in a systematic repetition of historical and generational failure" (Cervantes & McNeill, 2008). Still today, indigenous people experience trauma in Western healing systems. In many indigenous African cultures to talk directly about a trauma is opening oneself up to re-traumatization and re-victimization by negative forces that already caused a person harm (Green & Honwana, 2001). Similarly, an indigenous Ecuadorian healer reported that a client did not have PTSD symptoms until she began psychotherapy and was asked to talk about her past. Another cited the Western approach of "saving" people as a further perpetuation of colonialism. Holistic healing is needed, because "due to wounding, colonialization, marginalization, oppression [we] have spent inordinate amounts of time from a CBT standpoint in our heads, locked in our heads...and what is a very valuable gift from the creator becomes a prison" (p. 108). Lakota social worker Maria Yellow Brave-Heart describes the following effects of trauma on indigenous communities: (1) identifying with the dead (an aspect of cultural or historic trauma), (2) depression, (3) psychic numbing, (4) hypervigilance, (5) trauma fixation, (6) suicidality, (7) somatic symptoms, (8) grief and rage, (9) loyalty to ancestors through present-day suffering (an aspect of cultural or historic trauma), (10) low self-esteem, (11) victim identity, (12) re-victimization by authority figures, (13) mental illness, triggers and flashbacks, (14) fears of authority and intimacy, (15) domestic and sexual violence, (16) inability to assess risk and set boundaries, and (17) abuse re-enactment (2003).

### Connection between Body and Land

Where in Judeo-Christian culture the Earth is traditionally portrayed less as a home and more as a place to endure, indigenous thinking sees the Earth as the *source* of life, not a *resource* to be used for a period of time. The Earth's health is intimately connected with and reflective of human health. To refer to a walk in a forest as "being in nature" is indicative of a Western alienation with our environment. Whether in a city or forest, indigenous thinking says that nature is everywhere, because it is a fundamental reality (Gustafson, 1997). Because our bodies are made of earth, healing trauma requires connecting with the land (Kopacz & Rael, 2016). An ethnobotanist researcher of

the Potawatami Nation calls our modern culture “species poor,” citing how few Americans can name or discuss uses of plants in our environment (Kimmerer, 2016). Many indigenous people consider rocks, trees, animals and other beings as ancestors who can teach us how to live well, since they have survived on Earth much longer than we have.

Indigenous knowledge is experienced directly through the body, either in relationship to land and place or during ritual and ceremony (Gonzalez, 2012). Thus, expressive art and ceremony on land of traditional cultural significance are vital to healing, because land holds trauma and violent memory and reflects that energy into people’s bodies and psyches. In Australian aboriginal languages, “land” may be translated as “everlasting spirit” or “source of life” (Atkinson, 2002). “The land under each tribe’s feet is the [spiritual] source of its culture,” a place of reciprocal responsibilities (Kimmerer, 2016). During colonialization, violence took place on the land, shattering aboriginal ways of being, and colonial leaders forbid the performance of traditional ceremonies (Atkinson, 2002; Quinn, 2007). This resulted in abandonment and trauma to their core identity, creating immense inner crisis and disorientation still today.

Connecting with land in city environments is challenging, in part because it is so highly cultivated and lacks wilderness space. Research on the struggles of trees planted for commercial gain has found that such trees do not communicate with each other as well nor grow as healthily as trees in wild forests (Wohlleben, 2016). People in cities are similarly seen to be spiritually disoriented or lost in some way, because it is hard to feel a depth of connection and nourishment in manufactured environments (Reeves, 2013). City-dwellers tend to spend a lot of time in enclosed spaces such as cars or trains, and in desks and chairs indoors in rooms shaped like rectangles. While we create refuges and sanctuaries for other animals negatively impacted by city life, we struggle to connect with the Earth to nourish wild and mysterious aspects of ourselves (Estes, 1992).

## Spiritual wounding

Colonialization and the beliefs that led to it have spiritual roots in our ideas about the meaning of life, our innate nature and place in the world. Many religions and cultures in the Western world have traditionally held an idea of a Creator represented as an elderly, white-skinned Father Sky. Indigenous creation stories tend to focus on Mother Earth. Thus, indigenous people describe healing from trauma as a spiritual task of healing “soul wounds” (See e.g. Marsh, Coholic, Cote-Meek & Najavits, 2015; Beltran and Begun, 2014). According to indigenous thinking, colonizers previously experienced some kind of trauma disconnecting them from an intimate, reciprocal relationship with their land and place of origin. Conquering and privatizing land resulted in trauma re-enactment around the world (Smith, 2005). Some cultures describe a psycho-spiritual virus as the root of this trauma. Among the Anishinaabe in Canada the *Windingo* is a hungry, destructive force that consumes without end and even eats its own kind (Kimmerer, 2016). The Canadian Ojibway refer to *Wetiko*, “a cannibalistic spirit who embodies greed and excess,” acting like “an autoimmune disease of the psyche... [in which] the immune system of the organism perversely attacks the very life it is trying to protect” (Levy, 2014). The *Zar* spiritual disease in

northern Africa is similar (Monteiro & Wall, 2011). Among indigenous cultures in Asia, a poison in the mind makes us forget who we are, manifesting as anger, desire and ignorance (Kakar, 1982). The understanding is that we humans naturally carry destructive energy that needs to be regularly purged through individual and communal cleansing so that it does not grow out of control and destroy the people and the Earth. When this energy penetrates our spiritual beliefs, we act as if we are disconnected from each other and other life forms and engage in destructive behavior.

Where Western medicine seeks a cure for a disease and a treatment for a trauma, indigenous people view trauma and disease as potential gifts of healing that can offer important insights about how to live well and bring new leadership into a community (Reeves, 2013). Where Western psychology views the personality or ego as the center of being, an indigenous healer views a person’s eternal spirit as the center of being. To try to make trauma go away is seen as denying necessary spiritual initiation (Kopacz & Rael, 2016). Many indigenous cultures have a concept of a “shaman’s illness.” A shaman’s illness is simultaneously a traumatic death and initiation. Trauma destroys life as a person knows it, placing into a person a spiritual force of energy that shatters his or her previous identity. The gift of trauma is this spiritual offering of a huge amount of energy that can be redirected from harmful into harmonious states of being through healing and creation of a new identity, like a phoenix arising from ashes of a fire (Pendleton, 2014).

All traumatic experiences that propel a person into a state of terror and dissociation are seen as “soul loss,” meaning that the person is no longer fully present in ordinary reality, because parts of his or her spirit have split off, fled, or gotten lost. “Soul” is synonymous with consciousness (Nuñez, 2008). These soul parts are understood to be frozen in a person’s unresolved past, resulting in a loss of life force and disorientation in the present (Bright, 2009; Cervantes & McNeill, 2008). Negative emotions such as anger, bitterness, envy, fear, greed, hate, intolerance, pride, rage, resentment and vanity are poison the soul and cause soul loss (Nuñez, 2009). People who experience soul loss tend to feel weak, anxious, depressed, and exhibit signs of mental or emotional illness. Lost soul parts of a person are banished by internalized punishment or hidden away until the person is in a safe situation and supported to heal. A medicine man of the Ifá tradition of Africa and the Caribbean suggests that many patients in Western psych wards are uninitiated healers, and that unacceptable behaviors will calm down as people learn to effectively use their spiritual gifts (Ojelade, McCray, Meyers & Ashby, 2014). To heal, a person integrates fears and unknowns outside a culture’s current knowledge into a meaningful understanding of everyday reality, expanding the culture’s collective understanding of life and boundaries of the medicine wheel (Bright, 2009).

## Healing as a Community

One scholar of Cree origin describes indigenous knowledge and healing as utilizing a lens of community mind and thought (Robbins & Dewar, 2011). Firm individual ego boundaries encouraged by Western culture have been found to be “maladaptive and neurotic” for Indians and Japanese, where identity is socially constructed and health seen to be in relation to others rather than an autonomous self (Jaipal, 2004). Because emotional exchange is primarily social, if one person is exhibiting signs of traumatic illness, an entire family or community may be in need of ceremonial healing. Childhood trauma is less damaging

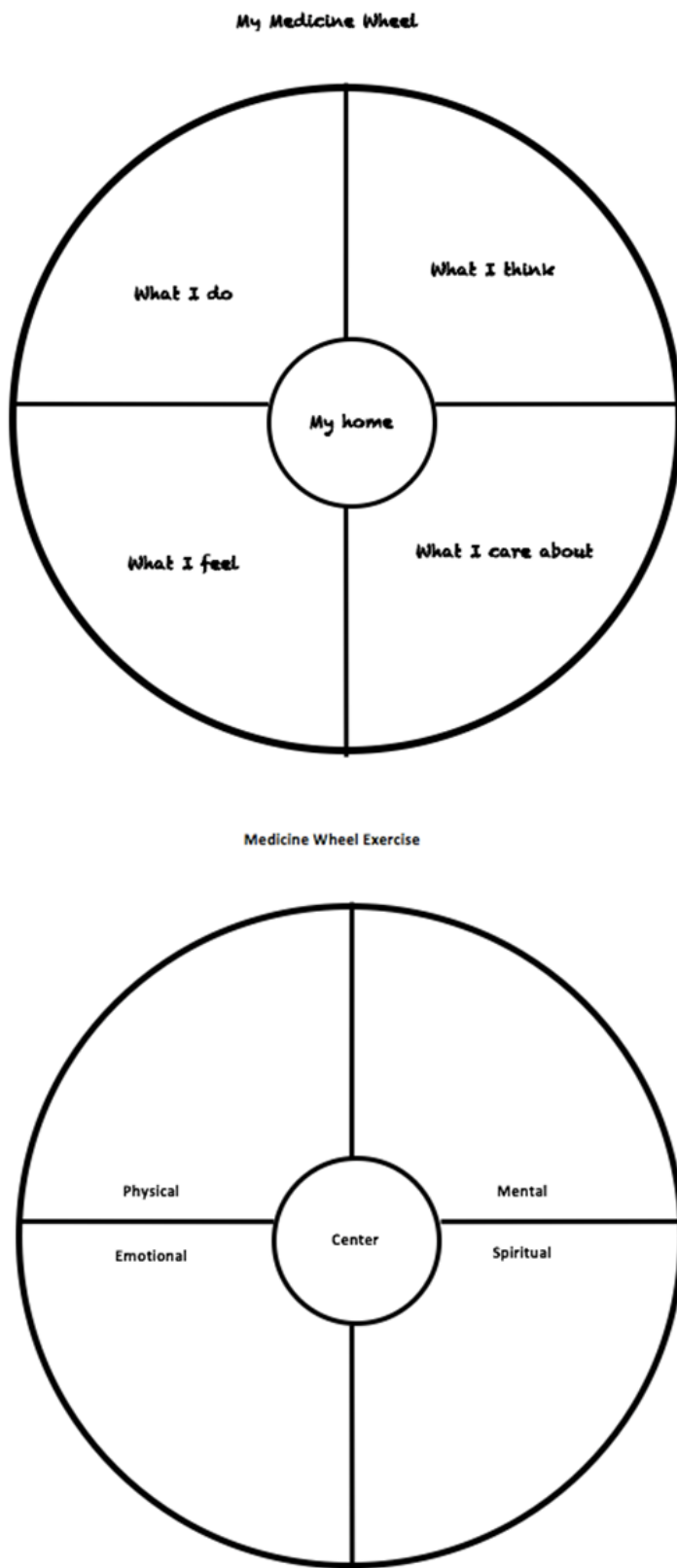
when a loving community of people holds a child after a violation and expresses “the universal truth that life wants the child to exist and that the universe can be a safe place” (Gustafson, 1997). Healing rituals as a community create cohesion, solidify family bonds and honor elders who carry cultural teachings about ethics and community responsibilities (Green & Honwana, 2001; Marsh, Coholic, Cote-Meek & Najavits, 2015). In many indigenous cultures angry spirits of the dead, either within a person’s ancestry and community or connected to a place, cause problems for modern people. In many indigenous African and Asian cultures if a person is not properly buried, their spirit causes “social pollution” and contaminates people with illness until honored (Green & Honwana, 2001; Tick, 2014). In indigenous cosmologies a person’s spirit exists eternally regardless of physical presence. Thus, soldiers returning from war must be supported by indigenous healers to engage in cleansing rituals and be purified of trauma before they return to their families (Green & Honwana, 2001; Kopacz & Rael, 2016). One described PTSD as an incomplete sense of identity after a traumatic experience requiring a person to restore a sense of meaning and enlarge his or her sense of identity, replenish soul and spirit in community, rectify moral wrongs, and heal rifts between a civilian and warrior sense of self (Tick, 2014). An Anishinaabe scholar healing from sexual trauma described attending a pow-wow as waking up and knowing she had finally come home (Desjarlais, 2012).

## Healing Trauma

### Use the Medicine Wheel

Transforming trauma requires a fundamental shift and a willingness to challenge basic beliefs (Levine, 1997). Since indigenous thinking places the heart at the center of the medicine wheel, a starting point for healing trauma is determining where our life is out of balance. One method is a medicine wheel exercise developed by the author to discern balances and imbalances in life, by adults and children, in Figure 3 below. The adult version has four quadrants for physical, mental, emotional, spiritual (what gives our life meaning) aspects of life, as well as a center (what is closest to our heart). The child version changes that language to be more age-appropriate. There is no wrong way to do this exercise; some people put activities like “meditation” in the center, others put people and places like “my wife” and “church,” and some put beliefs such as “acceptance.” The “in” and “out” in the adult version of the exercise are helpful for some people. If they are used, the “in” refers to what a person is receiving, and the “out” to what that person is giving. Through the “in” and “out” part of the exercise, a mother may realize that she is receiving a lot requests for emotional support from her family and is giving them support, but is not receiving enough emotional support herself, and needs to seek that out.

Figure 3. Medicine Wheel Exercises



### Alter Consciousness

An important tool for trauma healing is altering consciousness. According to indigenous thinking, a person who is suffering from trauma has lost soul parts that are not accessible in everyday reality. A person is able to regain access to these soul parts through techniques that alter consciousness, such as prayer or meditation, breath work, trance dance, sweat lodge, fasting, drumming, chanting, isolation in nature, or use



of ayahuasca and other psychotropic plants (See e.g. Monteiro & Wall, 2011; Cervantes & McNeill, 2008). The aim of these practices is to break out of everyday patterns of thinking and being so we can access subconscious or unconscious aspects of ourselves. The human body is designed to survive at all costs, no matter our spiritual state. We can re-member ourselves by moving through layers of pain, being with and expressing chaotic, pre-conscious and unconscious mental and biological processes such as images, sensations, kinesthetics, and dream-like states of consciousness outside the Western paradigm of psychology (Culbertson, 1995; Mann & Culbertson, 2006). Healing is a process of allowing emotion to flow out and cannot be forced. Altering consciousness may be “the single most widespread psycho-therapeutic technique in the world” (Kakar, 1982, p. 105). When done in groups, people may experience empathic exchange and an opportunity to connect with ancestors by acting out rituals embedded in a place or culture (Atkinson, 2002; Monteiro & Wall, 2011). Dance, visual art and other non-lingual communication may allow a person to express emotion in a less constricted way than words, including emotion that is not socially sanctioned. Sensory stimulation different to everyday reality such as fasting and sleeping outdoors may trigger an unaccessed depth of emotion that allows for more profound healing (Rael, 1998). To heal from soul loss, a person can also receive a soul retrieval from a shamanic practitioner (Ingerman, 1991).

### Honor the Earth

The land symbolizes the vast self, the big oneness connecting all beings, and tells stories through our sounds and movements. Sioux Elder Ohiyesa wrote in 1911 that children need to spend time in wilderness to become conscious of their relationship to all of life. Fundamental to an indigenous education is engendering in a person a love of the “Great Mystery” or the unknown and unexplored aspects of life, a love of nature, people and community (2001). For the majority of human evolution, connecting with the natural world was a crucial component of child development and a normal part of education. Children planted seeds and saw plants grow, picked fruits, killed animals and roasted them over fires for food, helped build shelters, and participated in other basic survival skills of their community. We can learn to identify plants and animals in our environments, along with basic tools of wilderness survival to help us connect with the place we live and with the wisdom of our ancestors. We can go camping, or take classes at a wilderness school. We can learn about ancestors of the land where we live, the land where we were born, and the land(s) our ancestors are from. For example, if our ancestors lived by the sea, we could honor our heritage by hanging a painting of the ocean in our home. We can also walk barefoot outdoors, swim in seawater or a lake, and spend time in wilderness listening to insects and animals. A common practice is creating a “sit spot” to regularly observe and be part of our natural environment. In a city, we can listen to a recording of a waterfall and chirping birds (many of which are free online), and soak our feet in saltwater if we live far from an ocean. We can honor the Earth’s cycles through food and ceremony, such as eating seasonally, acknowledging the gift of harvest at Thanksgiving, observing changes in the moon, and slowing down in winter.

To heal trauma, indigenous thinking suggests that we purify ourselves of negative energies through ritual and intention. Indigenous purification rituals often use smoke, or smudging. An herb may be burned to symbolize the purification of a space

for healing and to remind us of the sacredness of life. North American tribes tend to smudge with tobacco, cedar, sweetgrass or sage (Guédon, 2000). Scientific studies suggest that smudging may cleanse bacteria from the air (See e.g. Nautiyal, Chauhan, & Nene, 2007; Mohagheghzadeh, Faridi, Shams-Ardakani & Ghasemi, 2006). We purify our homes with intentional burning of an herb, aromatherapy or incense. We purify our bodies with smudging, or through a mindful bathing or cleansing ritual, such as a sweat or herbal bath. Finally, we can honor our innate wild, creative energy by “flowing”, allowing ourselves to be and do what arises naturally. Flowing can be learned or deepened through the guided process outlined in the self-help book *The Artist’s Way* (Cameron, 2016).

### Heal in context

We are each part of culture, family, place, and time, and understand our lives in this context. We may not think of a morning ritual of waking up to an alarm clock and hurrying out of the door as a daily ritual, but it is a modern one infused with meaning, an embodiment of a rushed, fast-paced lifestyle. Altering such a ritual can help us be more centered. A practice indigenous cultures value is not only daily ritual, but meaningful ceremony, as individuals, families and communities. What is meaningful varies by person and culture. Life is understood to be unsatisfying when we do not do enough ceremony, and ceremonies are most powerful when done regularly and intentionally in a community (Rael, 1998). People healing from trauma often find it helpful to engage in simple ceremonies, such as writing down fears and burning them in a small fire or flushing them down the toilet, or burying an object in the Earth that symbolizes a painful experience. Practices often referred to as restorative justice, peace circles or talking circles are common ceremonies in indigenous cultures for communal bonding, and preventing and addressing conflict. They are based on a physical embodiment of the medicine wheel with people sitting in a circle with no table between them, often with a medicine wheel in the center on the floor. The centerpiece symbolizes that which a community values, and the power of a talking circle is empathic listening and storytelling. A talking circle is an embodiment of respect, acceptance and inclusivity, and is an act of love. Part of the utility of such a circle is that we know our own experience with the reflection of another, allowing us to see how collective experiences shape our behaviors within families and communities (Atkinson, 2002). By engaging only in individual therapy, trauma healing is stifled. Professionals can gain much information about a client by observing interactions with their family and friends. In addition, survivors of trauma often feel more comfortable talking to family and friends than professionals. Where trauma has destroyed bonds, storytelling and empathic listening creates opportunities for collective healing (Herman, 1992). “Searching for meaning, sharing experiences, and trusting each other are unique healing experiences and are increasingly rare” (Kinzie, 2007). Creating opportunities for collective healing, such as facilitating a talking circle within a family or community can support an entire group of people to heal from trauma.

In addition to listening to living people, it is also important to heal ancestral trauma, often referred to as cultural or historical trauma. Indigenous thinking suggests that we look at ancestry in three ways: our blood lineage, our individual experiences and evolving sense of identity, and the ancestry of the place where we now live, the place we were born, places we have lived, and where our blood ancestors lived. A simple way to start healing

ancestral trauma is to create and tend an ancestral shrine. A benefit of this practice is that it creates a physical space outside of our bodies for ancestral trauma to exist so that we do not need to carry it internally (Pratt, 2007). Over time as the ancestral trauma is healed, the shrine becomes a celebration of our ancestry. An explanation of how to create an ancestral shrine is included as Figure 4, and is something anyone can do.

**Figure 4. Building an Ancestral Shrine**

<b>1 Create space for your ancestors</b>
<p><i>By creating a shrine for your ancestors, you are symbolically making space for ancestral trauma to live outside of your own body and mind, and to heal yourself and your ancestors through cultivating ancestral wisdom.</i></p> <ul style="list-style-type: none"> <li>You may put the shrine outside in your garden, inside on a display shelf, or keep it private in a small box you take out from time to time.</li> </ul>
<b>2 Cultivate your ancestral shrine</b>
<p><i>By placing items in the space, you acknowledge and honour your ancestors.</i></p> <ul style="list-style-type: none"> <li>Consider honouring three types of ancestors: your family lineage, ancestors of a place you live or have a connection with, and past versions of you.</li> <li>Add items that remind you of a 'past self' that was wounded, such as poker chip for a gambling addiction, or a crayon for an abused child.</li> <li>Add items that remind you of deceased family and friends, such as a bracelet that belonged to your grandmother.</li> <li>Add items that remind you of a specific time or place, such as a seashell for a childhood home by the ocean.</li> <li>Add offerings of beauty, such as a crystal, a flower or a candle.</li> <li>Add a drawing of your family tree.</li> <li>Add photographs or names written on paper to commemorate specific people, places or events.</li> <li>Add items that reflect your cultural heritage, like a flag of your home country.</li> <li>Add items that feel right to include, even if you're unsure what they mean.</li> </ul>
<b>3 Connect with your ancestral shrine</b>
<p><i>By connecting with your ancestral shrine, you make space in your heart and give time and energy to cultivating ancestral wisdom and healing trauma.</i></p> <ul style="list-style-type: none"> <li>Look at and engage with your ancestral shrine. Allow yourself to feel what comes up and express the emotion. Move, add, or remove items as feels right.</li> <li>Leave offerings for your ancestors, like a flower, chocolate, glass of water, a candle, glass of wine, or some other offering of thanks to your ancestors. These are symbolic and are disposed of later and not consumed if edible.</li> <li>Pray or meditate by your shrine for insight, strength and healing.</li> <li>Ask your ancestors questions, and see if you intuitively get any answers.</li> </ul>

**Conclusion**

Trauma causes us to be unable to fully feel our connection with the Earth, our own body, family and community, and makes it easier for us to destroy or ignore aspects of our being (Levine, 1997). To heal individual and collective trauma, we need to reconnect to the Earth, our bodies, the land, and our ancestors. Indigenous thinking asks us to look at material

reality as a metaphor instead of looking for scientific truth or legalistic fact (Rael, 1998). The medicine wheel suggests that the masculine is represented by the visible sunlit world above the ground, and the feminine by dark, rich fertile soil below Earth. Our modern Western cultural creation story is based on an understanding of God as only the sunlit world above the ground, and a de-valuing of the Earth below us and a hellish nightmare underground in our roots. Indigenous thinking suggests that this is a fundamental trauma affecting our identities and our ability to experience that we are interconnected with all beings and able to live in balance. Many of our ancestors were forced to adopt religious practices and beliefs and to abandon their homelands, and still today we are carrying and re-enacting these traumatic experiences deep in our roots. Perhaps as one indigenous writer suggests, we created the "artificial life of civilization" in order to seek help from a virus that overwhelmed our collective psyches and resulted in "great spiritual and moral loss" long ago (Ohiyesa, 2001, p. 53).

An indigenous approach to healing trauma suggests a need to experience empathy within our human family, living and ancestral, with other beings such as plants and animals, and to build a reverence for Mother Earth, our source of life. Through learning where we are out of balance on the medicine wheel, we are empowered to engage in healing practices based on indigenous wisdom. Through individual and collective efforts we can more deeply connect with the Earth, heal ourselves and our communities, and collectively experience a sense of belonging and placement where we are now living. We are increasingly interested in deeply listening in modern Western culture, with many people drawn to meditation, yoga, mindfulness and talk therapy. Perhaps the conditions are right for us to remember a deeper sense of awe and reverence for life, to measure wellness by strength of spirit, with spirit understood as a sense of wholeness (Feathers, 2014). On a medicine wheel each person and each being on Earth is an integral part of a whole, diverse, beautiful expression of life. Perhaps the greatest gift of our separation and colonial past is that through healing trauma, we can ultimately bring into being a holistic connection between humans, the Earth, and all beings. We can live simply, watching and waiting for beauty to appear (Rael, 2015).

**References**

Atkinson, J. (2002). *Trauma trails, recreating song lines: The transgenerational effects of trauma in Indigenous Australia*. Melbourne, Australia: Spinifex Press.

Bell, N. (2014). Teaching by the medicine wheel: An Anishinaabe framework for indigenous education. *Education Canada*, 54-56.

Beltran, R. & Begun, S. (2014). 'It is medicine': Narratives of healing from the Aotearoa Digital Storytelling as Indigenous Media Project (ADSIMP). *Psychology and Developing Societies* 26(2), 155-179.

Brave Heart, M. Y. H. (2003). The historical trauma response among Natives and its relationship with substance abuse; A Lakota illustration. *Journal of Psychoactive Drugs*, 35(1), 7-143.

Bright, B. (2009). *The Shamanic Perspective: Where Jungian Thought and Archetypal Shamanism Converge*. Retrieved from [http://findjungiantherapist.com/pdfs/The-Shamanic-Perspective-Jung\\_and\\_Shamanism-BBright.pdf](http://findjungiantherapist.com/pdfs/The-Shamanic-Perspective-Jung_and_Shamanism-BBright.pdf)

Cameron, J. (2016). *The artist's way: A spiritual path to higher creativity*. New York, NY: Penguin.

- Cervantes, J. & McNeill, B. (Eds.) (2008). *Latina/o healing practices: Mestizo and indigenous perspectives*. New York, NY: Routledge.
- Charbonneau-Dahlen, B. (2015). Hope: The dream Catcher-Medicine Wheel retention Model for diverse Nursing students. *Journal of Theory Construction & Testing*, 19(2), 47-54.
- Dapice, A. (2006). The medicine wheel. *Journal of Transcultural Nursing*, 17(3), 251-260.
- Desjarlais, S. (2012). Emptying the cup: Healing fragmented identity; An Anishinawbekwe perspective on historical trauma and culturally appropriate consultation. *Fourth World Journal*, 11(1), 43-96.
- Estes, C. P. (1992). *Women who run with the wolves: Myths and stories of the wild woman archetype*. Ballantine Books.
- Gonzales, P. (2012). *Red medicine: Traditional indigenous rites of birthing and healing*. Tuscon, AZ: University of Arizona Press.
- Green, E. & Honwana, A. (2001). Indigenous healing of war-affected children in Africa. *High Plains Applied Anthropologist* 1(21), 94-97.
- Guédon, M. (2000). Sacred smoke in circumboreal countries: An ethnobotanical exploration. *The Northern Review* 22, 29-42.
- Gustafson, F. (1997). *Dancing between two worlds: Jung and the Native American soul*. Mahwah, NJ: Paulist Press.
- Herman, J. (1992). *Trauma and recovery*. New York, NY: Basic Books.
- Ingerman, S. (1991). *Soul retrieval*. San Francisco, CA: Harper.
- Jaipal, R. (2004). Indian conceptions of mental health, healing and the individual. In Gielen, U., Fish, J. & Draguns, J. (Eds.). *Handbook of culture, therapy and healing*, pp. 293-308. Mahway, NJ: Routledge.
- Kakar, S. (1982). *Shamans, mystics, and doctors: A psychological inquiry into India and its healing traditions*. University of Chicago Press.
- Kimmerer, R. (2016, April). Robin Wall Kimmerer on scientific and Native American views of the natural world. (Tonino, L., interviewer) *The Sun*.
- Kinzie, J. (2007). PTSD among traumatized refugees. In Kirmayer, L., Lemelson, R., & Barad, M. (Eds.). (2007). *Understanding trauma: Integrating biological, clinical, and cultural perspectives*, pp. 190-206. Cambridge University Press.
- Kopacz, D. & Rael, J. (2016). *Walking the medicine wheel: Healing PTSD*. Tulsa, OK: Millchap Books.
- Levine, P. (1997). *Waking the tiger, Healing trauma: The innate capacity to transform overwhelming experiences*. Berkeley, CA: North Atlantic Books.
- Levy, P. *Dispelling Wetiko: Breaking the Curse of Evil*. *Quest* 102.4 (Fall), 146-151.
- Marsh, T., Coholic, D., Cote-Meek, S. & Najavits, L. (2015). Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in Northeastern Ontario, Canada. *Harm Reduction Journal* 12(1), 1-12.
- Medicine Wheel. (n.d.). Retrieved from: <http://www.crystalinks.com/medicinewheel.html>
- Mohagheghzadeh, A., Faridi, P., Shams-Ardakani, M., & Ghasemi, Y. (2006). Medicinal smokes. *Journal of ethnopharmacology*, 108(2), 161-184.
- Monteiro, N. M., & Wall, D. J. (2011). African dance as healing modality throughout the diaspora: the use of ritual and movement to work through trauma. *Journal of Pan African Studies*, 4(6), 234-52.
- Nautiyal, C. S., Chauhan, P. S., & Nene, Y. L. (2007). Medicinal smoke reduces airborne bacteria. *Journal of ethnopharmacology*, 114(3), 446-451.
- Núñez, S. (2008). Brazil's ultimate healing resource: The power of spirit. In Cervantes, J. & McNeill, B. (Eds.) *Latina/o healing practices: Mestizo and indigenous perspectives*, pp. 139-174. New York, NY: Routledge.
- Ohiyesa. (2001). *The soul of an Indian and other writings from Ohiyesa*. C. Nerburn (Ed.) Novato, CA: New World Library.
- Ojelede, I., McCray, K., Meyers, J. & Ashby, J. (2014). Use of indigenous African healing practices as a mental health intervention. *Journal of Black Psychology* 40(6), 491-519.
- Pendleton, B. (2014). *Narratives of trauma, spirituality, and healing: An Ecuadorian shamanic perspective*. (Doctoral dissertation). Retrieved from <http://pqdtopen.proquest.com/doc/1500558545.html?FMT=ABS>
- Pratt, C. (2007). *An encyclopedia of shamanism*. NY, NY: Rosen Publishing Group.
- Quinn, A. (2007). Reflections on intergenerational trauma: Healing as a critical intervention. *First Peoples Child and Family Review* 3(4), 72-82.
- Rael, J. (2015). *being & vibration: Entering the new world*. Tulsa, OK: Millichap Books.
- Rael, J. (1998). *Ceremonies of the living spirit*. Tulsa, OK: Council Oak Publishing.
- Reeves, A. (2013). *Biskanewin Ishkode (The fire that is beginning to stand): Exploring Indigenous mental health and healing concepts and practices for addressing sexual trauma*. (Doctoral dissertation). Retrieved from [https://tspace.library.utoronto.ca/bitstream/1807/43713/1/Reeves\\_Allison\\_J\\_201311\\_PhD\\_thesis.pdf](https://tspace.library.utoronto.ca/bitstream/1807/43713/1/Reeves_Allison_J_201311_PhD_thesis.pdf)
- Robbins, J. & Dewar, J. (2011). Traditional Indigenous Approaches to Healing and the modern welfare of Traditional Knowledge, Spirituality and Lands: A critical reflection on practices and policies taken from the Canadian Indigenous Example. *The International Indigenous Policy Journal*, 2(4). Retrieved from <http://ir.lib.uwo.ca/iipj/vol2/iss4/2>
- Smith, A. (2005). *Conquest: sexual violence and American Indian genocide*. Durham, NC: Duke University Press.
- Sussman, L. (2004). The role of culture in definitions, interpretations and management of illness. In Gielen, U., Fish, J. & Draguns, J. (Eds.). *Handbook of culture, therapy and healing*, pp. 37-65. Mahway, NJ: Routledge.
- Tick, E. (2012). *War and the Soul: Healing Our Nation's Veterans from Post-traumatic Stress Disorder*. Quest Books.

# It's good to go outside: A review of Nature-Based Child-Centered Play Therapy

Alexis Mitchell<sup>1</sup> & Natacha Benkendorff<sup>2</sup>

This paper provides an overview of the evidence-base for Child-Centered Play Therapy (CCPT) and nature-based therapies with children. In particular, it explores the theoretical roots of Nature-Based Child-Centered Play Therapy (NBCCPT), examines the current literature on its treatment efficacy, followed by a critical analysis of two contemporary studies of this approach. This paper concludes by reviewing some of the limitations of research in the field, and discusses possible future directions for research, ethical considerations, and implications for practice.

## It's good to go outside: A review of Nature-Based Child-Centered Play Therapy

Identifying effective therapeutic supports for children who suffer from emotional and behavioural problems is a growing concern in Australia. Play therapy is an established approach for working with young children with a growing evidence-base for its treatment efficacy (e.g., Baggerly, Ray, & Bratton, 2010; Blanco & Ray, 2011; Lin & Bratton, 2015; Ray, Armstrong, Balkin, & Jayne, 2015). Play therapy allows children to express themselves non-verbally, can be modified to suit the developmental stages, and can be conducted individually or in groups. Play is a natural activity providing children with opportunities to learn about themselves and their relationships in the world around them.

Research into the benefits of time in nature for children with behavioural and emotional concerns has emerged as an area of interest (Berger, 2006, 2008; Davis & Atkins, 2004; Etherington, 2012; Maller & Townsend, 2006; Peterson & Boswell, 2015; Stigsdotter et al., 2010). The use of nature in counselling has been influenced by ideas from ecology, environmental studies and environmental psychology (Greenleaf, Bryant & Pollack, 2014; Jordon, 2018; McLeod, 2013). It is widely acknowledged that outdoor play (compared to indoor play) provides unique opportunities and positive experiences, and is considered an essential component of childhood development (Louv, 2010; Wilson, 2008). However, with the rising availability of technology, young children are engaging in less and less

free outdoor play (Slutsky & DeShetler, 2017). Therefore, some children may welcome the opportunity to spend time outside during a counselling session. According to Gardner's theory of multiple intelligences (Gardner 2006, 2011), some children will have an innate affiliation with nature and a greater appreciation of their environmental surroundings (Wilson, 2008); resulting in a naturalist intelligence which should be embraced in a holistic approach for counselling children (Booth & O'Brien, 2008). Recently, an innovative approach to therapeutically working with young children in an outdoor setting has emerged: nature-based child-centered play therapy (NBCCPT) (Swank, Cheung, Prikhidko, & Su, 2017; Swank & Shin, 2015).

The purpose of this paper is to explore the theoretical roots of NBCCPT and examine the current literature on its treatment efficacy. An overview of the evidence-base for child-centered play therapy (CCPT) and nature-based therapies with children are presented, followed by a critical analysis of two contemporary studies which utilised NBCCPT. This paper concludes by looking at some of the limitations of research in the field thus far, discusses possible future directions for research, ethical considerations, and implications for practice.

## Child-Centered Play Therapy and evidence for its effectiveness

Psychoanalytical therapists such as Anna Freud (1928) and Melanie Klein (1932) were pioneers in developing play theories and techniques for working with children in therapy. Margaret Lowenfeld (1950/2010) went on to develop ground-breaking therapeutic play techniques, for the first-time incorporating possibilities for non-verbal spontaneous play with miniatures and sand trays. Virginia Axline's (1947) use of play to facilitate nondirective therapeutic principles in her work with children heralded the next, and perhaps most significant, development in the field of play therapy (Bratton, Ray, Rhine, & Jones, 2005; Kranz & Lund, 1993). Axline established

---

For correspondence: Dr Mark Pearson  
Email: mpearson@usc.edu.au  
<sup>1,2</sup> University of the Sunshine Coast

eight principles of nondirective play therapy emphasising the importance of a practitioner being able to follow the child's lead and respect the child's ability to solve his or her problems; much of current play therapy practice still encompasses these basic principles (Play Therapy United Kingdom, 2018). Contemporary scholars include Cochran, Nordling, and Cochran (2010), Louise Guerney (2001), and Garry Landreth (2012), who have all contributed significantly to the growing body of evidence in support of what is now commonly referred to as child-centered play therapy (CCPT).

Although many approaches to play therapy have emerged over time, CCPT appears to be the most frequently used approach in Australia (Play Therapy Australia, 2018), it has gained a strong international reputation (West, 1996; Wilson, Kendrick, & Ryan, 1992), and is also the most common approach used in the United States (Lambert et al., 2005). The basic tenets and structure of CCPT have been well documented in several works (i.e. Axline, 1989; Landreth, 2012; Ray, 2011; VanFleet, Sywulak, & Sniscak, 2010). In addition, there is extensive evidence supporting the efficacy of CCPT interventions for children with emotional, behavioural, and relational concerns (Baggerly et al., 2010; Blanco & Ray, 2011; Lin & Bratton, 2015; Ray, Armstrong, Balkin, & Jayne, 2015).

A number of randomised controlled trials (RCTs) demonstrated that children using CCPT showed statistically significant decreases in disruptive behaviours (Bratton et al., 2013; Garza & Bratton, 2005), social problems (Fall, Nevelski, & Welch, 2002), teacher/child relationship stress (Ray, Henson, Schottelkorb, Brown, & Muro, 2008; Ray, Schottelkorb, & Tsai, 2007), and increases in academic progress (Blanco, Muro, Holliman, Stickley, & Carter, 2015; Blanco & Ray, 2011) and language acquisition (Danger & Landreth, 2005). Controlled trials have also been utilised to test the efficacy of CCPT interventions for children with more serious mental health concerns such as anxiety (Ray et al., 2007; Stulmaker & Ray, 2015), depression (Tyndall-Lind, Landreth, & Giordano, 2001), and trauma (Schottelkorb, Doumas & Garcia, 2012; Shen, 2002).

Historically, RCTs have been regarded as the most reliable source of evidence in respect of therapy outcome (McLeod, 2015). However, the large volume of play therapy research that has been conducted in the past 80 years also includes many examples of case reports, qualitative, and observational studies in support of CCPT. Reviewing the strengths and limitations of the various research methodologies is beyond the scope of this article, however interested readers can refer to the following meta-analyses for more information regarding outcome effects of the various types of play therapy research (Bratton et al., 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015; Ray et al., 2015).

### **Nature-based therapies for children**

Nature provides calming and restorative impacts which are beneficial for physical and emotional well-being (Bermen, Jonides & Kaplan, 2008; Kaplan, 1995). When integrated into counselling, time in nature provides unique opportunities for healing (Greenleaf, Bryant & Pollack, 2014; Revell & McLeod, 2017). In terms of practical applications, one of the earliest approaches to use the outdoor environment for therapeutic

purposes was adventure therapy (McLeod, 2013). Adventure therapy emphasises the use of physical and psychological challenge to expose people to new experiences that invite them to view themselves in a new light (Ray, 2005; Richards & Smith, 2003). From this, new behaviours and strengths can emerge, all within the context of a challenging, yet supportive environment. Meta-analysis of participant outcomes by Bowen and Neill (2013) found that adventure therapy results in positive changes for a range of behavioural and mental health problems, particularly in older children. A recent outcome study into the sustained benefits of adventure therapy also showed improvements were retained over time (Bowen, Neill & Crisp, 2016). In addition, qualitative studies in adventure therapy, show time in nature can reduce stress, increase self-efficacy, and improve the subjective well-being of participants (Mutz & Müller, 2016).

Today, there exists a range of strategies for conducting counselling with children in outdoor settings. There is a growing body of evidence suggesting that outdoor play and time spent in nature for children help to increase creativity, social engagements, cognitive development, and emotional regulation (Gill, 2014; Kemple, Oh, Kenney & Smith-Bonahue, 2016; Townsend & Weerasuryia, 2010). Increasing student involvement in outdoor learning activities also correlates with improved academic performance (Quibell, Charlton, & Law, 2017). Qualitative studies show children's play becomes more active, engaged, and imaginative in more naturalised settings (Morrissey, Scott & Rahimi, 2017), leading to improvements in problem-solving, focus, creativity, and self-confidence (Brussoni, Ishikawa, Brunelle & Herrington, 2017; Maynard, Waters & Clement 2013). Exposure to nature during preschool has also been correlated with improved cognitive and self-regulatory functioning later in school (Ulset, Vitaro, Brendgen, Bekkhus & Borge, 2017). Based on the longitudinal data they obtained, these researchers also claimed that time in nature may be particularly important for children with inattention hyperactivity symptoms; which supports findings from previous research (i.e. Faber-Taylor & Kuo, 2011). Furthermore, in an investigation into patterns of intelligence in children with attention deficit hyperactivity disorder (ADHD), Schirduan and Case (2004) found that over half the students identified the naturalistic and spatial intelligences as their predominant or preferred intelligences.

Combining expressive art-based theories with an ecological philosophy also has potential for helping children at risk. A fully developed framework for the use of nature in therapy is the nature therapy approach created by Israeli therapist Ronen Berger (Berger 2004, 2005; Berger & McLeod, 2006). This manualised form of nature therapy uses healing metaphors, rituals, and drama techniques, and has supported thousands of young children with their resilience and recovery from trauma and loss due to war (Berger, 2016; Berger & Lahad, 2010).

There are several other creative approaches to using nature in therapies that have been developed in recent years. For example, Stewart and Echterling (2017) present a client-led play therapy case example where splashing water was used as a metaphor symbolising power and resilience which provided a breakthrough in the trauma recovery of a young child following a natural disaster. Further phenomenological case study research

has shown how outdoor drama therapy added value to therapy sessions with children by enhancing the clients' connection back to self and heightening experiences of metaphor and symbolism (Bassingthwaite, 2017). Similarly, the experience of making art in an outdoor studio following a natural disaster was believed to assist children in their recovery by helping them regain control and reconnect with their place of home (Linton, 2017).

### **Nature-Based Child-Centered Counselling: A contemporary counselling approach**

NBCCPT is a contemporary counselling approach that expands upon CCPT by emphasising the child's relationship with nature in addition to the therapeutic relationship with their counsellor. NBCCPT sessions take place within the natural environment and utilise natural materials instead of human-made toys. Swank and Shin (2015) were the first to introduce the idea of NBCCPT in a paper outlining the characteristics of this innovative therapeutic modality. The authors also presented three case reports providing initial observational evidence in support of using NBCCPT with children with behavioural problems. So far, there have been two published studies utilising NBCCPT with children. These studies and their outcomes are described in more detail below, and a review of the limitations, recommendations for future research, and implications for practice are included in the following sections.

Swank, Shin, Cabrita, Cheung, and Rivers (2015) implemented an A-B-A single-case research design to examine treatment effects for a NBCCPT intervention with four early elementary school children. The intervention was a seven-week program consisting of biweekly 30-minute individual NBCCPT sessions. Results from the study showed that two participants exhibited positive behavioural change during the 7-week intervention and maintained the change during follow-up, as measured by classroom observations. It is worth noting that the two participants who showed behavioural improvements during the intervention both had a formal diagnosis of ADHD prior to beginning the study. While these results are promising, they are not surprising given that previous researchers have found improvements among children with ADHD symptoms both when spending time in nature (Faber-Taylor & Kuo, 2009; Faber-Taylor, Kuo, & Sullivan, 2001) and when participating in traditional CCPT interventions (Ray et al., 2007).

Swank, Cheung, Prikhidko, and Su (2017) also used a single-case design to examine the effectiveness of nature-based, child-centered group play therapy (NBCCGPT) with five early elementary schoolchildren identified as having behavioural concerns. Children were randomly assigned to either a treatment ( $n = 3$ ) or waitlist ( $n = 2$ ) group. The treatment group participated in a six-week intervention that consisted of biweekly 30-minute sessions of NBCCGPT. Between group results indicated the treatment group were 2.03 times more likely to improve on-task behaviours, and 1.86 times more likely to decrease in total problem behaviours across the 6-week period compared to the waitlist group. The study also included a follow-up phase to track the behavioural changes of participants over time. Data from the follow-up phase revealed that children who participated in the NBCCGPT intervention were 2.59 times more likely to maintain

improved on-task behaviours, and .88 times more likely to maintain a decrease in total problems during the three weeks following the intervention.

### **Limitations and recommendations for future research**

Results from preliminary NBCCPT studies provide initial support for using this approach to address behavioural concerns in early primary schoolchildren. Although single-case design methodologies are well suited for counselling practitioners to document their work and provide evidence of the effectiveness of interventions, they are not without their limitations. For example, in both of the NBCCPT studies described above, there was a small sample size and the participant demographics were restricted to lower socioeconomic, African-American children. Consequently, ability to generalise findings to larger populations should not be assumed. Variability in participant data during the baseline phase was also a concern in both studies. When scores in the baseline differ, it becomes difficult to determine whether there is any pattern prior to beginning the intervention (Engel & Schutt, 2005).

Another potential limitation of the studies is that participant selection was largely at the discretion of teachers, who provided the only source of data about the children's behaviour prior to beginning the study. Positively, both studies utilised the Direct Observation Form (DOF; McConaughy & Achenbach, 2009) to measure behaviour before and after treatment. The DOF provides an objective measurement (as opposed to anecdotal reports) with high interrater reliability ranging from .71 to .97 (McConaughy & Achenbach, 2009). Future studies may consider obtaining additional data about potential participants from other sources such as counsellors and parents. In doing so, future researchers could also examine whether gains in behavioural improvements generalise to settings outside the classroom.

Given the improvements noted for the children in the studies with pre-existing ADHD diagnoses, researchers might also like to examine treatment effects with this and other more specific mental health population groups. Because NBCCPT is a new approach to working with children, any inquiries into this therapeutic modality will provide a valuable foundation to further testing of its treatment efficacy. Scholars interested in this area might consider replicating the existing studies, comparing their interventions to other group or play therapy interventions, or helping to further document and manualise the specific procedures involved. With a degree of standardisation of procedures, future researchers can focus on identifying what aspects of NBCCPT are most important to the therapeutic process and which process techniques are most effective at eliciting positive behavioural and emotional changes in children.

### **Ethical considerations, implications for practice, and concluding remarks**

The natural setting presents new opportunities and challenges that counsellors would need to consider when providing a safe, therapeutic environment. Therapy outdoors requires a strong therapeutic alliance, sound knowledge of the location, consideration of appropriate safety measures, and a

high degree of competence on behalf of the therapist, to cope with the unpredictability of being in nature (Berger, 2009; Revell & McLeod, 2016). Other issues raised by commentators include identifying appropriate training and supervision, revisions to discussions of informed consent, maintaining boundaries and protecting client confidentiality in an open counselling atmosphere, considerations for appropriate documentation of outdoor sessions, and how counsellors can best respect diversity and honour their clients' worldviews on nature (Hooley, 2016; Reese, 2016).

Despite its limitations and ethical complexities, NBCCPT provides counsellors with an innovative approach that addresses many of the barriers to offering traditional play therapy such as limited space for an indoor playroom, and problems associated with lack of funding for materials (Ebrahim, Steen, & Paradise, 2012; Swank & Shin, 2015). There is also evidence to suggest that because of the non-traditional approach of NBCCPT, counsellors may have an opportunity to reach children and families who are otherwise reluctant to seek counselling (Swank et al., 2015). However, as with any counselling approach, NBCCPT may not be appropriate for every child. For example, children with obsessive-compulsive tendencies, severe allergies, or those who are in need of visible boundaries may struggle in a natural environment (Swank & Shin, 2015).

It is not known how many counsellors currently incorporate nature-based therapies in practice and to what extent those that do so consider the ethical complexities of the approach (Reese, 2016); this in itself could be an area of future enquiry. Before implementing NBCCPT it is crucial for the counsellor to have experience with the approach and to be comfortable within the natural environment. Although there is initial support for going outside and using NBCCPT with children to address behavioural concerns, the approach is still developing, and a stronger evidence base is needed.

## References

- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington, VT: Achenbach Research Center for Children, Youth, and Families.
- Axline, V. (1947). *Play therapy*. New York: Ballantine Books.
- Axline, V. (1989). *Play therapy*. Edinburgh: Churchill Livingstone. (Original work published in 1947).
- Baggerly, J., Ray, D., & Bratton, S. (2010). *Child-centered play therapy research: The evidence base for effective practice*. Hoboken, NJ: John Wiley & Sons.
- Bassingthwaite, L. (2017). Taking dramatherapy into the outside space – the benefits and obstacles when working with children with SEMH issues. *Dramatherapy*, 38(1), 16-31. doi:10.1080/02630672.2017.1291846
- Berger, R. (2004). Therapeutic aspects of nature therapy. *Therapy through the arts: The Journal of the Israeli Association of Creative and Expressive Therapies*, 3 60-69.
- Berger, R. (2005). Using contact with nature, creativity and rituals as a therapeutic medium with children with learning difficulties. *Emotional and Behavioural Difficulties*, 11(2), 135-146. doi:10.1080/13632750802440361
- Berger, R. (2006). Using contact with nature, creativity and rituals as a therapeutic medium with children with learning difficulties. *Emotional and Behavioural Difficulties*, 11(2), 135-146.
- Berger, R. (2008). Going on a journey: a case study of nature therapy with children with a learning difficulty. *Emotional and Behavioural Difficulties*, 13(4), 315-326.
- Berger, R. (2009). Nature therapy: Thoughts about the limitations of practice. *Journal of Humanistic Psychology*, 50(1), 65-76. doi:10.1177/0022167809333999
- Berger, R. (2016). Renewed by nature: Nature therapy as a framework to help people deal with crises, trauma and loss. In M. Jordan, and J. Hinds (Eds.), *Ecotherapy: Theory, research and practice* (pp 177-185). London, UK: Palgrave.
- Berger, R., & Lahad, M. (2010). A safe place: Ways in which nature, play and creativity can help children cope with stress and crisis – establishing the kindergarten as a safe haven where children can develop resiliency. *Early Child Development and Care*, 180(7), 889-900. doi:10.1080/03004430802525013
- Berger, R. & McLeod, J. (2006). Incorporating nature into therapy: A framework for practice. *Journal of Systemic Therapies*, 25(2), 80-94. doi:10.1521/jsyt.2006.25.2.80
- Berman, M. G., Jonides, J., & Kaplan, S. (2008). The cognitive benefits of interacting with nature. *Psychological Science*, 19(12), 1207-1212. doi:10.1111/j.1467-9280.2008.02225.x
- Blanco, P., Muro, J., Holliman, R., Stickley, V., & Carter, K. (2015). Effect of child-centered play therapy on performance anxiety and academic achievement. *Journal of Child and Adolescent Counseling*, 1, 66-80. doi:10.1080/23727810.2015.1079117
- Blanco, P., & Ray, D. (2011). Play therapy in the schools: A best practice for improving academic achievement. *Journal of Counseling & Development*, 89, 235-242. doi:10.1002/j.1556-6678.2011.tb00083.x
- Booth, R., & O'Brien, P. J. (2008). An holistic approach for counsellors: Embracing multiple intelligences. *International Journal of Advanced Counselling*, 30, 79-92. doi:10.1007/s10447-008-9046-0
- Bowen, D. J., & Neill, J. T. (2013). A meta-analysis of adventure therapy outcomes and moderators. *The Open Psychology Journal*, 6, 28-53. doi:10.2174/1874350120130802001.
- Bowen, D. J., Neill, J. T., & Crisp, S. J. (2016). Wilderness adventure therapy effects on the mental health of youth participants. *Evaluation and Program Planning*, 58, 49-59. doi: 10.1016/j.evalprogplan.2016.05.005
- Bratton, S., Ceballos, P., Sheely-Moore, A., Meany-Walen, K., Pronchenko, Y., & Jones, L. (2013). Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy*, 22, 28-42. doi:10.1037/a0030318
- Bratton, S., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36, 376-390. doi:10.1037/0735-7028.36.4.376
- Brussoni, M., Ishikawa, T., Brunelle, S., & Herrington, S. (2017). Landscapes for play: Effects of an intervention to promote nature-based risky play in early childhood centres. *Journal of Environmental Psychology*, 54, 139-150. doi: 10.1016/j.jenvp.2017.11.001
- Cochran, N. H., Nordling, W. J., & Cochran, J. L. (2010). *Child*

*centered play therapy: A practical guide to developing therapeutic relationships with children.* New York: Wiley Books.

Danger, S., & Landreth, G. (2005). Child-centered group play therapy with children with speech difficulties. *International Journal of Play Therapy*, 14, 81-102. doi:10.1037/h0088897

Davis, K. M., & Atkins, S. S. (2004). Teaching a course in ecotherapy: We went to the woods. *Journal of Humanistic Counseling, Education and Development*, 43, 211-218.

Ebrahim, C., Steen, R. L., & Paradise, L. (2012). Overcoming school counselors' barriers to play therapy. *International Journal of Play Therapy*, 21, 202-214. doi:10.1037/a0029791

Engel, R., & Schutt, R. K. (2005). Single-subject design. In J. Westby (Ed.), *The practice of research in social work*. London, UK: Sage Publications.

Etherington, N. (2012). Gardening for children with autism spectrum disorders and special educational needs : engaging with nature to combat anxiety, promote sensory integration and build social skills. London, UK: Jessica Kingsley Publishers.

Faber-Taylor, A. F., & Kuo, F. E. (2009). Children with attention deficits concentrate better after walk in the park. *Journal of Attention Disorders*, 12, 402-409. doi:10.1177/1087054708323000

Faber-Taylor, A. F., & Kuo, F. E. (2011). Could exposure to everyday green spaces help treat ADHD? Evidence from children's play settings. *Applied Psychology: Health and Well-Being*, 3(3), 281-303. doi:10.1111/j.1758-0854.2011.01052.x

Faber-Taylor, A. F., Kuo, F. E., & Sullivan, W. C. (2001). Coping with ADD: The surprising connection to green play settings. *Environment and Behavior*, 33, 54-77. doi:10.1177/00139160121972864

Fall, M., Nevelski, L., & Welch, K. (2002). Outcomes of a play therapy intervention for children identified for special education services. *International Journal of Play Therapy*, 11, 91-106. doi:10.1037/h0088866

Freud, A. (1928). *Introduction to the technique of child analysis*. New York: Nervous and Mental Disease Publishing.

Gardner, H. (2006). *Multiple intelligences. New horizons*. New York: Basic Books.

Gardner, H. (2011). *Frames of mind: The theory of multiple intelligences*. New York: Basic Books.

Garza, Y., & Bratton, S. (2005). School-based child centered play therapy with Hispanic children: Outcomes and cultural considerations. *International Journal of Play Therapy*, 14, 51-80. doi:10.1037/h0088896

Gill, T. (2014). The benefits of children's engagement with nature: A systematic literature review. *Children, Youth and Environments*, 24(2), 10. doi:10.7721/chilyoutenvi.24.2.0010

Greenleaf, A. T., Bryant, R. M., & Pollock, J. B. (2013). Nature-based counseling: Integrating the healing benefits of nature into practice. *International Journal for the Advancement of Counselling*, 36(2), 162-174. doi:10.1007/s10447-013-9198-

Guerney, L. (2001). Child-centered play therapy. *International Journal of Play Therapy*, 10, 13-31. doi:10.1037/h0089477

Hooley, I. (2016). Ethical Considerations for psychotherapy in natural settings. *Ecopsychology*, 8(4), 215-221. doi:10.1089/eco.2016.0008

Jordon, M. (2018). Ecotherapy as psychotherapy: Towards an ecopsychotherapy. In M. Jordan, & J. Hinds (Eds.), *Ecotherapy:*

*Theory, research and practice* (pp 58-69). London, UK: Palgrave. Kaplan, S. (1995). The restorative benefits of nature: Toward an integrative framework. *Journal of Environmental Psychology*, 15(3), 169-182. doi:10.1016/0272-4944(95)90001-2

Kemple, K. M., Oh, J., Kenney, E., & Smith-Bonahue, T. (2016). The power of outdoor play and play in natural environments. *Childhood Education*, 92(6), 446-454. doi:10.1080/00094056.2016.1251793

Klein, M. (1932). *The psycho-analysis of children*. London: Hogarth Press.

Kranz, P. L., & Lund, N. L. (1993). Axline's eight principles of play therapy revisited. *International Journal of Play Therapy*, 2(2), 53-60. doi:10.1037/h0089263

Lambert, S., LeBlanc, M., Mullen, J., Ray, D., Baggerly, J., White, J., & Kaplan, D. (2005). Learning more about those who play in session: The national play therapy in counseling practices project. *International Journal of Play Therapy*, 14(2), 7-23. doi:10.1037/h0088900

Landreth, G. (2012). *Play therapy: The art of the relationship* (3rd edn.). New York, NY: Routledge.

LeBlanc, M., & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counseling Psychology Quarterly*, 14, 149-163. doi:10.1080/09515070126334

Lin, D., & Bratton, S. (2015). A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling & Development*, 93, 45-58. doi:10.1002/j.1556-6676.2015.00180.x

Linton, J. (2017). A natural response to a natural disaster: The art of crisis in Nepal. *Canadian Art Therapy Association Journal*, 30(1), 31-40. doi:10.1080/08322473.2017.1317201

Louv, R. (2010). *Last child in the woods: Saving our children from nature-deficit disorder*. London: Atlantic Books.

Lowenfeld, M. (1950/2010). The nature and use of the Lowenfeld World Technique in work with children and adults. *The Journal of Psychology*, 30(2), 325-331, Doi: 10.1080/00223980.1950.9916070

Maller, C. J., & Townsend, M. (2006). Children's mental health and wellbeing and hands-on contact with nature: Perceptions of principals and teachers. *International Journal of Learning*, 12, 357-373.

Maynard, T., Waters, J., & Clement, J. (2013). Child-initiated learning, the outdoor environment and the 'underachieving' child. *Early Years*, 33(3), 212-225, doi:10.1080/09575146.2013.771152

McConaughy, S. H., & Achenbach, T. M. (2009). *Manual for the ASEBA direct observation form*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

McLeod, J. (2013). *An introduction to counselling*. (5th edn.). London: Open University Press.

McLeod, J. (2015). *Doing research in counselling and psychotherapy*. (3rd edn.). London: SAGE Publications.

Morrissey, A., Scott, C., & Rahimi, M. (2017). A comparison of sociodramatic play processes of preschoolers in a naturalized and a traditional outdoor space. *International Journal of Play*, 6(2), 177-197. doi:10.1080/21594937.2017.1348321

Mutz, M., & Müller, J. (2016). Mental health benefits of outdoor adventures: Results from two pilot studies. *Journal of Adolescence*, 49, 105-114. doi:10.1016/j.adolescence.2016.03.009



- Peterson, D., & Boswell, J. N. (2015). Play therapy in a natural setting: a case example. *Journal of Creativity in Mental Health*, 10(1), 62-76.
- Play Therapy Australia. (2018). Advanced play therapy practices helping children heal and grow. Retrieved from <http://www.playtherapyaustralia.com/kids>
- Play Therapy United Kingdom (2018). Axline's basic principles of non-directive play therapy. Retrieved from <https://playtherapy.org.uk/ChildrensEmotionalWellBeing/AboutPlayTherapy/MainPrinciples/AxlinePrinciples>
- Quibell, T., Charlton, J., & Law, J. (2017). Wilderness schooling: A controlled trial of the impact of an outdoor education programme on attainment outcomes in primary school pupils. *British Educational Research Journal*, 43(3), 572-587. doi:10.1002/berj.3273
- Ray, D. (2011). *Advanced play therapy: Essential conditions, knowledge and skills for children practice*. New York, NY: Routledge.
- Ray, D., Armstrong, S., Balkin, R., & Jayne, K. (2015). Child centered play therapy in the schools: Review and meta-analysis. *Psychology in the Schools*, 52, 107-123. doi:10.1002/pits.2179
- Ray, D., Henson, R., Schottelkorb, A., Brown, A., & Muro, J. (2008). Impact of short-term and long-term play therapy services on teacher child relationship stress. *Psychology in the Schools*, 45, 994-1009. doi:10.1002/pits.20347
- Ray, D., & McCullough, R. (2015; revised 2016). Evidence-based practice statement: Play therapy (Research Report). Retrieved from Association for Play Therapy website: <http://www.a4pt.org/?page=EvidenceBased>
- Ray, D., Schottelkorb, A., & Tsai, M. (2007). Play therapy with children exhibiting symptoms of attention deficit hyperactivity disorder. *International Journal of Play Therapy*, 16, 95-111. doi:10.1037/1555-6824.16.2.95
- Ray, N. (2005). Transactions on the rock face. *Therapy Today*, 16(10), 15-17.
- Reese, R. F. (2016). Ecowellness and guiding principles for the ethical integration of nature into counseling. *International Journal for the Advancement of Counselling*, 38(4), 345-357. doi:10.1007/s10447-016-9276-5
- Revell, S., & Mcleod, J. (2017). Therapists' experience of walk and talk therapy: A descriptive phenomenological study. *European Journal of Psychotherapy & Counselling*, 19(3), 267-289. doi:10.1080/13642537.2017.1348377
- Richards, K., & Smith, B. (Eds.) (2003) *Therapy with adventure*. Augsburg: Ziel Publications.
- Schirduan, V., & Case, K. (2004). Mindful curriculum leadership for students with attention deficit hyperactivity disorder: Leading in elementary schools by using multiple intelligences theory (SUMIT). *Teachers College Record Volume*, 106(1), 87-95. doi:10.1111/j.1467-9620.2004.00449.x
- Schottelkorb, A., Dumas, D., & Garcia, R. (2012). Treatment for childhood refugee trauma: A randomized, controlled trial. *International Journal of Play Therapy*, 21, 57-73. doi:10.1037/a0027430
- Shen, Y. (2002). Short-term group play therapy with Chinese earthquake victims: Effects on anxiety, depression, and adjustment. *International Journal of Play Therapy*, 11(43-63). doi:10.1037/h0088856
- Slutsky, R., & DeShetler, L. M. (2017). How technology is transforming the ways in which children play. *Early Child Development and Care*, 187(7), 1138-1146. doi:10.1080/03004430.2016.1157790
- Stewart, A. L., & Echterling L. G. (2017). The sound of silence in play therapy. In C. A. Malchiodi, and D. A Crenshaw, (Eds.), *What to do when children clam up in psychotherapy: Interventions to facilitate communication* (pp 69-86). New York, NY: The Guilford Press.
- Stigsdotter, U. K., Palsdottir, A. M., Burls, A., Chermaz, A., Ferrini, F., & Grahn, P. (2010). Nature-based therapeutic interventions. In K. Nilsson and M. Snagster (Eds.), *Forests, trees and human health*. (pp. 309-342). New York, NY: Springer.
- Stulmaker, H., & Ray, D. (2015). Child-centered play therapy with young children who are anxious: A controlled trial. *Children and Youth Services Review*, 57, 127-133. doi:10.1016/j.childyouth.2015.08.005
- Swank, J. M., Cheung, C., Prikhidko, A., & Su, Y. W. (2017). Nature-based child-centered play therapy and behavioural concerns: A single-case design. *International Journal of Play Therapy*, 26(1), 47-57. doi:10.1037/pla0000031
- Swank, J. M., & Shin, S. M. (2015). Nature-based child-centered play therapy: An innovative counseling approach. *International Journal of Play Therapy*, 24(3), 151-161. doi:10.1037/a0039127
- Swank, J. M., Shin, S. M., Cabrita, C., Cheung, C., & Rivers, B. (2015). Initial investigation of nature-based, child-centered play therapy: A single-case design. *Journal of Counseling & Development*, 93, 440-450. doi:10.1002/jcad.12042
- Townsend, M., & Weerasuryia, R. (2010). Beyond blue to green: The health benefits of contact with nature for mental health and well-being. Retrieved from <https://www.beyondblue.org.au>
- Tyndall-Lind, A., Landreth, G., & Giordano, M. (2001). Intensive group play therapy with child witnesses of domestic violence. *International Journal of Play Therapy*, 10, 53-83. doi:10.1037/h0089443
- Ulset, V., Vitaro, F., Brendgen, M., Bekkhus, M., & Borge, A. I. (2017). Time spent outdoors during preschool: Links with children's cognitive and behavioral development. *Journal of Environmental Psychology*, 52, 69-80. doi: 10.1016/j.jenvp.2017.05.007
- VanFleet, R., Sywulak, A., & Sniscak, C. (2010). *Child centered play therapy*. New York, NY: Guilford.
- West, J. (1996). *Child centred play therapy* (2nd ed.). London, UK: Hodder Arnold.
- Wilson, K., Kendrick, P., & Ryan, V. (1992). *Play therapy: A nondirective approach for children and adolescents*. London, UK: Bailliere Tindall.
- Wilson, R. A. (2008). *Nature and young children: Encouraging creative play in natural environments*. London, UK: Routledge.

# Frangible Emotion Becomes Tangible Expression: Poetry as Therapy with Adolescents

John D. Allen<sup>1</sup>, Karen Carter<sup>2</sup> & Mark Pearson<sup>3</sup>

This article investigates a range of literature, research, and therapeutic outcomes associated with Poetry Therapy as a therapeutic modality for supporting adolescents. Poetry Therapy has been shown to be an effective counselling tool when engaging with adolescents and their experiences of transition from childhood to adulthood. Like all creative arts therapies, Poetry Therapy can strengthen self-understanding and be a bridge between known and forgotten aspects of the psyche. While there is a growing evidence base that strongly suggests Poetry Therapy is effective, there are recommendations to strengthen the reliability of research outcomes.

*“Through the act of arranging words on paper, we forge new meaning out of the feelings, images and memories that shape us.” (Chavis, 2011, p. 12).*

This paper explores the descriptive and research literature associated with poetry as a therapeutic process, and considers its appropriateness to supporting adolescents. ‘Adolescence’ refers to a period between puberty and adulthood, a time full of change and transitions in mind, body, and emotions, connecting two opposite and complex worlds between the fading cries of childhood and the impending calls of adult life. Poetry Therapy (PT) is recommended as a way these worlds can be reconciled through a voice of resolve expressed through poetry. PT has been shown to be an effective counselling tool when engaging with adolescents and the meanings they associate with their transitional experiences. Like all creative arts therapies, PT can strengthen self-understanding and be a bridge between known and forgotten aspects of the psyche. As an adjunct to talking therapy, expressive writing can potentially unlock the propensity for unhealthy suppression or self-concealment, thus allowing the integration of a more authentic ‘Self’ (Larson, Chaston, Hoyt, & Ayzenberg, 2015).

## Background

The written word, including poetry, has held a place in society for thousands of years; fragments of personal experience, descriptions of historical and social events, collected

and collated for generations to come. From Biblical scriptures such as the Song of Songs or the Psalms; the Poet’s Creed within the Quran; Buddhist exaltations of life and death, they all express observations of the human experience from a catchment of distilled poetic thoughts and feelings shared through words. The Greek root word for poetry is Poesis, meaning “calling into existence that which has not existed before” (Gorelick, 2007, p. 117). The creation of poetry can be a healing process through the breaking of an internal silence and overcoming barriers to authentic living (Bolton, 1999). This creative expressive illumination of ‘Self’ can be a powerful cathartic experience, which taps into the intuitive and often unreasoned or un-worded well of understanding within (Bolton, 1999). These aspects of self are positive qualities, strengths, or hidden treasures beneath surface awareness, until brought to light in a therapeutic moment of awakening (Pearson & Wilson, 2009). Those difficult-to-access aspects of the psyche deserve, and need, expression, and can incorporate transformations of anxious, confused or unsettled thoughts that have been implicitly stored (Bolton, 2008), to intentional resolve, illuminating illusive thoughts and feelings. Mazza (2016) asserts that life is defined in those fortuitous, but uncomfortable moments, when the only way through challenges is to crawl. In times of challenge a sense of emptiness can be replaced by a sense of hope.

Although the philosophers Sophocles and Nietzsche regarded the phenomenon of hope as illusory and deceptive, in the area of psychotherapy, it is now established that it is hope which leads to positive therapeutic changes (Tarhan, Bacanli, Dombayci & Demir, 2011). Daboui, Janbabai and Siavash (2018) found an eight-week group PT program increased hope and decreased anxiety with a group of women recovering from breast cancer. As far back as 1987, Mazza, Magaz and Scaturro provided case examples of abused young people’s PT creations that evidenced increases in hope, and discussed the

---

Correspondence to: Dr Mark Pearson  
Email: mpearson@usc.edu.au  
<sup>1,2</sup> University of the Sunshine Coast

way belonging to a PT group could enhance a sense of hope in individuals.

The best-known founders of Western psychotherapy, Sigmund Freud and Carl Jung, held conflicting viewpoints in relation to the value of poetry (Mazza, 2016). "Not I, but the poet discovered the unconscious," wrote Freud (NAPT, n.d.). Jung saw symbols within poetry as holding an allusive quality, whereas Freud regarded those symbols as troubling psychological symptoms. Freud viewed poetry negatively and coupled art with neurosis, whereas Jung considered that the poet held the right to interpret his or her own poems, believing a poet existed within each person (Mazza, 2016). Freud considered a poem to be a dream, which dismissed its value in communication, and his patriarchal perspective made it difficult to appreciate the matriarchal aspects of women's poetry (Burke, 1939). For Jung poetry was able to stretch beyond human imaginings to places unreachable (Conroy, 1999), allowing "a glimpse into the unfathomed abyss of what has not yet become" (Jung, 1961, p. 181), or a doorway to unconscious treasures. Along with Jung, other theoreticians, such as Adler, Jung, Arieti and Reik also confirmed that the poets were the first to chart paths that science later followed.

Samuel Crothers first used the term "bibliotherapy" in 1916, and in 1928, Eli Greifer, an inspired poet, began a campaign to show that a poem's message has healing power (NPTA, n.d.), and in 1932 Moreno uses the term "psychopoetry" to describe the use of selected literature in his work. However, the modern field of PT developed from the work of psychiatrist Dr Jack Leedy (1921 – 2004). Leedy opened a poetry therapy clinic in Brooklyn, and in 1986 published the classic *"Poetry as Healer: Mending the troubled Mind"*, with contributions from psychiatrists, psychologists and social workers, who had all used poetry for healing. Leedy's passion and commitment attracted the attention of therapists and educators, and he was instrumental in the formation of the first Association for Poetry Therapy (APT) in New York (Gorelick, 2007).

## Poetry Therapy in action

As one of the expressive arts therapies, PT is ideal for both individual and group therapy sessions. PT is pluralistic and therefore versatile and has been incorporated into several therapeutic modalities, such as Gestalt and Narrative therapies. The inclusion of storytelling, metaphors and journaling within therapy sessions are features of PT (Mazza, 2016). The value of poetry within counselling can be better explained through the mind of the poet Wordsworth, who stated that the act of writing poetry demands a depth of thought and is "the spontaneous overflow of feelings" (Mazza, 2016, p. 4). During this overflow the writer has the opportunity to decipher what meaningful value is illuminated. Distinguishing and identifying emotions is a key task of Emotion-focused Therapy (EFT; Greenberg, 2002). EFT offers clients coaching to discern which emotions need to be expressed out loud or reflected on, controlled or used to guide decision-making; when the emotional world is held secret, the flow of interpretation and understanding may be restricted or stifled by unconscious fear, or flooded by excessive expression.

The psychological turmoil that many adolescents

experience has been identified since the early days of psychology when Hall (1904) referred to the ' Sturm und Drang' (storm and stress) that seemed to be associated with this developmental stage (Berman & Davis-Berman, 2013). This stress is partly manifested, for some, through the development of mental health problems. Adolescents are more vulnerable to developing mental health problems based on their stage of development. Some of the factors that contribute to adolescent mental health problems include genetics, poverty, family instability, divorce, and substance abuse. The consequences of adolescent mental health disorders are serious and include psychological disability and even suicide (Patel, Flisher, Hetrick, & McGarry, 2007). It has been argued that these dynamics appear to be worldwide rather than restricted to certain countries (Patel et al., 2007).

PT has distinct activities and uses within therapy that can begin to resolve adolescent stress. It can generate reflection, where the symbols, concepts and personal expressions of published poets can be discussed and individual meaning formulated. When joy or pain is shared, the identification the adolescent discovers with the poet is reassurance that he or she is not alone (Leedy & Reiter, 2016). The 19th Century philosopher and essayist, J. S. Mill (Chavis, 2011) identified the curative powers of poetry within the pages of his autobiography, as having suffered from severe depression in his youth, it was when he saw his own affliction expressed in Samuel Coleridge's 'Dejection Ode' that healing began (Chavis, 2011). This positive experience encouraged him to explore poetry further, and it was through William Wordsworth's nature poetry he found the hope he needed to recover (Chavis, 2011).

Thomas and Krout (2006) researched the effects for bereaved adolescents participating in a 'Grief Song-writing Process', with poignant increases in rapport, trust, insight, integrating experiences, and creative responses to dealing with grief processes. Another PT activity is to allow the client space, a focused time of self-contact, where the emotional world can be explored and expressed in their own words. This may occur during a therapy session, or as a personal process outside of therapy sessions. There are specific gains through each process, particularly if the emerging self-awareness is shared with a therapist. An example of an outcome of self-expression from this process is demonstrated in 'Growing Pains'; the breach into adult concepts (Allen, 1975; See Appendix I). This poem accentuates the author's personal despair felt in "sleeping with dreams, waking with nightmares, black sunbeams, suicide light flares". During the process of writing a poem for the first time, a resolve occurs within this sixteen year old. He finds himself released through his tears, as expressed in the realisation that "suddenly it rains".

As with any style of therapy, the effectiveness of PT may be closely connected to establishing a therapeutic alliance, the readiness of the client, and the skill of the therapist (Angelotti, 1985). Counsellors need to get to know the client well, as well as the poetry being used to generate reflection, and recognise the creation and response to poetry as part of the normal adolescent development (Angelotti, 1985).

Pearson and Wilson (2009) expand on using the written word with the inclusion of drawings and symbols as part of a

therapy approach to bring richly-layered meaning to undiscovered aspects of the client's inner and outer worlds. They suggest these forms of therapy can utilise methods such as *reflective writing*, to develop self-awareness; *process writing*, to allow spontaneous emotional release; and *completion writing*, bringing together the fragments expressed as an integration of the experience (Pearson & Wilson, 2009). An example of reflective writing is presented here in the poem *No Need for Wings* (See Appendix II). In their experience, writing appears to have the potential to open and activate the neural pathways which previously carried traumatic information (Pearson & Wilson, 2009). They describe this personal journey in therapy, incorporating expressive writing, as an emotional first aid response (Pearson & Wilson, 2009).

Among the benefits of using PT with adolescents for personal insight gained through their experiences of transitional change, is also a way for clients to feel connected to others through a collective conversation across time and space, where identities are recognised through self-expression and/or the words of others (Kwok, 2010). Additionally, the expression of emotional, intellectual, and spiritual concerns can positively impact behaviours (Adedokun, 2001; Williams, 1990, as cited in Chuma-Ibe, 2011). Creating and reading these illuminations has a way of permeating or expanding an individual's understanding of life and the experience of the collective human condition.

Reflection on lyrics from songs which have personal significance for young people may be an alternative way to connect or share light on personal writing. A major strength of PT is the positive effect it can have on group cohesion, as where a sense of safety, comfort and belonging exists, then commitment can emerge. However, when choosing literature for the group, such as a poem or song lyrics, it is critical that care is taken by the therapist to select what is suitable for the particular clients (Golden, 2000).

In a study on the efficacy of art and writing therapy after traumatic experiences, Pizarro (2004) contended that participants using writing therapy showed a decrease in social dysfunction, and those using art therapy reported a positive reflection when relating the experience to others.

One group activity approach involving PT is to combine the creation of mandalas with writing poetry. Each participant writes down a word to express what they could see within each mandala and the creator of the mandala gathers the words to create a poem, as part of an integration process (Rappaport, 2014). This integration adds to both personal and group cohesion as a therapeutic process. Group therapy activities can add the social connection advantage, to increase positive outcomes.

## The growing evidence-base

Qualitative or phenomenological research, though representing less than ten percent of research in counselling and psychotherapy, is more focused on exploring, describing, and analysing meaning within the human mind (McLeod, 2015), and may therefore be ideal to capture the outcomes from PT. Due to the difficult-to-delineate nature of PT assessment frameworks in some research projects, the emerging evidence is primarily qualitative. As with the early stages of research in many areas of psychotherapy, a predomination of anecdotal/clinical observation

methods is prevalent in identifying outcomes based on the words and concepts used by adolescent clients, than exhibited behaviours.

People with experience as mental health clients, mental health nurses, writers and other professionals have used literature to benefit mental health service users in many ways, and various benefits have been described, but some accounts do not include evidence of clinical effectiveness (McArdle, & Byrt, 2001). "Further work is needed to clarify and measure the effectiveness of various expressive and therapeutic uses of literature" (McArdle & Byrt, 2001, p. 517). However, positive outcomes have been reported, with particular evidence of clinical effectiveness in some studies of PT.

In early research on the outcomes of using writing therapeutically, Pennebaker (1997) reported on the physical health improvements, subjective wellbeing and some positively adapted behaviours when emotional experiences are expressed in writing. Further research is necessary, to explore the phenomenon associated with engendering neural pathway connections in the adolescent developing brain, as according to Frankfurt and Penn (1998), writing expands personal voices by associating with feelings, memories, images, dilemmas, dreams and unconscious relationships, that therapeutic conversation alone struggles to connect and convey.

A peak period of research into the effectiveness of PT was 1999 to 2010, and this research was primarily in the fields of psychiatry and psychology (Heimes, 2011). While PT is more established and documented in the USA, there is still a need for developing new methods of evaluating its use (Heimes, 2011), as most of the studies correspond to Level 5 on the scale of evidence-based medicine, that is "expert opinion" (Oxford Centre for Evidence-based Medicine). The effectiveness of PT has been explored as applied to anxiety disorders, depression and schizophrenia, and initial research in its application in care of the elderly and terminally ill suggests it will have a growing number of contexts (Heimes, 2011). For example, group PT has been found, through self-reports, to improve quality of life in breast cancer patients (Gozashti, Moradi, Elyasi, & Daboui, 2017), however self-reports, while widely used, are considered to have a level of unreliability, particularly around sensitive information from adolescent participants (Johnson & Richter, 2004).

A qualitative analysis of lyrics, notably rap and hip-hop favoured by young black Americans, revealed a tendency within the lyrics to rebel against accepted norms, but without showing how to combat life's obstacles (Harper, Terry, & Twiggs, 2009). In response to this, PT was seen to inspire in a positive way, as this process allowed participants the time needed to consider the poems' hidden messages and assist them to better understand their own identities (Harper, Terry, & Twiggs, 2009).

The statement that "Writing is a way of saying things I can't say" (Bolton, 2008, p. 40), suggests that there are intuitive expressions that could, without expressive writing, remain unexpressed. By allowing thoughts to travel from the mind via the heart through the hands, in a loop of emotional release, the physical body is engaged in the healing process (Bolton, 2008). This is clearly expressed in the words of the poet Anne Sexton, who claimed that "Poetry led me by the hand out of madness"

(Lowe, 2006, p. 60). The fulfilling creative aspect of freely releasing words from the mind onto the page may stem automatic negative thoughts experienced by some young people (Jamison & Post, as cited in Lowe, 2006). Furthermore, there may be a more effective resolve achieved for some individuals, through other forms of expressive or experiential therapy approaches, or by presenting PT alongside another creative modality.

While research incorporating poetry therapy and expressive writing have shown positive outcomes with clients experiencing mental health issues, further research evidence is imperative to formulate understanding and applications that can positively influence mental health and wellbeing (McArdle & Bryt, 2001).

### Cautions in practice

Discernment is a key factor in how PT can be utilised to access client's emotions. Firstly, it is important to identify whether the emotions are core or *primary* emotions; chronic or *maladaptive primary* emotions; defensive or *secondary* emotions used to mask or obscure; or manipulative or *instrumental* emotions (Greenberg, 2002). Further cautions, Greenberg suggests, need consideration when a lack of rapport or safety is yet to be formed in the counselling relationship, when minimal insight into a client's story exists, or when emotions are overwhelming.

PT as a component of Gestalt Therapy has further contraindications. The founders, Fritz and Laura Perls, stated that Gestalt Therapy was not suitable for clients suffering from thought disorders such as schizophrenia (Perls, 1992). However, this recommendation was not respected by all therapists and concerned its founders (Perls, 1992). Lowe (2006) adds further sensitive approaches are required for clients with post-traumatic stress disorders, highlighting some negative effects of writing disclosure.

A consideration for the use of PT would be the levels of linguistic and cognitive functioning of adolescent clients. This could include past negative associations from the classroom, or being forced to write poetry as an assessable task. Gorelick (2007) acknowledges that PT needs to work within an individual's comfort zone and frame of reference.

Although there are no identified side-effects associated with PT, it has been found that children suffering from childhood traumas respond better to non-verbal therapies, such as sand-play therapy (Foa, Keane, Friedman, & Cohen, 2009). Therefore, with a younger adolescent client a counsellor could consider whether or not PT would be the most beneficial of the creative arts therapies.

### Implications for counsellors

Group therapy involving poetry may have improved outcomes when poems by external authors are used as a basis for reflection (Foa, Keane, Friedman, & Cohen, 2009). It may be too personal for some young people to share their work with others, and they may be better suited to individual counselling. With vulnerable children care must be taken to choose the therapy that protects them from any further stress or trauma (Foa, Keane, Friedman, & Cohen, 2009).

PT fits well with Narrative Therapy as a way to express

the meaning of a client's life experience (White, 2007). Problems can be objectified, metaphorically externalised and separated, re-claimed and re-authored by the client through sharing their poetry (Freedman & Coombs, as cited in Van Wyk, 2008). PT is well regarded in dealing with childhood behaviour problems, including bullying, anorexia nervosa, abuse, which are concerns common to adolescents (Carr, 1998).

Gestalt Therapy searches for the complex whole within each client, which consists of what is evident and hoped for, and unseen. Within Gestalt Therapy, in that search for wholeness and identity, poetry as therapy is regarded as a way to harmonise the complexities that exist within the client (Sučylaitė, 2016), and identifying and treating the client's core problem, rather than a symptom, is crucial to a successful therapeutic outcome. Coulehan (2010) shared his experience of successfully treating a post-operative distressed and angry patient with PT, following mismanagement by hospital staff. However, years later this client chose to send a story he had written to his hospital therapist, which revealed that his client's core problem or primary emotion was not anger, but loneliness. The anger was merely a symptom of this man's sense of isolation and aloneness (Coulehan, 2010).

### Implications for clients

As expressed by the poet Shelley, within poetry exists the "power to reveal and illuminate" (Mazza, 2016, p.4), as there may be an individual meaning identified by the client. The encouragement to use metaphors within PT has the capacity to reveal how a client views the world (Mazza, 2016). PT allows emotions a voice through symbolic representation and then recognition. This process may quieten reactive emotions, and help a client to see their intuitive knowing, rather than be told they have flawed thinking. Venturing into the unconscious can create profound personal revelations, as Jung (1990, p. 31) persuades us "It is only the things we don't understand that have any meaning." Self-compassion develops, as increased self-awareness, resulting from examining experiences in a safe environment can develop an empathetic understanding in young people towards others as well as themselves (Williams, as cited in Xerri & Agius, 2015).

PT can take an adolescent on a journey of self-discovery, which has the potential to build self-esteem and resilience to confront fears. To support patients recovering from cancer, a field of psycho-oncology has developed, where PT is one pathway to help reduce the inevitable negative emotions that diagnosis engenders. In this field, PT enables cancer patients to view their worlds from a different perspective, and to assist family members to deal with the imminent loss of a loved one (Heimes, 2011).

### Conclusion

Poetry has been an integral part of human society throughout recorded history, expressing the human spirit and the search for truth and meaning. PT helps the 'Self' to find those difficult-to-reach parched earth spaces within the soul, where hope is re-kindled, and becomes the soothing rain. It is the versatility PT offers that enables it to speak to many different young clients, as it may be introduced within a variety of therapeutic modalities. For some, this comes by sharing in the anguish of poets whose

suffering is similar; for others, peace is found when distressing emotions are released through their own words. Always the client is central, never the quality of writing. Releasing core problems and finding resolve are the counsellor's overriding concerns.

The link between the positive effects of mindfulness when introduced with PT, and the need to develop self-esteem and resilience in children approaching adolescence both need to be explored, along with establishing a more reliable evidence base. This paper has discussed the significance of poetry when viewed as a symbol of a client's frangible emotion, when guided to healing through tangible words.

## References

- Allen, J. D. (1975). Growing pains. In Allen, J. D. (2017). *The story bridge to the expression of the emotional self for landlocked men*. Unpublished manuscript, University of the Sunshine Coast, Queensland, Australia.
- Angelotti, M. (1985). Uses of poetry and adolescent literature in therapy for adolescents. *Child & Youth Services*, 7(1-2), 27-35.
- Berman, D., & Davis-Berman, J. (2013). The role of Therapeutic Adventure in meeting the mental health needs of children and adolescents: Finding a niche in the health care systems of the United States and the United Kingdom. *The Journal of Experiential Education*, 36(1), 51-64. doi: 10.1177/1053825913481581
- Bolton, G. (1999). Every poem breaks a silence that had to be overcome: The therapeutic power of poetry writing. *Feminist Review*, 62, 118-133. doi: 10.1080/014177899339225
- Bolton, G. (2008). Writing is a way of saying things I can't say - therapeutic creativewriting: a qualitative study of its value to people with cancer cared for in cancer and palliative healthcare. *Journal of Medical Ethics*, 34(1), 40-46. doi:10.1136/jmh.2007.000255
- Carr, A. (1998). Michael White's narrative therapy. *Contemporary Family Therapy*, 20(4), 485-503. doi:10.1023/A:1021680116584
- Chavis, G. G. (2011). *Poetry and story therapy: The healing power of creative expression*. London: Jessica Kingsley Publishers.
- Chuma-lbe, G. (2011). *Effects of bibliotherapy on behaviour modification of adolescents*. Deutschland: LAP LAMBERT Academic Publishing.
- Conroy, J. C. (1999). Poetry and human growth. *The Journal of Moral Education*, 28(4), 491-510. doi: 10.1080/030572499103034
- Coulehan, J. (2010). Poetry therapy. *Patient Education & Counselling*, 81(2), 257-258. doi: 10.1016/j.pec.2009.12.014
- Daboui, P., Janbabai, G., & Siavash, M. (2018). Hope and mood improvement in women with breast cancer using group poetry therapy: A questionnaire-based before-after study. *Journal of Poetry Therapy*, 31(3), 165-172. Doi: 10.1080/08893675.2018.1467822
- Dalton, T. A., & Krout, R. E. (2006). The Grief Song-writing Process with bereaved adolescents: An Integrated grief model and music therapy protocol. *Music Therapies Perspectives*, 24(2), 94-107. doi:10.1093/mtp/24.2.94
- Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. (2nd ed.). New York: The Guilford Press.
- Burke, K. (1939). Freud-and the analysis of poetry. *American Journal of Sociology* 45(3), 391-417. Retrieved from <https://jstor.org/stable/pdf/2769854.pdf>
- Golden, K. M. (2000). The use of collaborative writing to enhance cohesion in poetry therapy groups. *Journal of Poetry Therapy*, 13(3), 125-138, Retrieved from <http://www.metanoia.ac.uk/media/1519/golden-km-the-use-of-collaborative-writing.pdf>
- Gorelick, K. (2007). Poetry therapy. In C. A. Malchiori (Ed.), *Expressive therapies*, 117-140. New York, NY: The Guilford Press.
- Gozashti, M. A., Moradi, S., Elyasi, F., & Daboui, P. (2017). Improvement in patient-reported outcomes after group poetry therapy of women with breast cancer. *Social Determinants of Health*, 3(2), pp.58-63. doi: 10.22037/sdh.v3i2.17845
- Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, DC: American Psychological Association.
- Greenberg, L. S. (2004). Emotion-focused therapy. *Clinical Psychology and Psychotherapy*, 11, 3-16. doi: 10.1002/cpp.388
- Hall, G. S. (1904). *Adolescence: Its psychology and its relations to physiology, anthropology, sociology, sex, crime, religion and education*. New York, NY: Appleton.
- Harper, F. D., Terry, L. M., & Twiggs, R. (2009). Counselling strategies with black boys and black men: Implications for policy. *Journal of Negro Education*, 78(3), 216-232. Retrieved from <https://www.jstor.org/stable/25608742>
- Heimes, S. (2011). State of poetry therapy research (review). *The Arts in Psychotherapy*, 38(1), 1-8. doi:10.1016/j.aip.2010.09.006
- Hynes, A., & Hynes-Berry, M. (2011). *Biblio/poetry therapy: The interactive process: A handbook*. Saint Cloud, MI: North Star Press.
- Johnson, P. B., & Richter, L. (2004). Research note: What If We're Wrong? Some possible implications of systematic distortions in adolescents' self-reports of sensitive behaviors. *Journal of Drug Issues*, 34(4), 951-970. doi: 10.1177/002204260403400412
- Jung, C. (1961). *Modern man in search of a soul*. London: Routledge and Kegan Paul.
- Jung, C. G. (1990). *The archetypes and the collective unconscious*. Princeton, NJ: Princeton University Press.
- Kwok, P. (2010). Symposium on writing as spiritual practice: "Write what is in the Heart" *Spiritus*, 10, 76-79. The Johns Hopkins University Press.
- Larson, D. G., Chastain, R. L., Hoyt, A. T., & Ayzenberg, R. (2015). Self-concealment: Integrative review and working model. *Journal of Social and Clinical Psychology*, 34(8), 705-774. doi:10.1521/jscp.2015.34.8.705
- Leedy, J. J., & Reiter, S. (2016). *Poetry therapy*. International Psychotherapy Institute. Retrieved from [https://freepsychotherapybooks.org/product/907-Poetry\\_Therapy](https://freepsychotherapybooks.org/product/907-Poetry_Therapy)
- Lowe, G. (2006). Health-related effects of creative and expressive writing. *Health Education*, 106(1), 60-70. doi/full/10.1108/09654280610637201
- Mazza, N. (2016). *Poetry therapy: Theory and practice* (2nd ed.). London: Routledge. Retrieved from <https://www.taylorfrancis.com/books/9781317606994>
- Mazza, N., Magaz C., & Scaturro, J. (1987). Poetry therapy with

abused children. *The Arts in Psychotherapy*, 14, 85-92.

McArdle, S., & Bryt, R. (2001). Fiction, poetry and mental health: expressive and therapeutic uses of literature. *Journal of Psychiatric and Mental Health Nursing*, 8, 517-524. doi/pdf/10.1046/j.1351-0126.2001.00428.x

Oxford Centre for Evidence-based Medicine (2009). *Levels of evidence*. <http://www.cebm.net/?o=1116>

Patel, V., Flisher, A., Hetrick, S., & McGarry, P. (2007). Mental health of young people: A global public health challenge. *Lancet*, 369, 1302-1313. doi: 10.1016/S0140-6736(07)60368-7

Pearson, M., & Wilson, H. (2009). *Using expressive arts to work with mind, body and emotions: Theory and practice*. London: Jessica Kingsley Publishers.

Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science*, 8(3), 162-166. Retrieved from <http://www.jstor.org/stable/40063169>

Perls, L. (1992). Concepts and misconceptions of Gestalt Therapy. *Journal of Humanistic Psychology*, 32(3), 50-56. doi/pdf/10.1177/0022167892323004

Pizarro, J. (2004). The efficacy of art and writing therapy: Increasing positive mental health outcomes and participant retention after exposure to traumatic experience. *Art Therapy: Journal of the American Art Therapy Association*, 21(1), 5-12. Retrieved from <https://files.eric.ed.gov/fulltext/EJ683379>

Sučylaitė, J. (2016). Poem as a tool for self-cognition and self-creation. *Klaipėdos University*, 1, 19-27. doi.org/10.15181/atee.v1i0.1314

Tarhan, S., Bacanlı, H., Dombayci, M.A., & Demir, M. (2011). Quadruple thinking: Hopeful thinking. *Procedia Social and Behavioural Sciences*, 12, 568-576. doi:10.1016/j.sbspro.2011.02.069

Van Wyk, R. (2008). Narrative house: a metaphor for narrative therapy: Tribute to Michael White, *IFE Psychologia*, 16(2), 255-74. Retrieved from <https://www.ajol.info/index.php/ifep/article/view/23815>

White, M. (2007). *Maps of narrative practice*. New York, NY: W. W. Norton.

Xerri, D., & Xerri Argius, S. (2015). Galvanising empathy through poetry. *English Journal*, 104(4), 71-76. Retrieved from [https://www.danielxerri.com/uploads/4/5/3/0/4530212/xerri\\_\\_\\_xerri\\_agius\\_2015.pdf](https://www.danielxerri.com/uploads/4/5/3/0/4530212/xerri___xerri_agius_2015.pdf)

## Appendix I:

### Poem - Growing Pains (Allen, 1975)

Now at sixteen my life seems long  
 Dreaming of days that time's past on  
 Friendship of our friends at eight  
 No longer seem to beautifully relate

Playing games of meaningless thought  
 No rules, no limits, no conscience brought  
 No weight to carry, or blame to bear  
 On wars, death, or the filth in the air

Spare me time so I may fly  
 Back to times and years gone by  
 For this life I'm living now  
 Has too much to do with what and how

Sleeping with dreams  
 Waking with nightmares  
 Black sunbeams  
 Suicide light flares

Then suddenly it rains...

## Appendix II:

### Poem - No Need for Wings Carter, 2012

Words are thoughts with flight,  
 When ill and weak may I call your name?  
 And ask of you to visit me,  
 And share your thoughts as once you might.  
 No need for words that crack and splinter,  
 And leave our souls all in a winter,  
 For once our thoughts have mingled so,  
 They have no need of wings...  
 They are already free.

# Sandplay Therapy: A Safe, Creative Space for Trauma Recovery.

Mark Pearson<sup>1</sup> & Helen Wilson<sup>2</sup>

The relational healing space that sandplay therapy generates is discussed as conducive to trauma recovery. The attentive, non-directive role adopted by a sandplay therapist is seen as providing security and creative options for non-threatening trauma expression. Early research literature on a range of applications of sandplay is now considered alongside contemporary understandings of trauma-informed therapy. This provides evidence for supporting trauma survivors through sandplay therapy.

**Keywords:** *counselling, expressive therapies, sandplay therapy, trauma*

The sandplay process appears deceptively simple – client shaping the sand and arranging figurines, that soon become symbolic for them, therapist watchfully holding the space and then simply inviting reflection on the final creation. The use of Sandplay Therapy as a psychotherapeutic tool, with clients of all ages, requires an extensive background of training in therapy. When offered to traumatised clients, a wider understanding of trauma-informed practice is essential. This paper reviews some of the recent research that found sandplay a valuable tool in trauma recovery, and discusses how the setting for the process and the theoretical framework, first formulated by Dora Kalff (2003), parallels in many ways contemporary trauma-informed practice.

A well-grounded understanding of the complexities of the human psyche, the mechanisms of therapy, and of attachment-oriented and trauma-informed practice is essential prior to trauma recovery work with sandplay. Extensive experiential and theoretical training, first as a counsellor, and then as a sandplay specialist is essential. Despite its superficial simplicity, the ethical professional application of the sandplay therapy technique requires extensive training, on-going skills practice and regular clinical supervision.

## Background of Sandplay Therapy

In Switzerland in 1956, Jungian therapist Dora Kalff, mentored by C. G. Jung, developed sandplay therapy for providing therapeutic support for young clients. Her method grew

from three sources: Dr Margaret Lowenfeld's *World Technique*, the Analytic Psychology of C. G. Jung, and Eastern contemplative traditions (M. Kalff, 2013). Kalff found that the technique also offered a powerful support for adult clients, and soon attracted clients from across Europe and the USA (Kalff, 2003).

Kalff reported on the need to follow client interests and collaborate in offering emotional release activities and various forms of therapeutic art expression (e.g. painting, sculpting with clay) as an adjunct to work with the sandtray (Kalff, 2003). In contemporary counselling this flexibility would be congruent with pluralistic practice (Cooper & McLeod, 2011). The growing practice-based evidence literature, often presented in the form of case studies, has continued to document a wide variety of contexts in which sandplay therapy has supported therapeutic change. Among this literature are an increasing number of reports on supporting traumatised clients, of all ages in recovery from trauma, where sandplay has been used.

When observing sandplay therapy in action, for example via a Youtube clip, it is tempting to see it as a very simple process: provide a client with small objects, a container, and the natural material of sand and they will set about constructing images that reflect their external and internal experiences. However, the shaping of sand, the selecting of miniature objects and creation of a sandpicture can be guided by both conscious or non-conscious logic. In the case of trauma survivors, it may be that the creative process emerges directly from implicit, sensory-based memory, and the client may have little to say about their spontaneous creation. This spontaneous creative process provides therapeutic benefit even without discussion or analysis. However, exploration of the sandpicture can be enhanced, if the client wishes, with verbal processing. In trauma-informed work, the verbal processing must be entirely at the wish of the client, and is more likely to emerge later in the therapeutic journey.

The term 'sandplay' has become something of a generic term over recent years. There are several major traditions in using sandtrays and miniatures, for example, 'sandplay therapy'

---

Corresponding author: Dr Mark Pearson  
Email: mpearson@usc.edu.au  
<sup>1,2</sup> University of the Sunshine Coast



the style developed by Dora Kalff and often used by analytical psychologists (e.g. Aite, 2007; Ammann, 1991; Weirrib, 1983), an evolution of Lowenfeld and Kalff's work where psychotherapy is not indicated and most often conducted in group settings, now termed 'expressive sandwork' (Pattis Zoja, 2011). A more informal style of using sandtrays and miniatures has evolved directly from Lowenfeld's work used in play therapy (e.g. Axline, 1971; Oaklander, 1988) is now termed 'sandtray work' (e.g. Katz & Rekayek, 2010; Mayes, Mayes, & Williams, 2007; Walker, 1998), and the self-discovery expressive therapies style of sandplay that integrates Kalff's methods and principles within a creative arts context (Pearson & Wilson, 2001). A variety of practice methods exist, side-by-side with Kalff's original style.

While Sandplay Therapy in Kalff's style and in the Play Therapy tradition remains a spontaneous undirected process, there are also many reports in the literature of therapists creating somewhat structured activities using these materials. The directed approaches have been called 'directed sandplay' (e.g. Boik & Goodwin, 2000; Tennessen, & Strand, 1998) and 'symbol work' (Pearson & Wilson, 2001). Boik and Goodwin differentiate between spontaneous sandtray creations and directed processes, however pointing out that once subject matter has been suggested, the facilitation remains non-intrusive. Pearson and Wilson (2001) point out that the directed method of symbol work can be ideal for supporting clients facing an immediate crisis.

### Trauma-informed practice

Traumatic events have the potential to overwhelm human adaptations and "generally involve threats to life or bodily integrity, or a close encounter with violence and death" (Herman, 1992, p.33). Trauma leaves neurological consequences. Evidence shows that early trauma is "expressed in right-brain deficits in the processing of social, emotional and bodily information" (Klorer, 2005, p. 214). Furthermore, severe maltreatment and lack of significant attachment figures in the early years also leads to adverse brain development (De Bellis, 2001). Traumatic memories appear to be stored in the right hemisphere, which makes verbal expression of trauma memories more difficult (Schiffer, Teicher, & Papanicolaou, 1995). For many traumatised clients reason and executive function may not be readily available, and in general, trauma memories are stored implicitly as sensory-based experiences. Therefore, therapists cannot depend on clients' use of words. Therefore, the use of non-verbal therapeutic activities is recommended to allow contact with, and expression of, implicit memories (Steele & Malchiodi, 2012). Expressive therapies can provide these therapeutic experiences, and in addition, support the development of the therapeutic alliance with "a caring adult who provides opportunities to create and communicate" (Malchiodi, 2008, p. 153).

"Trauma-informed practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for everyone" (Hopper, Bassuk, & Olivet 2010, p. 82). Counselling based on this premise creates opportunities for survivors to rebuild a sense of control and empowerment. Trauma-informed care and practice has recognised the prevalence of trauma and its impact on the emotional, psychological and social wellbeing of people (Hooper et al, 2010). What is needed then are ways of support that are sensitive to providing opportunities for clients to rebuild control in their lives.

Traumatised clients may come to believe that the world is threatening and bewildering, and people are neither predictable or trustworthy. This means the 'need' for control becomes paramount (Steele & Malchiodi, 2012), since the person responds to their surroundings from these beliefs. Therapists need to create relationships with clients and therapeutic settings that can begin to prove there are exceptions to these beliefs.

Kalff's emphasis that a core component of sandplay therapy is the provision of a 'safe and protected space' (Kalff, 2003) suggests that, in the hands of an experienced, and regularly supervised counsellor, a client's work in and around the sandtray, can provide a raft of benefits. For example, the therapy room and the sandtray itself provide freedom and containment; the therapeutic relationship engenders trust and safety, and the central therapeutic activity of using sand and symbols allows transfer of trauma from implicit to explicit mode. When memories can be played out safely, symbolically, and non-verbally the process allows resolution without the re-traumatising risk of being required to recount terrifying events.

Imagery has the most potential for therapy when it comes from the client, rather than being provided or imposed by the therapist (Klorer, 2005). In trauma recovery therapist "directives aimed at certain issues are not nearly as effective as the metaphors brought by the client" (Klorer, 2005, p. 218). Sandplay Therapy provides multiple options for clients to generate their own healing metaphors.

### Sandplay in trauma focused therapy

For clients of all ages, violence toward the body and psyche is difficult to address solely with verbal therapy. A therapist will be well served by having a variety of modalities to rely on when dealing with clients with abuse histories (Zappacosta, 2013). It can also be both painful and potentially re-traumatizing to rely on talk therapy to act as the primary healing agent (Zappacosta, 2013).

Because, when using sandplay therapy, the hands are engaged in touching and shaping the sand, the process invites a regenerative relationship to the body, which has usually been deeply numbed in somatic reaction to abuse. The safety of touching the sand can invite the body to begin to return to a more natural state of aliveness rather than living in varied states of dissociation and compartmentalization (Zappacosta, 2013).

The impact of immigration detention on children was explored through a project where they created 'worlds' in the sandtray and from this generated stories to express their subjective experience (Kronick, Rousseau, & Cleveland, 2018). An analysis of the children's sandtrays, and how they created the images, confirmed that the experience of detention was traumatic.

Erik Erikson (1977), the esteemed child psychologist, identified three types of play: traumatic, cathartic and integrative. For young clients working through a traumatic experience, playfulness within a therapy session can help transform the process into one of renewal (McCarthy, 2006). Cathartic play, such as orchestrating long battles in the sandtray, allows the body to rid itself and the psyche of the destructive sensations and experiences of trauma that otherwise become deep-rooted, chronic problems. Cathartic play seen in battle scene in the sand creates a breaking apart of habitual form in the service of a new form (McCarthy, 2006). Cycles of destruction and construction within the sandtray are very familiar to sandplay therapists.

With young clients sandplay has been used to improve

the security of adolescent attachment schemas (Green, Myrick, & Crenshaw, 2013), and in group therapy (Flahive & Ray, 2007; James & Martin, 2002). Sandplay has been recommended as an ideal medium for traumatised young clients by a number of authors (e.g., Harper, 1991; Howe, 2005; Troshikhina, 2012; Webber, Mascari, Dubi & Gentry, 2006). Porat and Meltzer (1998, 2013) described the way sandplay has made significant inroads in the healing process of Israeli children impacted on by the trauma of war. McCarthy (2006) also described the way sandplay helps with somatic memory recovery after trauma. In addition, Lacroix et al. (2007) demonstrated the effectiveness of Sandplay Therapy with refugee children recovering from a tsunami. Sandplay has been utilised in the support of young patients recovering from serious illness; for example in hospitals (Miller & Boe, 1990), with those recovering from traumatic brain injury (Plotts, Lasser & Prater, 2008), and with those recovering from cancer (Mindell, 1998). Sandplay effectiveness has been noted as a major contributor to recovery in the treatment of children who have experienced sexual abuse (Grubbs, 1994; Harper, 1991; Hong, 2007; Mathis, 2001; Reyes, 2003; Zappacosta, 2013).

A complex, longitudinal, qualitative study with sexually abused children, being treated with sandplay therapy found consistent themes played out in the trays: stories of violence, aggression between people, the need for care and protection and ways to resolve conflicts (Tornero & Capella, 2017). While these themes are very familiar to sandplay therapists, and described by Kalff from her extensive clinical observations (Kalff, 2003), it is helpful to have research confirmation that the shifting dynamics in the trays clearly evidenced therapeutic progress. Ultimately the work in the trays allowed these children to assign new meanings to their traumatic experiences (Tornero & Capella, 2017). This study also illuminated the way therapists can be co-participants in the clients' processes of metaphorical reconstruction.

Sandplay therapy has been described as highly supportive within adult counselling and psychotherapy (Mitchell & Friedman, 2003). Sandplay has been reported as a core therapeutic tool in treating adults with PTSD (Moon, 2006), with combat veterans suffering severe nightmares (Coalson, 1995), with substance abuse offenders (Garza, Monakes, Watts, & Wiesner, 2011), with eating disorders (Myers & Klinger 2008), in the treatment of borderline personality disorders (La Spina, 2004), with sexual addiction treatment (Spooner & Lyddon, 2007), with dissociative disorders (Sachs, 1990), and with adults experiencing traumatic nightmares (Daniels & McGuire, 1998).

### **Sandplay: A safe psychological space**

When supporting traumatised clients creating a safe environment and strengthening feelings of safety and trust must take priority (St Thomas & Johnson, 2007). The most widely used and seemingly effective approaches are methods that provide reassurance and support while gradually, often indirectly, exploring a traumatic past (St Thomas & Johnson, 2007). This reassurance and safety allow clients to make sense of overwhelming experiences and to identify and express underlying emotion, necessary for healing to take place (St Thomas & Johnson, 2007).

Unique to sandplay, containment is offered in three different configurations. It is offered within the parameters of the sandtray itself, within the therapeutic relationship, and within the therapy room, which can provide a secure and insulated setting (Zappacosta, 2013).

For contemporary counsellors working with a range

of clients with mild to severe trauma, offering a holding environment with strong boundaries provides the sought after safe and protected space with a reliable other. Kalff emphasised the importance of responding to a client's need for safety: "If you can provide a free and protected space, you will see the evolution of life as it is taking place in the sand tray" (Turner, 2013, p. 2). A client comes to therapy as a sort of container – filled with anxieties, mixed feelings, losses, hidden strengths, achievements, joys, confusions and remembrances. The therapy room, the therapeutic alliance, and the sand tray, provide safe boundaries in which that container can empty out and replenish.

The process of sandplay creates a shared non-verbal space where therapist attunement, client issues, images and symbols come together. The direction of the healing process is not presupposed or presumed; uncertainty is welcomed not avoided. Working with miniature objects and sand offers a way to expand psychological, emotional, somatic and spiritual possibilities and encourage experimentation that is often avoided by those who are distressed or whose lives carry a legacy of abuse, neglect, emotional upheaval, or trauma. Additionally, at a certain stage of the therapy journey, formerly hidden, positive aspects of the psyche are unearthed and future potential rehearsed in a safe, trusted environment.

As a psychotherapeutic process over time, possibly over many trays, Sandplay Therapy offers a relational healing space (Cunningham, 2005). The process avoids a client being 'fenced in' by therapist bias or agenda. Watching, observing, holding the space, silently formulating - and often abandoning - a working hypothesis, a sandplay therapist allows themselves to visit the individual experience of the inner and outer world that belongs to no-one but the person who created the image (Pearson & Wilson, 2001).

The box of sand and the small objects provide the client with a space, and tools, outside of themselves, where chaotic aspects of the inner world can be placed, seen, organised, reorganised, reconstructed, or deconstructed. The firm boundary of the tray defines the place where the person takes up an interactive – and active – role in their own change process.

The focus in Sandplay Therapy is on a safely emerging relationship built up between client and therapist, that leads to a client's enhanced relationship with themselves. A sandplay therapist holds the space open for easeful emergence of a client's inner material, as well as emergence of their inner resources, which often present clearly in the sandpicture. Sandplay Therapy offers a way for this to happen, free from premature interpretation or direction. The stability of the therapist's observer role is an integral part of holding and containing a client's vulnerability as they begin to process, review, question, unravel, transform and restore the foundations on which they had built their sense of self.

### **References**

- Aite, P. (2007). *Landscapes of the psyche. Sandplay in Jungian analysis*. Milan: IPOC.
- Ammann, R. (1991). *Healing and transformation in sandplay. Creative processes become visible*. Chicago, IL: Open Court.
- Axline, V. (1971). *Dibs: In search of self. Personality development in Play Therapy*. London: Penguin.
- Boik, B. L., & Goodwin, E. A. (2000). *Sandplay therapy: A step-by-step manual for psychotherapists of diverse orientations*. New York, NY: W. W. Norton & Co.
- Coalson, B. (1995). Nightmare help: Treatment of trauma

- survivors with PTSD. *Psychotherapy*, 32(3), 381-388.
- Cooper, M., & McLeod, J. (2011). *Pluralistic counselling and psychotherapy*. London: Sage.
- Cunningham, L. (2005). *Relational sandplay therapy*. New York: Mustard Seed Press.
- Daniels, L. R., & McGuire, T. (1998). Dreamcatchers: Healing traumatic nightmares using group dreamwork, sandplay and other techniques of intervention. *Group*, 22(4), 205-226.
- De Bellis, M. D. (2001). Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment, and policy. *Development and Psychology*, 13(3), 539-564. doi: 10.1017/S0954579401003078
- Erikson, E. (1977). *Toys and reasons*. New York: W. W. Norton.
- Flahive, M., & Ray, D. (2007). Effect of group sandtray therapy with preadolescents. *Journal For Specialists In Group Work*, 32(4), 362-382. Doi: 10.1080/01933920701476706
- Garza, Y., Monakes, S., Watts, R. E., & Wiesner, V. (2011). Implementing Adlerian sand tray therapy with adult male substance abuse offenders: A phenomenological inquiry. *Journal of Addictions & Offender Counseling*, 31(2), 94-107.
- Green, E. J., Myrick, A. C., & Crenshaw, D. A. (2013). Toward secure attachment in adolescent relational development: Advancements from sandplay and expressive play-based interventions. *International Journal of Play Therapy*, 22(2), 90-102. doi: 10.1037/a0032323
- Grubbs, G. A. (1994). An abused child's use of sandplay in the healing process. *Clinical Social Work Journal*, 22(2), 193-209.
- Harper, J. (1991). Children's play: The differential effects of intrafamilial physical and sexual abuse. *Child Abuse & Neglect*, 15, 89-97.
- Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
- Hong, G. (2007). *Sandplay Therapy: Research and practice*. Hove, UK: Routledge.
- Hooper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services & Policy Journal*, 3(1), 80-100.
- Howe, D. (2005). *Child abuse and neglect. Attachment, development and intervention*. Hampshire, UK: Palgrave Macmillan.
- James, L., & Martin, D. (2002). Sand tray and group therapy: Helping parents cope. *Journal for Specialists in Group Work*, 27(4), 390-405. doi: 10.1177/019339202237601
- Kalff, D. (2003). *Sandplay: A psychotherapeutic approach to the psyche*. Cloverdale, CA: Temenos Press. (originally published in English in 1980)
- Kalff, M. (2013). *Experience related case study: Like a masked ball?* Paper presented at the 22nd Congress of the International Society for Sandplay Therapy, Venice.
- Katz, A., & Rekeyek, R. M. A. (2010). Israeli Arab-Jewish sandtray group work: Creating a world together. *Psychotherapy and Politics International*, 8(2), 113-127. doi: 10.1002/ppi
- Klorer, P. G. (2005). Expressive therapy with severely maltreated children: Neuroscience contributions. *Art Therapy*, 22(4), 213-220.
- <https://doi.org/10.1080/07421656.2005.10129523>
- Kronick, R., Rousseau, C., & Cleveland, J. (2018). Refugee children's sandplay narratives in immigration detention. *European Child & Adolescent Psychiatry*, 27(4), 423-437. Doi: 10.1007/s00787-017-1012-0
- Lacroix, L., Rousseau, C., Gauthier, M. F., Singh, A., Giguere, N., & Lemzoudi, Y. (2007). Immigrant and refugee preschoolers' sandplay representations of the tsunami. *The Arts in Psychotherapy*, 34, 99-113. doi:10.1016/j.aip.2006.09.006
- La Spina, V. (2004). Sandplay therapy in the treatment of borderline personality disturbance. In E. Pattis Zoja (Ed.), *Sandplay therapy: Treatment of psychopathologies* (pp. 31-58). Einsiedeln, Switzerland: Daimon Verlag.
- McCarthy, D. (2006). Sandplay therapy and the body in trauma recovery. In L. Carey (Ed). *Expressive and creative arts methods for trauma survivors*, (pp. 165-180). London: Jessica Kingsley Publishers.
- Malchiodi, C. A. (2008). Creative interventions and childhood trauma. In C. Malchiodi (Ed.), *Creative interventions with traumatized children* (pp. 3-21). New York: Guilford.
- Mathis, C. R. (2001). The story of a sexually abused child's sandplay: A single case study. (Doctoral dissertation). Falls Church, VA: Virginia Polytechnic Institute & State University.
- Mayes, C., Mayes, P. B., & Williams, E. (2007). Sandtray therapy, reflectivity and leadership preparation. *International Journal of Leadership in Education*, 10(4), 357-378. doi:10.1080/13603120701370777
- Miller, C., & Boe, J. (1990). Tears into diamonds: Transformation of child psychic trauma through sandplay and storytelling. *The Arts in Psychotherapy*, 17, 247-257.
- Mindell, N. (1998). Children with cancer: Encountering trauma and transformation in the emergence of consciousness. *The Arts in Psychotherapy*, 25(1), 3-20.
- Mitchell, R. R., & Friedman, H. S. (2003). Using sandplay in therapy with adults. In C. E. Schaefer (Ed.), *Play therapy with adults* (pp. 195-232). Hoboken, NJ: John Wiley & Sons.
- Moon, P. K. (2006). Sand play therapy with US soldiers diagnosed with PTSD and their families. In G. R. Walz, J. C. Bleuer, and R. K. Yep (Eds.), *Vistas: Compelling perspectives on counseling 2006*, (pp. 63 – 66). Alexandria, VA: American Counseling Association.
- Myers, C. E., & Klinger, K. N. (2008). Creating new worlds: Using sandtray therapy with eating disorders. In S. L. Brooke (Ed.), *The creative therapies and eating disorders* (pp. 95-108). Springfield, IL: Charles C. Thomas Publisher.
- Oaklander, V. (1988). *Windows to our children. A gestalt therapy approach to children and adolescents*. New York: The Centre for Gestalt Development.
- Pattis Zoja, E. (2011). *Sandplay therapy in vulnerable communities. A Jungian approach*. London: Routledge.
- Pearson, M., & Wilson, H. (2001). *Sandplay and symbol work: Emotional healing and personal development with children, adolescents and adults*. Melbourne: ACER.
- Plotts, C. Lasser, J., & Prater, S. (2008). Exploring sandplay therapy: Application to individuals with traumatic brain injury. *International Journal of Play Therapy*, 17(2), 138-153. doi: 10.1037/1555-6824.17.2.138

- Porat, R., & Meltzer, B. (1998). Images of war and images of peace. *Journal of Sandplay Therapy, 7*, 25-73.
- Porat, R., & Meltzer, B. (2013). Images of war and images of peace in sandplay therapy. In E. Perroni (Ed.). *Play: Psychoanalytic perspectives, survival and human development* (pp. 133-153). Hove, UK: Routledge.
- Reyes, C. J. (2003). Combining art and sandtray therapies with sexually abused children. In H. Kaduson and C. Schaefer (Eds.), *101 favorite play therapy techniques* (3rd ed.) (pp. 125-128). Northvale, NJ: Jason Aronson.
- Sachs, R. G. (1990). The sand tray technique in the treatment of patients with dissociative disorders: Recommendations for occupational therapists. *The American Journal of Occupational Therapy, 44*(11), 1045-1047. doi:10.5014/ajot.44.11.1045
- St Thomas, B., & Johnson, P. (2007). *Empowering children through art and expression: Culturally sensitive ways of healing trauma and grief*. London: Jessica Kingsley Publishers.
- Schiffer, F., Teicher, M., & Papanicolaou, A. (1995). Evoked potential evidence for right brain activity during the recall of traumatic memories. *Journal of Neuropsychiatry and Clinical Neurosciences, 7*(2), 169-175. doi 10.1176/jnp.7.2.169
- Spooner, L. C., & Lyddon, W. J. (2007). Sandtray therapy for inpatient sexual addiction treatment: An application of constructivist change principles. *Journal of Constructivist Psychology, 20*(1), 53-85. doi:10.1080/10720530600992782
- Steele, W., & Malchiodi, C. A. (2012). *Trauma-informed practices with children and adolescents*. New York: Routledge.
- Tennessen, J., & Strand, D. (1998). A comparative analysis of directed sandplay therapy and principles of Ericksonian psychology. *The Arts in Psychotherapy, 25*(2), 109-114.
- Tornero, M. D. L., & Capella, C. (2017). Change during psychotherapy through sand play tray in children that have been sexually abused. *Frontiers in Psychology, 8*, Article 617, 1-12. doi: 10.3389/fpsyg.2017.00617
- Troshikhina, E. (2012). Sandplay Therapy for the healing of trauma. In J. A. Lavrijsen and M. Bick (Eds.). *Is this a culture of trauma?* Whitney, UK: Inter-disciplinary Press.
- Turner, B. (Ed.) (2013). *The teachings of Dora Kalff: Sandplay*. Cloverdale, CA: Temenos Press.
- Walker, S. C. (1998). Stories of two children: Making sense of children's therapeutic work. *The Arts in Psychotherapy, 25*(4), 263-275.
- Webber, J., Mascari, J. B., Dubi, M. & Gentry, E. (2006). Moving forward in trauma response and treatment. In G. Walz, J. Bleuer and R. Yep (Eds). *VISTAS: Compelling perspectives on counselling*. (pp. 17-21). Alexandria, VA: American Counseling Association.
- Weinrib, E. L. (1983). *Images of the self*. Boston: Sigo Press.
- Zappacosta, J. D. (2013). Sandplay therapy: A way of rediscovering inner wisdom in the body and psyche. In S. Loue (Ed.), *Expressive therapies for sexual issues* (pp. 181-199). New York: Springer.

# Dance Movement Therapy for the Treatment of Depression

Rachel Fletcher<sup>1</sup> & Heidi Gerschwitz<sup>2</sup>

This study examined recent literature to determine the effectiveness and use of Dance Movement Therapy (DMT) as an additional treatment for depression. Seven studies spanning Europe, the USA and Asia, published during the past eleven years, were analysed. The results indicate the efficacy of DMT both as a primary and complementary group intervention with both clinically and generally depressed clients. Moreover, DMT appears most effective with men, however further research is required. New assessment measures using an iPad app are currently being developed. However, there is a need for more quality research using uniform assessment scales to ascertain which type of DMT is most effective with depressed clients; whether aspects of DMT can successfully be incorporated into a talk therapy session; and whether the therapist needs specific training in DMT to be effective.

Expressive Therapies (ET) modalities are a creative, effective means of non-verbal communication for clients who find talk therapy challenging (Malchiodi, 2015). Pearson and Wilson (2009) observed that when left untreated, unprocessed feelings can be held detrimentally in the body and generate somatic symptoms. Dance/Movement Therapy (DMT) (DMT Association, n.d.) is an ET that uses movement to release these ingrained emotions within the framework of a therapeutic relationship, providing relief and healing both physically and emotionally. DMT is used with individuals and groups, with populations dealing with mental illness and those who have difficulty learning (Zubala & Karkou, 2015). While DMT emerged in the USA in the 1960s, it is a relatively new approach to help people struggling with depression (Koch, Kunz, Lykou & Cruz, 2013). The literature on DMT and its application for treating adults with depression will be examined. (For a detailed timeline of the development of DMT please see Appendix 2).

## Depression

Depression is the most prevalent mental illness in Australia, affecting over one million people annually (Clarke, 2011). Furthermore, the World Health Organisation (WHO, 2018) declared that depression is the leading disabling illness worldwide. More women than men suffer from depression, and at its worst depression may lead to suicide, the second most

common cause of death amongst people aged 15 to 29 years old (WHO, 2018). Treatment for depression mainly consists of medication and/or talking therapies, which may not be suitable for everyone, so DMT provides an alternative or addition to traditional treatments (Meekums, Karkou & Nelson, 2015).

## Significant elements of DMT for depression

DMT has been incorporated into therapy for people with depression, comorbid anxiety and stress due to its active nature (Zubala & Karkou, 2015). This is significant because research has indicated that people with depression do not move their upper limbs to the same extent as healthy individuals (Koch, Morlinghaus & Fuchs, 2007). DMT philosophy is based on the concept of using bodily and motor expression in therapeutic movement to relieve the intensity of strong negative emotions held in the body (Sherwood, 2008). These suppressed emotions implicitly impact our daily interactions. Consequently, DMT's healing value occurs when movement and self-expression within a therapeutic space connect with the unconscious (Pallaro, 2007). The cathartic element of DMT may lead to corrective emotional experiences that can be shared within a safe group (Punkanen, Saarikallio & Luck, 2014).

DMT is different to dance or exercise because it integrates physical, emotional, cognitive and social aspects in treatment (Meekums, 2002). DMT group therapy also aims to promote aspects of Bowlby's theory of secure attachment, considered necessary for healthy adaptive relationships (Homann, 2010). The attachment patterns and behaviours of people with depression are generally defined as insecure or avoidant (Costello, 2013). The reciprocal movement behaviour in DMT, which is a typical aspect of secure attachment interactions, can facilitate participants' communication and may therefore enhance their sense of connection and agency (Pylvänäinen &

Correspondence to: Dr Mark Pearson  
Email: mpearson@usc.edu.au  
<sup>1,2</sup> University of the Sunshine Coast

Lappalainen, 2018).

In order to work as a DMT therapist in the UK or USA a Master of DMT qualification is required (Association of Dance Movement Psychotherapy, 2018; American Dance Therapy Association, 2018); however, this is not yet available in Australia (Dance Movement Therapy Association of Australasia, 2018).

## History and Development of DMT

DMT originated from Austrian Reich's Body Psychotherapy in the 1940's, which recognised when people subconsciously store difficult emotions in their body, movement can free them (Karkou & Sanderson, 2006). Subsequently in the UK, Rudolf Laban, a German dance artist, noted movement revealed subconscious thoughts and emotions and created Movement Analysis categories (Newlove & Dalby, 2004; Panagiotopoulou, 2011). Concurrently in the USA, dance teachers, Marion Chace worked with groups in circles and focused on the needs of the person (Panagiotopoulou, 2011), and Mary Whitehouse focused on the process and therapeutic relationship and developed Authentic Movement (Chodorow, 1990); and Trudi Sloop used imagination for creative expressive movement (Karkou & Sanderson, 2006).

Three broad styles of DMT include the Chace approach from which mirroring was derived and is now used in most DMT approaches; Mary Whitehouse's Authentic Movement where the mover explores the unconscious and is witnessed; and the psychodynamic oriented approach where past conflicts are identified and addressed through analysis of movement and group relationships. A fourth technique, Integrative Dance Therapy, is used by therapists in Germany and integrates concepts from the first two approaches (Brauninger, 2014). In 1982, DMT received worldwide official recognition and integrated both the UK and American developments. (See Appendix 2 for DMT timeline).

## Contemporary developments

Dance/movement therapy is taught in universities worldwide and is credited as effective in mind-body wellness, self-care, depression, chronic pain and chronic illnesses (Hopkins, 2016). Masters level university courses will be available in Australia in 2020 (DTTA, 2018). In order to understand the specific therapeutic mechanisms of DMT Australian research is underway to develop an iPad application to collect data about client experiences with DMT (DTTA, 2018). The iPad application may also be used to create reliable scales and technological innovation in the field, thereby contributing to the establishment of more scientific enquiry around this developing therapeutic modality.

## Evidence for the effectiveness of DMT for depression

Research into the application of DMT for depression is limited globally. The majority of reliable DMT research comes from the UK, USA, Scandinavia and minimally from Korea and Germany (Kiepe et al., 2012; Meekums, Karkou & Nelson, 2015). In Australia, despite DTTA's financial encouragement in the form of research grants, no recent Australian studies addressing depression utilising DMT were identified (DTTA, 2018). Evidence-based research from the previous eleven years consists of randomised control trials that compared the effects of DMT on depression with psychological therapies, drug treatment or other physical therapies. Depression was the primary focus of

only four European studies and a Korean study. The remaining trials included depression as one of several assessment measurements such as quality of life (Brauninger, 2014) or body image (Pylvänäinen & Lappalainen, 2018). These trials were considered to be relevant because many diagnoses, for instance anorexia, cancer and PTSD, include depression as a symptom (Chaiklin & Wengrower, 2016). (See Appendix 1 for as list of the scales used in DMT research).

There was a lack of information regarding whether all DMT participants were also receiving counselling. Trained DMT therapists conducted all the group sessions, with the exception of the Canadian study, which was conducted by nurses (Stewart, as cited in Mala, Karkou, & Meekums, 2012). However, therapists' level of skills and experience were not evaluated. This omission overlooks an assessment of their ability to develop a strong therapeutic relationship with clients to enable sufficient trust for attachment issues to be expressed (Pylvänäinen & Lappalainen, 2018).

There have been a number of pilot studies, developed with the intent to generate wider research. The Finnish pilot study did not include a control group (Punkanen, Saarikallio & Luck, 2014). The German pilot study examined the effects of physical movement on psychiatric patients with depression, comparing DMT with a group that listened to music and a group that rode a home trainer bike (Koch, Morlinghaus & Fuchs, 2007). Participants' levels of depression and vitality improved in all the studies, except the Hong Kong study, which did not lessen depression in cancer clients who had received chemotherapy prior to participation, although stress levels were reduced (Ho et al., 2016). Different styles of DMT or only some aspects of DMT were used in the studies, which meant that a clear picture of how DMT created improvements for depression did not occur, and this was compounded by typically small sample sizes (<40). Results indicated that DMT is effective for men and women experiencing depression (Koch, Morlinghaus & Fuchs, 2007), and other research has highlighted its effectiveness with adolescents (Zubala, MacIntyre, Gleeson & Karkou, 2014).

The number of sessions varied amongst the studies, ranging from less than 10 up to 36 sessions. Because most studies did not specify the precise style of intervention, accurate comparisons of their efficacy could not be made. Scales and measures (see Appendix 1) differed depending on whether the study focused on depression as the main or subsidiary client concern. For example, Pylvänäinen and Lappalainen (2018) conducted a study on depressed psychiatric outpatients with the main aim of improving body image. The majority of participants in all the studies were female apart from the study by Koch, Morlinghaus and Fuchs (2007), who concluded that men benefited more from DMT than women. Longer-term effects of this type of intervention were not included in these trials and is a recommendation in future studies (Meekums, Karkou & Nelson, 2015).

## Rationale for the inclusion of DMT by counselors to treat depression

DMT has been found to be helpful for most types of depression, including clients presenting general symptoms of depression, and is most effective in people who are clinically depressed (Koch, Morlinghaus & Fuchs, 2007; Punkanen, Saarikallio & Luck, 2014; Pylvänäinen, Muotka & Lappalainen, 2015). Because individual clients experience depression differently, a single type of therapy is unlikely to be suitable for all

presentations (Meekums, 2002). DMT therefore offers therapists and clients an additional, creative, non-verbal treatment method to pharmacological, psychosocial or psychological interventions (Zubala, MacIntyre, Gleeson & Karkou, 2014). Finally, considering the financial limitations experienced by many mental health support organisations, DMT is an affordable way to treat a range of depression-related conditions. It is optimally delivered in a group format, providing meaningful and safe social interactions for people with depression.

## Conclusion and recommendations for future research

Research evidence shows that DMT is useful for treating depressed people, with most dramatic results in people diagnosed with clinical depression. Group dance/movement therapy is beneficial partly due to its social aspect. There is a need for better quality research in terms of larger sample sizes, inclusion of a control group and specified style of DMT used. It would also be helpful to establish whether DMT is effective used alone, or in conjunction with talk therapy; and/or with in an expressive therapies framework, specifically, the identification of any DMT techniques that could be incorporated into the therapy room without the counsellor undergoing significant additional training. The potential healing benefits of DMT for people with depression may have been somewhat overlooked within the therapy professions due to the lack of consistent, clearly defined and agreed upon methods and measurements.

## References

- American Dance Therapy Association (ADTA). Definition. Retrieved from: <https://adta.org/faqs/>
- Association of Dance Movement Psychotherapy (ADMP). Definition. Retrieved from: <https://admp.org.uk/>
- Brauninger, I. (2014). Specific dance movement therapy interventions. An intervention and correlation study. *The Arts in Psychotherapy, 41*, 445-457. <http://dx.doi.org/10.1016/j.aip.2014.08.002>
- Chaiklin, S., & Wengrower, H. (Eds.). (2016). *The art and science of dance/movement therapy: life is dance*. London, UK: Routledge Taylor and Francis Group.
- Chodorow, J. (1990). *Dance therapy and depth psychology: The moving imagination*. New York, NY: Routledge.
- Clarke, D. (2011). *Beyondblue guide to the management of depression in primary care: A guide for health professionals*. Melbourne, Victoria: Beyondblue: The National Depression Initiative.
- Costello, P. C. (2013). *Attachment-based psychotherapy. Helping patients develop adaptive capacities*. Washington, DC: American Psychological Association.
- Dance Movement Therapy Association of Australasia (DTTA). (n.d.) Website. Retrieved from: <https://dtaa.org.au/>
- Ho, R. T. H., Fong, T. C. T., Cheung, I. K. M., Yip, P. S. F., & Luk, M. (2016). Effects of a short-term Dance Movement Therapy Program on symptoms and stress in patients with breast cancer undergoing radiotherapy: A randomized, controlled, single blind trial. *Journal of Pain and Symptom Management, 51*(5), 824-831. Retrieved from <http://dx.doi.org/10.1016/j.jpainsymman.2015.12.332>
- Homann, K.B. (2010). Embodied concepts of neurobiology in dance/movement therapy practice. *American Journal of Dance Therapy, 32*, 80-99. doi:10.1007/s10465-010-9099-6
- Hopkins, C. (2016). Dance/movement therapy careers amid changing systems: The first 50 years. *American Journal of Dance Therapy, 38*, 285-292. doi: 10.1007/s10465-016-9233-1 38(2), 285-292.
- Karkou, V., & Sanderson, P. (2006). *Arts therapies: A research based map of the field*. Philadelphia, PA: Elsevier.
- Kiepe, M-S., Stöckigt, B., & Keil, T. (2012). Effects of dance therapy and ballroom dances on physical and mental illnesses: A systematic review. *The Arts in Psychotherapy, 39*, 404 - 411. Retrieved from: <http://dx.doi.org/10.1016/j.aip.2012.06.001>
- Koch, S., Kunz, T., Lykou, S., & Cruz, R. (2013). Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis. *The Arts in Psychotherapy, 41*, 46 - 64. Retrieved from: <http://dx.doi.org/10.1016/j.aip.2013.10.004>
- Koch, S. C., Morlinghaus, K., & Fuchs, T. (2007). The joy dance. Specific effects of a single dance intervention on psychiatric patients with depression. *The Arts in Psychotherapy 34*. 340-349. doi: 10.1016/j.aip.2007.07.001
- Mala, A., Karkou, V., & Meekums, B. V. F. (2012). Dance/movement therapy (D/MT) for depression: A Scoping Review. *Arts in Psychotherapy, 39* (4), 287 - 295. Retrieved from: <https://doi.org/10.1016/j.aip.2012.04.002>
- Malchiodi, C. (2015). *Expressive therapies*. New York, NY: The Guilford Press.
- Meekums, B. (2002). *Dance movement therapy*. London: SAGE Publications Ltd.
- Meekums, B., Karkou V., & Nelson E. A. (2015). Dance movement therapy for depression. *Cochrane database of systematic reviews, 6* UK: Wiley and Sons. Retrieved from: <http://dx.doi.org/10.1002/14651858.CD009895>
- Newlove, J., & Dalby, J. (2004). *Laban for all*. New York, NY: Routledge.
- Pallaro, P. (Ed.). (2007). *Authentic movement. A collection of essays*. London: Jessica Kingsley Publishers.
- Panagiotopoulou, E. (2011). Dance therapy models: An anthropological perspective. *American Journal of Dance Therapy, 33*(2), 91-110. Retrieved from: <http://dx.doi.org/10.1007/s10465-011-9118-2>
- Pearson, M., & Wilson, H. (2009). *Using expressive arts therapies to work with mind, body and emotions. Theory and practice*. London, UK: Jessica Kingsley.
- Punkanen, M., Saarikallio, S., & Luck, G. (2014). Emotions in motion: Short-term group form dance/movement therapy in the treatment of depression: A pilot study. *The Arts in Psychotherapy, 41*, 493-497. Retrieved from: <http://dx.doi.org/10.1016/j.aip.2014.07.001>
- Pylvänäinen, P., & Lappalainen, R. (2018). Change in body image among depressed adult outpatients after a dance movement therapy group treatment. *The Arts in Psychotherapy, 59*, 34-45. Retrieved from: <https://doi.org/10.1016/j.aip.2017.10.006>
- Pylvänäinen, P. M., Muotka, J. S., & Lappalainen, R. (2015). A dance movement therapy group for depressed adult patients in a psychiatric outpatient clinic: effects of the treatment. *Frontiers in Psychology, 6*(980), 1-11. doi: 10.3389/fpsyg.2015.00980
- Sherwood, P. (2008). Expressive artistic therapies as mind-body

medicine. *Body, Movement and Dance in Psychotherapy*, 3(2), 81-95. doi: 10.1080/17432970802080040

World Health Organisation (WHO). (2010). *Depression*. Retrieved from <http://www.who.int/news-room/factsheets/detail/depression>. Accessed 24.08.18

Zubala, A., & Karkou, V. (2015). Dance movement psychotherapy practice in the UK: Findings from the arts therapies survey 2011. *Body, Movement and Dance in Psychotherapy*, 10(1), 21-38. doi:10.1080/17432979.2014.920918

Zubala, A., MacIntyre, D. J., Gleeson, N., & Karkou, V. (2014). Description of arts therapies practice with adults suffering from depression in the UK: Qualitative findings from the nationwide survey. *The Arts in Psychotherapy* 41, 535-544. doi: 10.1016/j.aip.2014.10.005

## Appendix 1

### Scales and Assessments used in the Research Papers

BIA	Body Image Assessment
BDI	Beck Depression Inventory
CORE/OM	Clinical Outcomes in Routine Evaluation/ Outcome Measure
DACL	Depression Adjectives Checklist
HADS	Hospital Anxiety Depression Scale
PSS	Perceived Stress Scale
SLC-90	Symptoms Check List
TAS-20	Toronto Alexithymia
TBFI	The Brief Fatigue Inventory
TIPI	Ten Item Personality Inventory
TBPI	The Brief Pain Inventory
TPSQI	The Pittsburgh Sleep Quality Index
RQ	Relationship Questionnaire
SCL-90/R	Symptom Checklist 90 Revision
SWLS	Satisfied With Life Scale

## Appendix 2

### Timeline of Development of Dance Movement Therapy

#### 1940's

##### Europe

- Austria, Reich's Body Psychotherapy recognised a connection between emotions and movement (Karkou & Sanderson, 2006).
- The UK, Rudolf Laban's Movement Analysis looked educationally at body movement and the emotions that are unwittingly communicated (Newlove, & Dalby, 2004; Panagiotopoulou, 2011).

##### The USA

- Marion Chace worked in psychiatric hospitals and focused on self-expression and the needs of the person, not the dance technique, and used circle groups and mirroring as a supportive interactive method of communication with schizophrenic patients (Panagiotopoulou, 2011).

- Mary Whitehouse worked with high anxiety clients and focused on the process and therapeutic relationship. She developed Authentic Movement in the 1950's where purposeful and spontaneous movement are used to explore the unconscious and connect with hidden emotions (Chodorow, 1990). 1950's

- Trudi Sloop worked with schizophrenic patients and used imagination to creatively encourage expressive movement (Karkou & Sanderson, 2006). 1960's

- Dancer Judith Kestenberg, observed the correlation between movement and emotions and created the Kestenberg Movement Profile. This was influenced by Laban's Movement Analysis categories (Bannerman-Haig, 2006).

- Judith Kestenberg, influenced by Laban, observed the correlation between movement and emotions and created the Kestenberg Movement Profile (Bannerman-Haig, 2006).

#### 1982

##### GLOBALLY

DMT became officially recognised and integrated movement concepts developed from Rudolf Laban's work and perspectives from American dancers:

- Chace Approach which is most commonly used;
- Authentic Movement;
- the Psychodynamic Oriented Dance Therapy approach where past conflicts are identified and addressed through analysis of movement and group relationships; and
- Integrative Dance Therapy, developed in Germany integrating concepts from the American pioneers (Brauninger, 2014).

#### 1984

##### FRANCE

- Schott-Billman developed Expression Primitive which focuses on cultural awareness and specific group movements with psychiatric patients

#### 1994

##### AUSTRALIA

- The Dance Therapy Association of Australia formed and is now known as the Dance Movement Therapy Association of Australasia (DTTA).

#### NOW

##### GLOBALLY

- Dance therapy is now taught in universities worldwide and is credited as effective in mind-body wellness, self-care, depression, chronic pain and chronic illnesses (Hopkins, 2016).
- Unfortunately, in the USA, due to health insurance coverage issues, DMT is labelled an alternative or holistic treatment limiting it to private paying clients.

Four main types of Dance/movement therapy are practised, comprising: Authentic Movement; the Psychodynamic Oriented Dance Therapy approach where past conflicts are identified and addressed through analysis of movement and group relationships (Karkou & Sanderson, 2006); and the German Integrative Dance Therapy, which integrated concepts from the American pioneers (Brauninger, 2014). Additionally, in 1984, Schott-Billman developed Expression Primitive which focuses on cultural



awareness and specific group movements (Panagiotopoulou, 2011).

### **Appendix 3**

#### **Number of sessions per study**

HongKong study of 6 sessions, by Ho, et al.,

Canadian study 7 sessions of by Stewart in Mala, Karkou & Meekums

German study of 8 sessions, by Koch

Swiss study of 10 sessions, by Brauninger

South Korean study of 36 sessions by Jeong in Mala, Karkou & Meekums

Finnish study of 20 sessions by Punkanen, Saaikallio & Luck

Finnish study of 12 sessions by Pylvänäinen, Muotka & Lappalainen

# Psychodrama: Conception, Evolution, Evidence and Applications

Carolyn A. Rogers<sup>1</sup> & Diana Kosowicz<sup>2</sup>

Psychodrama has been evolving since its creation by Jacob Moreno in 1921. It is an approach that was designed to allow catharsis through spontaneous recreation of scenes from life, performed on a stage, and leading to enhanced balance in life. This review explores the development of and rationale for psychodrama, the stages of the process, the contemporary models and applications, particularly its use with those recovering from trauma, and the wider evidence base.

*"Psychodrama was born on Fool's Day, April 1, 1921, between 7:00 and 10:00 p.m."* (Moreno, 1946b, p. 1).

Psychodrama began as an experiment in improvisation and spontaneity on a Viennese stage in 1921, instigated by its founder Jacob Levy Moreno, a Romanian-American psychiatrist, psychosociologist, and educator (Moreno, 1946b). Today, Psychodrama is utilised worldwide as a psychotherapy which may be applied across different cultures, age groups and various mental health conditions, such as depression, recovery from sexual abuse, alcoholism and post-traumatic stress disorder (PTSD) (Dehnavi, Hashemi, & Zadeh-Mohammadi, 2016; Landy 2007; Sang, Huang, Benko, & Wu, 2018; Souilm & Ali, 2017; Varma, Karadag, Oguzhanoglu, & Özdel, 2017).

Psychodrama is defined as the action of the psyche, and is an individual action psychotherapy which uses a group setting (Landy, 2007; Moreno, 1946b; Propper, n.d.). The historical premise of Psychodrama was that all people are born actors in which they play different roles in their daily lives. By tapping into their spontaneity, recreating scenes from life and acting out past traumas on a 'therapeutic' stage, they are able to reach catharsis and achieve balance in their lives (Moreno, 1939).

Contemporary developments of Psychodrama include the Therapeutic Spiral Model, the Experiential Reintegration Model and the Cognitive Behaviour Psychodrama Group Therapy, which can be utilised with clients who have suffered various forms of trauma which has caused a disruption in a persons' life (Hudgins & Toscani, 2013; Kipper, 2000; Treadwell & Dartnell, 2017). There have been mixed results in outcome evidence for Psychodrama's effectiveness as a psychotherapy, however, there are claims it provides a safe environment for those who have suffered from trauma (Baim, Burmeister, & Maciel, 2007;

Napier et al., 2014; Treadwell & Dartnell, 2017).

As Psychodrama nears the 100 year mark since its conception, this review will survey its development from an experiment in spontaneity, historical applications as a psychotherapy, contemporary developments, research evidence, and how it is currently applied with individuals experiencing trauma. Psychodrama has evolved into many similar types of psychotherapy, including but not limited to, Sociodrama and Drama-therapy, however for the purpose of this review, Psychodrama is referred to as the original concept developed by Moreno.

## Conception and Historical Development

While Psychodrama evolved as a therapeutic technique, its genesis was not like other psychotherapies of the time, for example psychoanalysis, through collaboration with therapy peers and scholarly documentation, it's conception was as a public performance by its creator J. L. Moreno (Moreno, 1946b). In a Viennese theatre in 1921, Moreno stood alone on a stage, with only an empty throne like chair with a crown perched upon it as company, in front of an audience of his peers and local townspeople (Moreno, 1946b). There was no play, no script and no actors; this event was an experiment in spontaneity. Moreno invited audience members to the stage, to sit on the throne and to share with the audience the drama of their lives. Essentially some members of the audience became the actors and the remainder of the audience became the jury (Moreno, 1940a, 1946b). Although this theatrical event was deemed a failure, Moreno continued to explore the premise of psychodrama and developed it further during the 1920s at the Theatre of Spontaneity in Vienna, and later in Beacon, New York (Moreno, 1946b). It was not until the early 1940s that psychodrama became a formalised psychotherapy with its own professional association, moving away from its traditional roots of theatrical improvisation and experimentation into a structured format that was subjected to rigorous experimental control (Kedem-Tahar & Kellermann, 1996; Moreno & Toeman, 1942).

The development of Psychodrama took place during the time when Freuds' individual psychoanalysis, the 'talking cure',

For correspondence: Dr Mark Pearson

Email: mpearson@usc.edu.au

<sup>1,2</sup> University of the Sunshine Coast

Australian Counselling Research Journal ISSN1832-1135

was the dominant psychotherapy in Austria and across Europe (Landy, 2007; Moreno, 1946b). Psychotherapy was deemed a private matter and only for the rich, Psychodrama was met with resistance in Europe as it was thought to be bringing private matters into the public eye (Moreno, 1946a; Moreno & Toeman, 1942). Moreno believed that change occurred more in a person by dramatizing a previous trauma, that had lead the person to a place of imbalance or mental illness, unlike psychoanalysis which focused more on talking (Landy, 2007). Moreno found that people at the time, regardless of economic status, suffered from similar neurosis and maladjustments to those who could afford psychoanalysis. Psychodrama was one of the first forms of group based psychotherapy, and was a way for those from lower socio-economic backgrounds to be able to seek the help they needed (Moreno, 1940b). Psychodrama was used originally to treat many conditions including, alcoholism, marital problems, psychosis, manic depression and psychoneurosis (Moreno, 1939). Psychodrama was also utilised to help those who the psychoanalyst believed could not be helped, for example, misfits, narcissists and schizophrenics (Moreno, 1940b; Moreno & Toeman, 1942).

### Spontaneity and Catharsis

The original aim of Psychodrama was to provide a therapeutic environment in which spontaneity and catharsis could be induced in a mentally ill person to bring back balance to the individual (Moreno, 1940a). Moreno believed that the dramatic re-enactment of a past trauma would access the unconscious parts of a persons' psyche, and by acting out or objectifying the problem or previous trauma on the stage, that it would produce a mental catharsis in the individual (Moreno, 1939, 1940a, 1940b). Moreno (1940a) defined mental catharsis, as the bringing back of equilibrium to a mentally ill persons' psyche. Although, mental catharsis as a theory of change was first introduced by psychoanalysts, they later abandoned the theory. Moreno believed mental catharsis still had relevance to produce change thus he incorporated it into his theory of psychodrama (Moreno, 1940). Moreno and Toeman (1942) identified three ways in which catharsis could be achieved: 1) self-therapy, where a person finds catharsis by themselves; 2) the dialogue method, where the person converses with a trained therapist to possibly reach catharsis; and 3) the dramatic and or group method, which contains both self-therapy and dialogue method. Dramatic method was shown in an early study to be more affective in an individual reaching catharsis than self – and or dialogue – methods (Moreno & Toeman, 1942). Another early study by Moreno (1939) showed that when a patient was in a psychodramatic state, they re-called more of the trauma in further detail, than was recorded during the initial interview.

### Roles and Role Theory

As well as spontaneity and catharsis to promote change, psychodrama utilises Moreno's role theory. Role theory states that all people are interconnected, and each individual reacts in a different way depending upon the environment in which they find themselves at a given moment. There are three types of roles all individuals play throughout their lives, social, psychodramatic and psychosomatic. The social role is the role where individuals fit in relation to others, for example co-worker, daughter, or friend (Landy, 2007). The psychodramatic roles are ones of companionship, adventurer and the words we speak. The psychosomatic roles are our thoughts, feelings and

behaviour (Tavon, 2001; The Moreno Psychodrama Society, n.d.). People are considered to play many roles and counter-roles throughout their lives, similar to an actor on the stage. The roles in a Psychodrama include the protagonist (the client), the director (the therapist) and the auxiliary egos (other members of the group). The role each member of the group portrays, including the therapist, are essential to the mentally ill individual reaching catharsis (Moreno, 1940b).

The client in the dramatic act becomes the protagonist, the person central to the psychodrama, the portrayer of his own real world in an imaginary setting, the psychodramatic stage (Landy, 2007; Moreno, 1946a). The protagonist recalls an earlier scenario that has caused problems and conveys this to the director. The protagonist will most usually direct their attention to each auxiliary ego they wish to play each role of people in their real world, for example their mother (Landy, 2007). The director of the production is the therapist and in their role they act as producer, therapist and analyst of the scene (Tavon, 2001). It is important that the director be seen by all members of the group, and that they can see all the group, this fosters an illusion that communication and an interpersonal relationship is being made between all participants and the director, it also allows the director to see facial expressions, reactions and body language of all participants, which adds therapeutic value (Moreno & Toeman, 1942). The director sets the scene from the discussion with the protagonist and directs the auxiliary egos, chosen by the protagonist as to where to stand (Landy, 2007). The auxiliary egos are the other group participants, originally they were staff or confederates of the therapist, however, today auxiliary egos are other members of the therapy group. Auxiliary egos act as prompts or foils for the protagonist, which enables them to complete the imaginary scene (Moreno, 1940b). Auxiliary egos may take on the role of any person, for example an adult may play the role of a child (Moreno, 1969).

### The Psychodramatic Session

There are three phases in a psychodramatic session, the warm-up, the action and the analysis. Each phase of the session has a specific purpose and takes place on a different level of the therapeutic stage, the stage was designed to add therapeutic value to the session (Landy, 2007). The psychodramatic stage has three levels and it is on the bottom level that the therapist/director sits facing the audience members, who will become the protagonist and auxiliary egos, to conduct the first phase of the psychodrama, the interview. The interview begins the session and consists of the therapist introducing a topic for discussion, from this discussion an audience member is chosen or volunteers to become the protagonist (Moreno, 1946b).

#### The Warm-up.

After the protagonist has been identified the warm-up phase begins, the director and protagonist sit together on the second tier of the stage facing each other at eye level, it is an important part of psychodrama that the client feels that they are equal to the therapist (Moreno, 1946b). The protagonist is asked to recall the time of a specific incident, for example a past trauma, and assumes that role through the use of body positions, words and mental imagery, this process is said to create spontaneity (Moreno, 1939; Landy, 2007). The protagonist also indicates to the director who else was present at the time and chooses auxiliary ego's to take part. The warm-up process may be short or long, the timing depends upon the protagonist (Moreno, 1939).

### The Action Phase.

The action phase is where the scene of the trauma is acted out, the protagonist and auxiliary egos take their place on the top tier of the stage and the director begins the action (Moreno, 1946b). The director may use various techniques in this phase such as mirroring, role reversal, the double and the soliloquy, to invoke a response from the protagonist (Landy, 2007). In mirroring the protagonist, steps away from the staged scene to observe the action from the outside, they act as their own therapist, an auxiliary ego takes on the protagonist's role. Role reversal involves the protagonist switching to another role in the drama being acted out, for example, taking on the role of their mother. The double is an auxiliary ego taking on the role of the protagonist and projecting back to them the empathy they desire, the aim is for the protagonist to become aware of feelings and thoughts that may be buried deep inside. The soliloquy takes place between acts, the protagonist is left alone on the stage and acts out their thoughts and feelings they are having in the here and now (Landy, 2007; Propper, n.d.).

### The Analysis.

Analysis of the session takes place on the bottom tier of the stage, which usually begins after the protagonist has reached an emotional release or catharsis. The analysis may include other group members sharing similar experiences with the protagonist, which may help the protagonist to further process the session (Landy, 2007).

### Contemporary Developments and Rationale

Moreno's concept of psychodrama and its application have been approached in a transdisciplinary way by many current psycho-dramatists (Baim et al., 2007). Its development and reformulation over the years can be observed, among others, in Rogerian psychodrama, psychoanalytic psychodrama and Jungian psychodrama (Baim et al., 2007). Its aspects and techniques have also been used within psychoanalytic object relations theory, cognitive therapy, Glasser's reality therapy, behaviour therapy, Adler's individual psychology, Gestalt, Bowen's family system therapy and Berne's transactional analysis (Baim et al., 2007; Blatner, 1997; Gershoni, 2003). Currently, Psychodrama is represented around the world with individual associations in countries such as Britain, Australia & New Zealand, America and India (The Moreno Psychodrama Society, n.d.). Psychodrama forms part of the International Association for Group Psychotherapy and Group Processes (IAGP) which aims to advance the knowledge and scientific evidence of the effectiveness of Psychodrama (IAGP, n.d.). The IAGP is affiliated with psychodrama organisations and associations worldwide including but not limited to Brazil, Belgium, Costa Rica, France, Spain, Great Britain and Turkey (Rakhawy, n.d.). More recently psychodrama has been gaining popularity in Asian countries such as Taiwan and China (Lai & Tsai, 2014; Sang et al., 2018). The rationale of psychodramas inclusion in contemporary times is due to its wide range of applications to various mental illnesses, for example PTSD; domestic violence; survivors of natural disasters and war and an ongoing commitment from current psychotherapists to continue to build on Moreno's original concepts (Baim et al., 2007; Blatner, 2012; Hudgins, 2002; Hudgins & Toscani, 2013; Gershoni, 2003).

### Research Evidence

Many countries recognize psychodrama as a

psychotherapy method which is successfully utilized in the treatment of trauma, however, there is still a lack of systematic research on the effectiveness of psychodrama (Baim et al., 2007; Kipper & Ritchie, 2003; Uneri, Yildirim, Tanidir, & Aytemiz, 2016). According to the available research, experiential therapies are as effective as psychodynamic and cognitive approaches, and more successful when applied for treating anxiety and PTSD (Baim et al., 2007; Elliott, Greenberg, & Lietaer, 2004; Greenberg, Watson, & Lietaer, 1998). Altinay (2003) describes how psychodrama can be utilized when helping trauma survivors after natural disasters. The researchers went to Turkey after a massive earthquake killed almost 30,000 people and left 100,000 of others without any shelter. The researches ran a series of meetings for two types of groups, i.e. trauma survivors and those who were about to be train how to provide interventions based on psychodrama. Altinay formulated his model of intervention, however, basing it on core tenets of Moreno's original concept (2003). The results were more promising than one could have wished for. It was observed and self-reported by participants that even after one psychodrama session all the problems and anxieties caused by the earthquake trauma were gone (Altinay, 2003). The benefits of implementing psychodrama into psychological interventions were also observed by Chang (2005) who investigated how it was adjusted to cultural frame and possibilities when helping children who survived an earthquake in 1999 in Taiwan. There is evidence that psychodrama does not meet the standards for evidence-based research, yet Austrian and Hungarian governments give it accreditation to be utilized as a form of psychotherapy (Baim et al., 2007). It has been a challenge for researchers to create a valid and standardized psychological instrument that would measure the effectiveness of psychodrama (Napier et al., 2014). especially since there is a plethora of qualitative research based on self-reports or observations. The emphasis is put "... on meaning, not measurement." (Napier et al., 2014, pp.118). The analysis of available research on psychodrama described in Baim et al. (2007) found that there are at least a few studies that show good results when applied to treating various mental health disorders, especially PTSD and depression (Dehnavi et al., 2016; Souilm & Ali, 2017; Varma, Karadag, Oguzhanoglu, & Özdel, 2017). The future of more evidence-based research on psychodrama seems to depend on its combination with or implementation into one of the main psychological approaches such as, for instance, cognitive behavioural therapy (CBT) (Napier et al., 2014).

### Psychodrama and Trauma

The Australian Psychological Society defines trauma as experiencing or witnessing a life-threatening or frightening situation that "...can result in difficulty in coping or functioning normally." (2018, para. 1). Traumatic experiences strongly influence cognitive, emotional, behavioural, physical, psychological and biochemical processes in our mind and body (van der Kolk, McFarlane, & Weisæth, 1996). In some people, memories of traumatic events may not get processed due to distortion of perceptions and thoughts, yet the body, on a sensorimotor level stays active as if the threat was still present (Dayton, 2005). What distinguishes psychodrama from other available therapies is that it perceives the client's use of body as a way of expressing hidden or unconscious thoughts and feelings (Fong, 2006). It serves as a bridge, which can help with the awareness of sensorimotor feelings to access and express verbally the experienced trauma. Under the counsellor's guidance through physical re-enactment, the body and mind are brought to

here-and-now, which enables the memories of traumatic events to be processed (Kipper, 1998; Van der Kolk, 2014). People who have experienced trauma tend to be hypervigilant and sensitive to any signs of danger in their environment (Van der Kolk, 2014). When they experience catharsis of emotions, the new insight appears and feelings, once perceived as being strongly conjoined get separated, hence understood much better, clients get back their ability to react adequately to various situations they face (Dayton, 2003). Since various psychotherapeutic approaches incorporate psychodrama technique in the gamut of the methods they use to help the client, this form of intervention is applied both in individual and group treatment (Baim et al., 2007; Clark & Davis-Gage, 2010).

## Contemporary Models

There are three contemporary therapeutic models, developed on the grounds of Moreno's classical psychodrama, and utilised to with clients who have had traumatic experiences: The Therapeutic Spiral Model (Hudgins & Toscani, 2013); the Experiential Reintegration Model (Kipper, 2000); Cognitive Behavioral Psychodrama Group Therapy.

The Therapeutic Spiral Model's (TSM) theoretical base lies in Moreno's spontaneity and creativity idea as well as Blatner's Role Theory (Blatner, 2000; Hudgins & Toscani, 2013). Blatner's role theory differs from Moreno's in the following aspects: presence of observing ego, management of defences, intrapsychic, intrapersonal and transpersonal strength (Baim et al., 2007). TSM is a three-day workshop with the key goal to ensure that the client will not be re-traumatized when faced with their intense emotions (Baim et al., 2007). TSM is effective and safe for those who, after experiencing trauma are struggling with dissociative mood and PTSD (van der Kolk, 2014; Hudgins & Toscani, 2013). The signs of trauma lessen through spontaneity and creativity that create change by enabling a new self-organisation, relating to others empathetically, adaptive use of emotional release (catharsis) and repair, and new personal narratives (Baim et al., 2007).

The Experiential Reintegration Model (EMR) also known as Experiential Reintegration Action Therapy (ERAT) is applied in a group therapy setting and its main goal is to enable, alter, enrich, replace, examine or correct the painful experiences of trauma. The client re-enacts the traumatic event with no alterations, however, the client implements a new satisfactory ending and their stored-up emotions can be released (Baim et al., 2007). ERAT consists of the following key elements: "experience, a significant experience, context, emotional reactions, reintegration" (Baim et al., 2007, pp. 42). Experiences that are processed during ERAT are divided into four categories from two-dimensional perspective, i.e. its occurrence in the past or not; emotional perception of the event, either positive or negative (Baim et al., 2007). Such division enables the therapist to choose the directional strategy appropriate for the given category of the experience. The emphasis is put on changing the impact traumatic experience has had on the client by allowing and encouraging the protagonist to create a new alternative positive ending, an experience that will be cathartic and that will provide the client with some perspective (Baim et al., 2007). The other approach within this model is to allow the client to enact the worst-case scenario. The aim of using this strategy is to help clients realize that the difficult situations they have had experienced may have had more damaging impact on them and their life (Baim et al., 2007). There are some restrictions concerning applying this

technique, namely the clients' past experience should be rather moderate in its nature and be used only when the therapist is sure that "...the protagonist's ego is strong enough to prevent unintended harm." (Baim et al., 2007, pp.49). Moreover, the last two strategies refer to the present and the future since the client is encouraged to enact the new experiences he or she would like to occur in reality and to practice the acquired skills (Baim et al., 2007).

Psychodrama techniques have been successfully combined with cognitive behavioural therapy when working with groups (Fisher, 2007; Treadwell & Dartnell, 2017; Treadwell, Kumar, & Wright, 2002). Treadwell created a Cognitive Behavioral Psychodrama Group Therapy (CBPGT) approach that focuses on clients recognizing their negative thought patterns and then rehearsing new behaviours in the safe environment of group session (2017). Moreno's influence can be observed in the way sessions are structured, i.e. they consist of three following parts: warm-up, action, and sharing (Treadwell & Dartnell, 2017). The similarities of cognitive approaches and psychodrama were investigated (Baim et al., 2007; Fisher, 2007) and showed that they can complete each other (Treadwell & Dartnell, 2017).

In conclusion, Psychodrama seems to be widely acclaimed as its application can be observed in different schools of psychotherapy and there are no signs that its time has come to and end. On the contrary, Moreno's work has given rise to many contemporary developments of psychological interventions. Psychodrama as a method has been shown to help people to process traumatic experiences, through spontaneity and mental-catharsis and effectively reduces symptoms of trauma as well as other mental health problems. The combination of psychodrama techniques with cognitive approaches seems to be very promising, as far as evidence-based data is concerned. Moreover, the research shows that it appears to be as effective as other psychological approaches.

## References

- Altinay, D. (2003). A psychodramatic approach to earthquake trauma. In J. Gershoni (Ed.), *Psychodrama in the 21st century: Clinical and educational applications* (Vol. 21, pp. 167-173). New York, NY: Springer Publishing Company.
- Australian Psychological Society. (2018). *Trauma*. Retrieved from <https://www.psychology.org.au/for-the-public/Psychology-topics/Trauma>
- Baim, C., Burmeister, J., & Maciel, M. (2007). *Psychodrama: Advances in theory and practice*. New York, NY: Taylor and Francis.
- Blatner, A. (1997). Psychodrama: The state of the art. *The Arts in Psychotherapy*, 24(1), 23-30. [https://doi.org/10.1016/S0197-4556\(96\)00057-3](https://doi.org/10.1016/S0197-4556(96)00057-3)
- Blatner, A. (2000). *Foundations of psychodrama: History, theory, and practice* (4th ed.). Retrieved from <http://psycnet.apa.org/record/2000-07509-000>
- Blatner, A. (2012). *Healing world trauma with the Therapeutic Spiral Model: Psychodramatic stories from the frontlines*. London, England: Jessica Kingsley Publishers.
- Chang, I. I. C. (2005). Theatre as therapy, therapy as theatre transforming the memories and trauma of the 21 September 1999 earthquake in Taiwan. *Research in Drama Education: The Journal of Applied Theatre and Performance*, 10(3), 285-301. <https://doi.org/10.1080/13569780500275907>

- Clark, T. L., & Davis-Gage, D. (2010). *Treating trauma: Using psychodrama in groups*. Retrieved from [http://counselingoutfitters.com/vistas/vistas10/Article\\_59.pdf](http://counselingoutfitters.com/vistas/vistas10/Article_59.pdf)
- Dayton, T. (2003). *Psychodrama and the treatment of addiction and trauma in women*. In J. Gershoni (Ed.), *Psychodrama in the 21st century: Clinical and educational applications* (Vol. 21, pp. 175-195). New York, NY: Springer Publishing Company.
- Dayton, T. (2005). The use of Psychodrama in dealing with grief and addiction-related loss and trauma. *Journal of Group Psychotherapy, Psychodrama and Sociometry*, 58(1), 15-34. doi:10.3200/JGPP.58.1.15-34
- Dehnavi, S., Hashemi, S. F., & Zadeh-Mohammadi, A. (2016). The effectiveness of psychodrama on reducing depression among multiple sclerosis patients *International Journal of Behavioral Sciences*, 9(4), 32-35. Retrieved from [http://www.behavsci.ir/article\\_67930\\_623a42170363c8d44bf3a3c2e11fb66a.pdf](http://www.behavsci.ir/article_67930_623a42170363c8d44bf3a3c2e11fb66a.pdf)
- Elliott, R. K., Greenberg, L. S., & Lietaer, G. (2004). Research on experiential psychotherapies. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change: 5th edition*. (pp. 493-539). Retrieved from <https://strathprints.strath.ac.uk/3266/>
- Fisher, J. A. (2007). Congenial Alliance: Synergies in cognitive and psychodramatic therapies. *Psychology of Aesthetics, Creativity, and the Arts*, 1(4), 237-242. <http://dx.doi.org/10.1037/1931-3896.1.4.237>
- Fong, J. (2006). Psychodrama as a preventive measure: Teenage girls confronting violence. *Journal of Group Psychotherapy, Psychodrama and Sociometry*, 59(3), 99-108. <http://dx.doi.org/10.3200/JGPP.59.3.99-108>
- Gershoni, J. (2003). The use of structural family therapy and psychodrama: A new model for children's group. In J. Gershoni (ed.), *Psychodrama in the 21st century: Clinical and educational applications*, (Vol.21, pp.49-61). New York, NY: Springer Publishing Company.
- Greenberg, L. S., Watson, J. C., & Lietaer, G. (1998). *Handbook of experiential psychotherapy*. New York, NY: Guilford Press.
- Hudgins, K. (2002). *Experiential treatment for PTSD: The therapeutic spiral model*. New York, NY: Springer Publishing Company.
- Hudgins, K., & Toscani, F. (2013). *Healing world trauma with the therapeutic spiral model: Psychodramatic stories from the frontlines*. London, England: Jessica Kingsley Publisher.
- International Association for Group Psychotherapy and Group Processes. (n.d.). *Sections*. Retrieved from <https://www.iagp.com/sections/index.htm>
- Kedem-Tahar, E., & Kellermann, P. F. (1996). Psychodrama and drama therapy: A comparison. *The Arts in Psychotherapy*, 23(1), 27-36. [https://doi.org/10.1016/0197-4556\(95\)00059-3](https://doi.org/10.1016/0197-4556(95)00059-3)
- Kipper, D. A. (1998). Psychodrama and trauma: Implications for future interventions of psychodramatic role-playing modalities. *International Journal of Action Methods*, 51(3), 113-121. Retrieved from: <https://search.proquest.com/openview/037f53282fbcfac524fdeb38cfe282b/1?pq-origsite=gscholar&cbl=29096>
- Kipper, D. A. (2000). Surplus reality and the Experiential Reintegration Model in psychodrama. *International Journal of Action Methods*, 53(3/4), 137-152. Retrieved from <https://search.proquest.com/openview/309ba8de50af604b2aecb10f891a134b/1?pq-origsite=gscholar&cbl=29096>
- Kipper, D. A., & Ritchie, T. (2003). The effectiveness of psychodramatic techniques: A meta-analysis. *Group Dynamics: Theory, Research, and Practice*, 7(1), 13-25. <http://dx.doi.org/10.1037/1089-2699.7.1.13>
- Lai, N.-H., & Tsai, H.-H. (2014). Practicing psychodrama in Chinese culture. *The Arts in Psychotherapy*, 41(4), 386-390. <https://doi.org/10.1016/j.aip.2014.06.005>
- Landy, R. J. (2007) Drama therapy and psychodrama. In C. A. Malchiodi (Ed.), *Expressive therapies* (pp. 90-116). New York, NY: The Guilford Press.
- Moreno, J. L. (1939). Psychodramatic shock therapy a Sociometric approach to the problem of mental disorders. *Sociometry*, 2(1), 1-30. <https://www.jstor.org/stable/2785305>
- Moreno, J. L. (1940a). Mental catharsis and the psychodrama. *Sociometry*, 3(3), 209-244. <https://www.jstor.org/stable/2785151>
- Moreno, J. L. (1940b). Psychodramatic treatment of psychoses. *Sociometry*, 3(2), 115-132. <https://www.jstor.org/stable/2785437>
- Moreno, J. L. (1946a). Psychodrama and group psychotherapy. *Sociometry*, 9(2/3), 249-253. <https://www.jstor.org/stable/2785011>
- Moreno, J. L. (1946b). Psychodrama: Vol. 1. Retrieved from <http://dx.doi.org/10.1037/11506-000>
- Moreno, J. L., & Toeman, Z. (1942). The group approach to psychodrama. *Sociometry*, 5(2), 191-195. <https://www.jstor.org/stable/2785432>
- Napier, A., Dutton, C., Baim, C., Tauvon, K. B., Christey-Casson, J., Chesner, A.,...Brown, T. (2014). *Empowering therapeutic practice: Integrating psychodrama into other therapies*. London and Philadelphia: Jessica Kingsley Publishers.
- Propper, H. (n.d.). *A concise introduction to Psychodrama, Sociodrama and Sociometry*. Retrieved from <http://www.asgpp.org/pdf/psychodrama.conciseintro.pdf>
- Rakhawy, M. (n.d.) *Affiliates*. International Association for Group Psychotherapy and Group Processes. Retrieved from <https://www.iagp.com/affiliates/index.htm>
- Sang, Z., Huang, H., Benko, A., & Wu, Y. (2018). The spread and development of Psychodrama in Mainland China. *Frontiers in Psychology*, 9, 1-7. doi:10.3389/fpsyg.2018.01368
- Souilm, N. M., & Ali, S. A. O. (2017). Effect of psychodrama on the severity of symptoms in depressed patients. *American Journal of Nursing Research*, 5(5), 158-164. doi:10.12691/ajnr-5-5-1
- Tauvon, L. (2001). A comparison of psychoanalytic and psychodramatic theory from a psychodramatist's perspective. *Counselling Psychology Quarterly*, 14(4), 331-355. <https://doi.org/10.1080/09515070110092316>
- Treadwell, T., & Dartnell, D. (2017). Cognitive Behavioral Psychodrama group therapy. *International Journal of Group Psychotherapy*, 67(sup1), S182-S193. <https://doi.org/10.1080/0207284.2016.1218285>
- Uneri, O., Yildirim, E., Tanidir, C., & Aytemiz, T. (2016). Using the psychodrama in adolescents with social anxiety disorder. *Anadolu Psikiyatri Dergisi*; Sivas, 17(5), 347-353. doi:10.5455/apd.207763
- van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma*. New York, NY: Penguin.

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

Varma, G., Karadag, F., Oguzhanoglu, N., & Özdel, O. (2017). The role of group psychotherapy and psychodrama in the treatment of depression. *The Turkish Journal of Psychiatry*, 20(4), 308-317. doi:10.5505/kpd.2017.86158