Section I

CLINICAL SETTINGS

Chapter 2

TRAUMA-CENTERED DEVELOPMENTAL TRANSFORMATIONS: DISMANTLING THE HOLD OF ILLEGITIMATE POWER

DAVID READ JOHNSON AND REBECCA DAVIS

GIVEN CIRCUMSTANCES

The Background Field

We find ourselves in a set of circumstances, a world we have been thrown into, with only a small area immediately around us where we experience agency. Pressing upon us are the *present circumstances* – people, objects, environment, needs, projects, and obstacles – that take up our immediate attention. But behind these is what might be called the *background field* of experience, the givens of our world. Within this field, often outside our awareness, are the traces and remnants of history, the wounds and victories resulting from the too eager exchange of power and energy. Our collected traumatic events and their distorted schemas lay represented in the architecture, language, and normative behaviors embedded in daily experience: the names of heroes on streets and buildings, statues of victorious generals, portraits on walls of founders and patriarchs, flags on capitols, and names of territories such as Indiana, the Empire State, Louisiana, Washington, Georgia and the West Indies; entities such as Columbia University, the Tomahawk missile, Indian summer, Exxon stadium, or even the Staples auditorium. Each of these background entities carries with them a history of domination and defeat, victory and victimhood that too often supports the continued supremacy of men over women, light skin over dark skin, large size over small size, West over East, heterosexual over queer preference and

identity, wealth over scarcity, upper class over lower, strong over weak, and on and on.

Just as rain may drop equitably across a region, the turbulent terrain of hill and valley directs the water into narrower paths, causing flooding and destruction, so too does the unequal terrain of the background field direct the streams of power and energy into narrower rivulets where they erupt in overtly destructive ways, such as when this man beats his wife, or that person drives a vehicle into a crowded parade, or that one molests a minor child. Traumatic occurrences, especially interpersonal ones, are the result of the concentrations of illegitimate power from within the background field, though we attribute them too often to the pathology of the specific perpetrator. Each perpetrator is but an example, a spokesperson, for larger-scale historical oppressions. Though laws are made that instruct us otherwise, the message from the wider field is that certain illegitimate and unethical exercises of power are sanctioned.

That being said, often the press of present circumstances demands our attention: in that moment just before our car crashes into the barrier, as he presses his body down upon ours, as she tells me – again – that I was never wanted, as they all laugh as I enter the school building. Poverty, police brutality, government surveillance, abusive authorities of all kinds, our own and others' incompetence, the breaking down of objects and machines, and disappointments of daily life, all of these add to the weight bearing down on us, unequally, at times randomly, and at others, with purpose and intention.

THE ADAPTIVE SHIELD

What emerges as our personhood, our identity, our persona, our role system, name it what you like, is that layer of self that forms in response to the demands and burden of these Circumstances, being a curious mixture of replication and resistance. In that we replicate our circumstances, in order to fit in and become a member of our surround, we form resonances with the histories and schemas and distortions of our collective past, held within the background field, and like the DNA inside us, carry it forward. In our resistance, particularly to the pains caused by the assaults of the present circumstances, we push back and attempt to reject their influence, forming layers of defense and fortification. In the end we find ourselves as if locked in a prison with the enemy.

If we are fortunate enough to be grown inside a reasonably nurturing and protected environment and have been able to avoid very harmful circumstances, our identity/persona/shield may not be so thick or rigid

or fortified, leaving openings between the outside world and our unique, embodied, immutable presence underneath. Trauma and its cohort of abuse, neglect, prejudice, poverty, and maltreatment, however, creates the need for a particularly thick and rigid and fortified *adaptive shield*, layered with both identifications and rejections of the power-carrying vehicles of the Given Circumstances. So much energy and effort are required to sustain this defense, that little room is left for innate presence, so much so that the immutable core may no longer be perceived, leaving trauma victims feeling "hollow" or "absent" or "only a hole," being the essence of disembodiment. The person inevitably applies these adaptations in their new interactions with others, replicating and re-enacting the illegitimate exercises of power held in both the present and background circumstances, carrying them forward into the given circumstances of their own children.

THE AIM OF TRAUMA TREATMENT

Though there are many different methodologies, many trauma treatments aim for a similar outcome: to dislodge the adaptative layer of the Self from the grip of its Present Circumstances (as well as the background field), to create discrepancy between one's personhood and the surrounding storm, and to open up a path into the inner presence of the person's being, which is *unique* (for there has never been, nor will ever be, another one of you), *immutable* (for no matter how one is represented, one is here), and *free* (for no matter how one may be dominated, consciousness remains aware). Both the background field and present circumstances are ever-present and embedded in our language and thought, our bodies and impulses. Extracting their influence and separating them from existence is a monumental task, yet it can be done. For a person in this world to be seen, to be heard, and to be held by another – provides the confidence necessary to face the adversity of experience. I can be frightened. I can be injured. How I am represented can suddenly change, or be wiped out. But my presence remains.

This work, and the work reported in this chapter, are aimed at that reconfiguring of the self in its relation to its given circumstances; it is therefore limited to transformation of one's experience of the world, not direct action to change that world and those circumstances (Landers, 2012; Mayor, 2018). That work – social action – is in the end the most important, for until the Given Circumstances and the background field are cleared of their historical legacies of oppression, inequity, dominance, and division, traumatic events will continue to occur. Psychotherapy is not enough to address these issues. Psychologically informed social and political action is necessary.

PRINCIPLES OF TRAUMA-CENTERED PSYCHOTHERAPY

Trauma-centered developmental transformations are embedded within a trauma-centered psychotherapeutic approach (Johnson & Lubin, 2015; Lubin & Johnson, 2008). This approach rests on a number of basic assumptions. First, distortions in cognition, emotion, behavior, and interpersonal relations occur as a result of the impact of fear or shame. Second, fear schemas are sustained by deep-seated and pervasive avoidance in the victim and in society. Trauma-centered treatment therefore requires overcoming the avoidance in the victim in order to desensitize the fear-based schemas that have taken root. As a result of the avoidance, it is assumed that all trauma narratives are incomplete, meaning that the worst elements of the traumatic experience are revealed last. Finally, it is understood that trauma is a relational experience between the victim and their perpetrator, and thus all trauma schemas serve to stabilize perceived risk within current interpersonal relationships.

Trauma-centered treatment occurs once a trauma-centered frame has been established between the client and the therapist. It is essential that the client understand that the therapist will be asking them to discuss their traumatic experiences, for the purpose of decreasing their fears of current triggers of their memories. Once that frame has been established, the treatment proceeds on the basis of the following principles: immediacy, engagement, and emotionality.

Generally, inquiry into the client's traumatic memories occurs immediately. Delay often intensifies the client's anticipatory anxiety, leading to abandonment of the treatment just before the trauma inquiry begins. By demonstrating to the client a calm and confident approach to the material, the therapist serves as a reliable guide whom the client can trust.

In trauma-centered psychotherapy, the therapist is highly engaged in the inquiry and exploration with the client; they are not blank screens or passive mirrors. They do not wait for the client to reveal material at their own pace. They are not neutral toward the terrible events that have occurred. Therapists actively engage in the revealing of the personal narrative, from what is called an *experience-near perspective*, that is, as if they too were there with the client.

Finally, in trauma-centered psychotherapy, it is understood that the client is extremely upset by the events that happened in their lives, and that they have been suppressing the expression of these emotions for many years. As the trauma inquiry proceeds, clients will become emotionally upset and cry, often deeply and sometimes loudly. The therapist must be able to tolerate these emotional displays and not attempt to curtail them. This expression will not be viewed as re-traumatizing the client (which is instead what happens if the therapist directs or forces a client into a behavior that is similar to the

original trauma), but rather as the natural venting of distress associated with the traumatic event. The therapist is tasked with expanding both the client's and the therapist's capacity to hold them.

Specific methods used in trauma-centered treatment include: 1) conducting a detailed trauma inquiry; 2) pointing out aspects of the client's current behaviors that reflect their protective responses to their traumatic experiences; 3) pointing out differences between the present and past situations that highlight the maladaptive elements of their behaviors; and 4) pointing out how their continued fear of their perpetrator leads them to misperceive and/or misinterpret similar patterns of perpetration in the behavior of people close to them.

A trauma-centered approach is usually conducted in a standard verbal format, in individual and group therapy. Though trauma-centered psychotherapy emphasizes the desensitization process involving imaginal exposure to the memories of the traumatic event, other methods may be used to prepare clients for this work by building strengths and resilience; teaching skills of emotional regulation; or educating them about the nature of trauma and its effects. In all cases, however, the treatment requires that the client's avoidance must be overcome, leading to a temporary increase in their arousal, followed by desensitization to traumatic cues through a process of vividly reviewing their traumatic experience in a safe and nonthreatening environment (Foa & Rothbaum, 1998). The Institute of Medicine reviewed all treatment approaches to PTSD and concluded that trauma-centered (exposure) treatment was the only treatment with strong evidence of efficacy (over medication and cognitive-behavioral approaches) (IOM, 2007).

DEVELOPMENTAL TRANSFORMATIONS (DvT) THEORY

For a more detailed description of DvT theory, see Johnson & Pitre (2020).

Movement

The goal of trauma-centered DvT is to introduce movement into the adaptive system that has formed to protect the self from the oppressive circumstances, suffocating and invading the person's fundamental, unique presence in the world. The protective layer is thick, opaque, and immovable, and obstructs contact between the person and caring people outside. The DvT concept in this regard is called *varielation*, or more colloquially *shaking the tree*. Varielation is purposefully varying one's responses

away from what is immediately expected; that is, playing the character, scene, line, or word slightly differently, slightly off. The process is essentially the same as in jazz, where the players purposefully play off the beat or note to create new resonances and dissonances in the music, which communicate feeling to the other players.

The DvT therapist, who has the advantage of being active in the encounter with the client and therefore becomes a proximal element in their present circumstances, intentionally attempts to disrupt, destabilize, and create openings in the client's defensive position. The main avenue for this is, ironically, acting, which is often defined as "living truthfully under imaginary circumstances" (Meisner, 1987). By constantly changing the imaginary circumstances – that is, by transforming the scenes in DvT into new scenes – the client is presented with an entirely different set of present circumstances to which to adapt. Their highly rigidified defensive stance is forced to shift, ever so slightly, in order to counter a new situation. When the therapist switches from being a dominating person to a submissive one, the client is forced to give up one set of responses for another. The therapist will varielate aspects of their role, the scene, the action, and even small aspects of their character's style, speech, or posture, to intentionally create a twist or skew in the interpersonal interaction, which forces a new adaptation. This includes *transforming the scene to the here and now* where the therapist comments about what is going on, or mentions an element of the client's history (Johnson, 2013).

By increasing the physical proximity, the frequency of scene/role changes, and the variety of perspectives on the same situation, the therapist destabilizes the client's ability to defensively adapt, leading eventually and unpredictably to the emergence of an opening or gap or discrepancy in the client, exposing their vulnerable inner self. In this moment, the client expresses an *affect of surprise,* being either *delight* if pleasurable, *alarm* if a threat, or *awe* if balanced (Johnson, 2017). This expression is usually accompanied by a significant release of body and vocal energy, as these *nonrepeating elements* evoke our existential situation of thrownness.

The Moment

Varielation leads to a temporary loosening of the grip of the client's representational world, which filters incoming stimuli from the environment. This sensitive moment – for which the DvT therapist has been prepared – is only about 3-5 seconds long (Johnson, 2020). In this *present moment*, the client's adaptive shield weakens, just enough to expose the vulnerable self to another. The therapist immediately 1) makes eye or body contact, noting the moment with a verbal or bodily exclamation (e.g., "Whoa!" "Oh" "What's this?"), 2) joins in the movement/action with the client to create mutuality, and

3) most importantly, does no harm, which means to do nothing in particular other than being there, and to positively frame the moment through look and gesture. These actions communicate corrective messages to the traumatized individual, who has protected themselves by saying, 1) "I am all alone." 2) "No one understands me because they were not there when I was hurt." and 3) "No one appreciates how much I was harmed."

The purpose of the adaptive shield (or trauma schema) is to separate oneself from the source of pain, fear, or shame. Certainly, the last thing one wants is to envelope oneself with the perpetrator! Instead, it is best to assume that anyone might become a perpetrator (indeed even the self), so separating oneself from everyone seems like a wise strategy, though with very negative consequences. In contrast, these crucial Moments require contact, proximity, and mutuality between the client and the therapist, not separation. Trauma separates a person's subjectivity (mind) and objectivity (body) from the other's mind and body; trauma separates their own mind from their own body. DvT provides the antidote in lessening these separations, especially in these moments of contact. This process is called *entanglement* (Johnson & Pitre, 2020). As in most intimate moments between two people, where the adaptive shields have been lowered even if temporarily, the boundaries between minds and bodies soften: I find myself gazing at you only to feel suddenly your gaze on me; as we hold each other in our arms, I am uncertain whether the warmth that I feel comes from me or from you, whether I am pressing you or you are pressing me. The fences we celebrate in our relations with strangers or neighbors impede our relationships with our partners and family. Thus in these Moments when the client's defenses have opened and contact is made, the DvT therapist intentionally welcomes the entanglement of subjective and objective states with the client. The key factor however is not the entanglement, but the experience of no harm. The iconic photo of the baby being thrown up in the air by the parent illustrates the same process: the baby is in midair, showing delight, while the arms of the parent lay just below, stretched out in celebration. Here is the thing: at this moment, the baby does not feel alone, for their eyes are locked in with those of the parent. The eyes, the air, the arms, the faces of baby and parent are entwined in a seamless unity; though separated in space (objectively) the baby remains held by the parent through the entire sequence, as safe as if cuddled tight in their arms. This is healthy entanglement.

The experience of being seen, heard and held in the gaze of a caring witness cannot be overestimated in the healing journey of traumatized people. These may be fleeting moments, but they form a foundational base of existential confidence, that turmoil can be weathered. In a healthy childhood we have many of these moments: cuddled in the arms of a parent or caretaker while a storm swirls outside, or being read a fairy tale in which a child is threatened,

or gobbled up, or stolen. Resilience is built not in the absence of threat, but paradoxically being exposed to the threat while in the presence of a protective other, that nurturing adult that neuroscience research has shown can buffer the experiences of toxic stress in children (Shonkoff, 2012). Though the dramatic world of the playspace within a DvT session can be understood as an *imaginal buffer,* in these Moments of opening, it is the real physical and psychic presence of the therapist, in contact with that of the client, that serves the buffering function.

Revealing the Exercise of Power

The adaptive shield that forms our personal identity/persona is constructed of various representations of reality, which include bodily movements, sounds, roles, clothing, and most of all language. These representations reflect those of previous generations, current events, interpersonal communications, and autonomous creative acts of individuals. The consensual world attains a measure of stability through the mutual agreement, or consensus, as to what representations mean or refer to. The actual signs or names of things are quite arbitrary, but their acceptance is not. Behind every name or representation is an exercise of power that limits its variability. For example, there are 26 letters in the English alphabet, and no one is allowed to change them or make up a new letter. Why not? Who set it up in the first place? Your parents generally give you their own surname, and then add on a first name. Try changing your name, especially your last name. Generally, making a change in a name or representation will quickly reveal the source of the authority that established it. Notice the reaction of some to the introduction of the pronoun "they"; or the reaction of alumni to the renaming of a college dorm.

Many components of reality are accepted as fact when actually they are exercises of power that remain unquestioned. In the system of longitude in geography, 0 degrees longitude runs through Greenwich, England. Which country was powerful at the time that system was initiated? The country code system for telephones assigns code 1 to the United States. Which country was ascendant at that time? Ever wonder why the roots of the months September, October, November, and December are 7, 8, 9, and 10, yet they are the 9th through 12th months of the year? That is because two months were added: July and August. On whose authority? Caesars Julius and Augustus.

Reality is a construction made by consensus among a referent group (Foucault, 2008), and therefore reality is an illusive reflection of authority. The sense of solidity that Reality has derives from the injunction against noticing the arbitrary nature of representations, and the acts of power that determine them. Plato's famous allegory of the cave required the observers to be chained and their heads prevented from turning back to see puppets being

manipulated (Plato, 2007). For if people were made aware that these "real things" were made up (constructed), the authority underlying them would be weakened. The problem is that in many cases that source of authority is long gone and no longer operative, and yet we remain in their grip, as if haunted by the spirits of ancestors, or crushed by the deadwood in the forest. In fact, though perhaps not intentionally, by not questioning these structures, we *continue to choose* to remain in their grip. DvT aims to bring that choice into awareness. Society and the individual are constructions perpetually intertwined, each influencing the other in acts of continual co-creation. DvT aims to reveal our active engagement with the systems underlying our given circumstances (Johnson & Sajnani, 2015).

This is never more true than in trauma. Trauma is an extreme enactment of authority and power, in this case illegitimate and harmful power, of one over another. The victim's ability to fend off the perpetrator fails, and their defenses collapse, leaving the imprint of the perpetrator and the manner in which reality is constructed, inside the victim. Too often the victim is not aware that they are carrying a somatic and psychic imprint of the perpetrator, suffering from its omnipresence and constricting influence, which causes illness (usually PTSD).

In DvT, as representations within the Present Circumstances are shaken through varielation, alternatives emerge, which destabilizes the client's assumptions about the world and themselves. At the same moment, the sources of power that established these representations (or schemas) are revealed, and within the play the client and therapist have an opportunity to portray these sources of power, some of which are benign and protective (such as a loving parent or mentor), and some of which are harmful or oppressive (such as those who caused the traumatic event). It is essential that the client be given the opportunity to discern which representations are health-promoting and truthful, and which are oppressive and lies. The play then becomes a mutual and co-created attempt at sorting out the illegitimate figures and dispelling their paralyzing power.

THE ETHICS OF PLAYING THE PERPETRATOR

In trauma-centered DvT it is essential that the client and therapist have a mutual and explicit understanding that aspects of the traumatic event will be replayed, including the figure of the perpetrator. In order to desensitize the client to the triggering influence of their experience, exposure is required, even though it is an imaginal exposure. In order for the perpetrator's power to be revealed and then dismantled, it must be represented in the playspace. The moment this occurs, the therapeutic frame is challenged, for what if instead of being played or symbolized, the original harm is re-enacted (Mayor, 2010)?

The key elements that sustain a safe and therapeutic space in the midst of the revelations of trauma include 1) mutuality, 2) discrepancy, 3) reversibility, and 4) no harm, all characteristics of the DvT playspace. The therapist continuously establishes an explicit, mutual understanding with the client that they are co-creating the scene. The therapist plays their own roles in a way that clearly marks a strong discrepancy between them and reality. By transforming and reversing roles frequently, the therapist communicates to the client that the roles of victim and perpetrator switch back and forth, and that the client is not locked in the role of victim. And finally, the therapist's demeanor at all times is filled with warmth, fun, humor, and care for the client, in a way that clearly communicates that no harm will befall them in the session.

Working with Marginalized Clients

Where existing differences in power, privilege, and history of the actual client and actual therapist exist, special considerations are needed. In DvT, unlike many other forms of psychotherapy (such as client-centered psychotherapy) as well as psychodrama and playback theatre, the play is intended to be discrepant from actual experience; that is, the form of the enactments are not necessarily consistent or well-aligned with the actual characters or events. These discrepancies are essential elements of the varielation and destabilizing of the representations.

However, for clients who hold marginalized identities, there is significantly less discrepancy between the roles in the playspace and in reality. Racism, for example, is held in multiple forms within the background field, but for clients of color this traumatogenic material bleeds into their present circumstances in many everyday interactions where they may experience racial slurs or microaggressions. In the case where the therapist is white, and therefore a member of the perpetrator class, there remains a potential for real harm to be enacted at any point, despite the good intentions of the therapist. Trauma collapses discrepancy, making it very difficult for the traumatized client to experience the joyful distinction between the therapist-as-symbolic perpetrator, and therapist-as-potential-perpetrator (Mayor, 2012). This response cannot itself be dismantled because it is built into the fabric of the background field, and functions as a survival mechanism to help the client move safely through their everyday life.

This situation is similar but not the same as attempting to treat a client whose trauma is ongoing (e.g., in a continuing domestic violent relationship, or sexually abusive relationship), where the primary principle is to first remove the client from the ongoing traumatic situation before beginning treatment. However, when treating a client holding a marginalized identity

within a system of racism or homophobia, there is no way to remove them from this situation.

Therapists who are members of a perpetrator class may respond in one of two unhelpful ways. The therapist may be fully aware of the presence of racism in the background field, but disassociates themselves from awareness of themselves as a member of the perpetrator class. In this case, the therapist will experience themselves playing the role of the racist as liberating and relieving, for they will feel "See, I'm obviously not like that!" They may mistakenly assume the client feels that way as well, when instead the client may feel that the scene is a harmful reenactment of what happens to them every day.

Alternatively, the therapist may overidentify as a member of the perpetrator class, responding with guilt and fear that they will replay the harm. Here the therapist is likely to avoid playing the perpetrator or even bringing up the issue at all. The client may experience the therapist's guilt, avoidance, and tension as unsafe, and feel a need to withdraw or be on guard. Trust will wither.

One might conclude that trauma treatment cannot be conducted when the therapist is a member of the perpetrator class and the client a member of an oppressed class. But the authors feel that it is critical for these clients to have access to the freedom and joy that can result from the creation of space between their adaptive shields and their fully embodied selves. Experiencing these moments of liberation is an essential part of their healing and capacity to resist ongoing systems of oppression. The potential benefits of DvT outweigh the challenges. However, there is no alternative but for the therapist to engage with these messy, troubling, pernicious issues without disassociating or avoiding them. The therapist must be capable of bringing identity, positionality, and the unique duality of the therapist's perpetrator roles into awareness within the playspace, to accept their own vulnerability and demonstrating a willingness to learn.

When facing the horrors and fears of the client's experiences, as well as the background field of historical and systemic oppression from which they arise, the therapist must constantly work to achieve awareness of their own location within systems of power and privilege, as well as victimization. It is best practice for the therapist to explicitly acknowledge to the client not only their visible identifications (e.g., race, ethnicity, gender) but also their invisible identifications (e.g., religion, ability status, sexual orientation) in the initial phases of treatment, especially if these identifications overlap with relevant aspects of the client's traumatic experience. This depth of revelation is difficult for many therapists, as it is in opposition to the traditional opacity of the therapist's role, as well as the therapist's desire for privacy. In DvT, due to the unique level of engagement in the play by the therapist, such

transparency is less at odds with this recommendation for best practice. Indeed, the therapist's one-sided opacity and privacy, in contrast to the demand for transparency from the client, *are* the building blocks of the therapist's privilege and power. Though DvT exists within the same social contract as other therapies, DvT's efficacy is not reliant on actually having that power or privilege (Johnson, 2013).

The TC-DvT therapist's training therefore *must* include a deep exploratory process of identifying and playing with their own lived identities in the presence of experienced practitioners and players who hold various marginalized identities before embarking on the challenging task of embodying the perpetrator-victim dynamics with clients. Understanding the embedded nature of the traumatogenic material held in the background field but expressed in the client's present circumstances – for real and potentially through the therapist – is key. The therapist therefore must give the client open access to their own dual standing as symbolic and real perpetrator.

Suggested Approaches of the Therapist

Discrepancy – the difference between the client's perpetrators and the perpetrator portrayed in the play – is an important component for creating a safe playspace for the marginalized client. The therapist should explicitly discuss the systemic and historical dimensions of oppression that impact the client, and clearly position themselves within that history, especially if they are a member of the perpetrator class. Any perceived discomfort in discussing these issues will only tighten the grip of the client's adaptive shield and intensify the lack of trust in the relationship. It should be expected that the client may not wish to talk about or play with those systemic traumas burdening them, as they cannot expect the therapist to release them from white supremacy, homophobia, ageism, etc. Because these identity-based assaults are not merely momentary hurts but attacks upon one's fundamental existence as a Being, the client may need time to approach them. Many clients feel exhausted from having tried to work on these issues with potential allies within the perpetrator class, who too often assume that marginalized people want to talk about it. So often after these conversations, white people (for example) feel exhilarated and proud of themselves, while people of color are left to return to the same situation, having helped white people feel better about themselves.

When the therapist is *not* a member of a perpetrator class vis-à-vis the client, the TC-DvT process usually proceeds smoothly, as the traumatic situation does not match the background field. Discrepancy is strong and helps to create a mutual working space. The client still projects their trauma schema onto the therapist, but it is easier for the therapist to point out the

discrepancy. When the client senses and enjoys that too and realizes that they are no longer in danger, the desensitization process succeeds. When the therapist is a member of the perpetrator class, however, there remains a potential for an actual microaggressive act, and/or the client might perceive an action as microaggressive more easily. In either case, the relationship will suffer. Members of a dominant majority hold power over those who are not, regardless of the state of interaction, and regardless of their intention or desire.

The confrontation of these issues, if not openly played with, too often leads to a feeling of discomfort in the therapist, who responds by subtly withdrawing or avoiding the issues, directing the play away from these subjects, or alternatively, attempts to compensate by proving to themselves and the client that they are not the perpetrator by anxiously intensifying the portrayals. In either case, the client will feel the potential for new harms growing exponentially.

The other technique that can be useful is for the therapist to address systemic harms in incremental fashion, taking one small aspect at a time, and allow it to be repeated, named, varielated, and digested, before moving on to other aspects. This might include a "look" from someone or the use of a short but demeaning phrase of a stereotypical nature. It may then be a reaction in a job interview, or in being denied a raise or promotion. The advantage of moving incrementally is that not only does it give the client space and time to approach the topic, but it also allows the therapist time to question their assumptions about how the client will react. The therapist should avoid being drawn into the grip of the real story: using divergent varielations through sounds and images will help both to maintain an experience of discrepancy and to allow unintegrated elements to be shaken loose. These steps will encourage trust to grow between the player and the client.

In summary, the fundamental challenge is how to handle Difference, especially when difference has brought significant harm. Difference, in the end, is what characterizes life and it cannot be avoided: there is always a power differential between roles. To avoid dealing with the pain of difference will only lead to an impasse: where one can only portray who one is. A Catholic can only play a Catholic; a white person only a white person; a Black therapist can only treat Black clients; in the end, I can only treat someone more or less like me. Theatre is based on the capacity of human beings to portray roles they are not; and thus, trauma conflicts with the bases of theatre (Johnson, 2010). The aim of TC-DvT, therefore, is to overcome the effects of trauma and invite the client into the theatrical playspace, where they can play with difference. One should begin with the small differences, leading up to the foundational differences, continuously countering the avoidance that rides shotgun to power. Unlike real roles, imaginal roles can be reversed, transformed, played with, giving the client experience in questioning and experimenting with new behaviors.

Trauma-centered DvT has the capacity to aid the client in dismantling the bonds of illegitimate power that stem from traumatic events in their life; indeed, this is the project of psychotherapy. However, merely naming positionality or playing with identity politics will not be sufficient to dismantle systemic power and privilege. The historical, systemic forces held within the background field, such as racism and gender bias, will require collective effort of a different kind. By helping clients become aware of and learn to question the representations that constrain them, to identify and reveal the sources of power that control them, DvT can help prepare people for the hard work of social justice writ large, as citizens of a world transformed, with forests cleared, welcoming new growth.

METHODOLOGY

Preparation

There is no one procedure for conducting DvT with traumatized clients. Each client presents a very unique situation. However, in all trauma-centered DvT, the therapist will have conducted a thorough trauma history with the client prior to beginning DvT. It is essential that the client knows that the therapist knows the basic details of their traumatic story. It is essential that the therapist clearly establish the trauma-centered frame, which means that an explicit statement is made that the treatment will be directly addressing the client's traumatic experience, and that the client is expected to reveal their thoughts and feelings about their traumatic memories as they emerge in the session. This statement is made even if the client is a young child, using age-appropriate language. Previous work with Developmental Transformations with traumatized populations includes Dintino and Johnson (1996), James and Johnson (1996, 1997), James, Forrester, and Kim (2005), Landers (2002), and Reynolds (2011).

Entering the Forest: Disrupting the Adaptive Shield

Initial sessions of DvT help to reduce the client's avoidant defenses, usually evident in the play as identification with the aggressor. Play allows a victim to reverse roles and identify with their aggressor (perpetrator), and show mastery over their victimization by dominating their playmate. The classic example is the child who comes home from the dentist and in play becomes the dentist and tortures their willing parent. However, this strategy is actually a form of avoidance of the uneasy feelings of their victimhood, and leads to desires to

master or dominate others, not a preferable outcome (Johnson, 1998). The following DvT process helps transform this avoidant stand.

Stage 1: Therapist Initiates a Challenge

The therapist begins the session by presenting, in play, a challenge or demand on the client. The choice of challenge is based on the therapist's understanding of this particular client but is usually not a direct reference to their trauma. Examples include becoming a monster and coming after the client; shutting the door loudly and chuckling in a sinister manner; telling the client "No, you cannot do it!"; miming loading a gun or unsheathing a sword; as a spouse or parent, demanding an explanation; or just moving closer.

Stage 2: Aggressor-Aggressor Struggle

The presentation of this demand will almost always evoke the client's adaptive shield, who then resists or battles the therapist in their respective roles. With many clients, adults as well as children, this will be classic games of tag, sword or gun fights, screaming matches, spousal arguments, silent treatments, or hide and seek, without any direct reference to the client's traumatic material. The interactions are fun, stereotyped, and exuberant.

Stage 3: Perpetrator-Victim Interaction

Once the conflict has begun, the therapist will notice that their guns do not work, bullets do not pierce, arguments are rebuffed, while those weapons of the client are always effective. Here, the therapist shifts and allows the attacks of the client to work: each time (and every time) the client asserts themselves, the therapist plays out being killed, hurt, insulted, or fooled. Then up again and another attack on the client, followed by defeat. In traumatic play, the client will be impelled to repeat this victory over and over again, often calling out to the therapist, at the moment they hit the floor, "again!" Many child therapists naturally tire of dying after the third or fourth time, and show less interest in being the victim, with less physical engagement, attempting to redirect the child to another activity. In contrast, the DvT therapist intensifies their victimization: dying in slow motion, in Academy Award style, writhing, gagging, taking one's time as the poison takes effect, indulging in the shame of being insulted or humiliated, pleading dependently and pitifully for forgiveness from their spouse….importantly, just past the point that the client shouts "again!" whereby the therapist counters with "but I'm not done (dying, crying) yet, wait a moment!" Then the therapist jumps up again and attacks as before, and the whole process repeats.

Stage 4: The Rounding

The client almost always enjoys this process immensely, and it will be repeated well beyond the number of times any normal person could tolerate. However, as each time the therapist intensifies and indulges in a more lavish, crazy, cool, wonderful victimization, at some point, called the *rounding*, the client realizes that it will be much more fun to be the victim than to continue to be the perpetrator, and then suggests, "my turn!" Now magically the therapist's guns work, now the bullets penetrate, now the insults have effect, as the client, mimicking the therapist, writhes and cries out while performing their death or defeat.

Stage 5: Victim-Perpetrator Interaction

The therapist and client repeat the scene and its variations with the therapist in the perpetrator role, and the client in the victim role. Here the client's defense of identifying with the perpetrator has collapsed, and they are now playing the vulnerable role, consistent with their role in their trauma. The therapist is now aligned with the role of their perpetrator. Quite some time may pass as the therapist and client repeat these scenes. The therapist's job now is to intensify the perpetration by slowing down the interaction, coming up with small variations of evil intent, more harmful methods, more elaborate preparations, building with greater anticipation the torturous attack. This task may be difficult for some therapists, who feel identified with being the "good enough mother" or wise "guide," and find torturing their clients sadistically – even in play – somehow uncouth. But it is an essential part of the desensitization process.

Stage 6: The Release

At some point in this play, the client will have so immersed themselves in their victimization, so vividly played out their injury, and have repeated this so many times, they will feel absolutely no reason to hold on any longer, have no reason to maintain their adaptive shield anymore, and suddenly, they will relax . . . usually they lay there, completely still, completely at the mercy of the therapist/perpetrator. No struggle left. (This moment is called the *release.*) The play has now dissipated the repetitions, and the client stands now on the edge of the next moment, open, no script . . . vulnerable.

Stage 7: Victim – Comforter Interaction

Once the release has occurred, the therapist shifts roles and becomes a comforting figure, usually a nurse, doctor, therapist, parent, friend, who

comes over to the nearly inert client and tends to them, speaking kindly, cleaning their wounds, singing softly to them, telling them a story, and often, picking them up like a baby and holding them or rocking them. The therapist expresses their sadness, their love, for the client's character; communicates that now all danger has passed, all damage has been done, even all is well. There is often silence. The client is almost always silent. The trauma has happened. The victim has been found. The victim is being cared for. There is nothing more to say. Their eyes, initially closed, open to the gaze of the therapist. This is the Moment of contact with the inner presence of the client.

When working with young children under the age of 12, the caretaker (parent or foster parent) is usually asked to join the session. Initially, they watch the play from the witnessing circle in the corner of the room. However, when the play reaches the Victim-Comforter stage, instead of the therapist transforming into the Comforting role, the caretaker is recruited into the play to comfort the child. In such cases, the therapist remains in the Perpetrator role, and may continue to threaten the child, who now is protected by their caretaker, who fights off the perpetrator. This intervention is very effective in bonding the child to their caretaker.

Very Vulnerable Children

In a number of cases with very young children (under 5) or children who have been traumatized very recently, or very severely, the defense of identification with the perpetrator has not yet been crystallized. Thus if the therapist were to begin the session in a challenging role, the child might become frightened, consistent with their vulnerable role in the traumatic situation. In such cases, the child has not organized their adaptive shield yet, and thus the work described above of reducing their avoidance is unnecessary. In these cases, the therapist will begin the process by joining the client in their vulnerable role, hiding from or fighting off the monster together; or may move directly into a protective and/or comforting role. As the child feels more comfortable being in the presence of the symbolic perpetrator, supported by the therapist, the work of deepening the links to the trauma and the process of varielation can commence.

Theoretical discussion about this process can be found in Johnson (1998) and Pitre, Sajnani, and Johnson (2014). Another detailed case example of this process can be found in Pitre (2015).

Case Example

(All names and critical events have been altered to preserve confidentiality.)

Rajah is a 9-year old Hispanic-Caucasian boy now living in a foster home with two parents and three foster siblings. From birth to age 4 he was exposed

to the domestic violence of his biological father toward his biological mother, in a home that was poorly resourced, with sometimes little to eat, and few toys to play with. A younger sibling died of SIDS at the age of two when he was 3 years old. His parents were both involved with drugs and neither worked. At the age of 4, his father was incarcerated for attempted murder and Rajah has never seen him since then. His mother then moved from place to place, sometimes staying at strangers' houses. She may have prostituted herself for lodging. When Rajah was six, he was sexually molested by one of his mother's paramours ("Mr. Sam") over a three-month period, usually when his mother had left the apartment. The man forced Rajah to give him oral sex, usually after watching pornographic movies together. On two occasions, the man attempted to have anal sex with Rajah, but Rajah resisted, and when he began crying, the man desisted. Shortly after this, Rajah signaled a teacher at school that he was afraid to go home, and she called in a referral. Rajah reported these details to the investigators and the man was arrested and eventually jailed. Rajah was removed from his mother's care and placed in foster care at the age of 7. One year later his parents' rights were terminated and he was moved to the current pre-adoptive foster home.

The following is from Rajah's first DvT session. The therapist (DJ) had spent the first session with Rajah and his foster parents, reviewing the trauma history and discussing Rajah's recent behaviors in the home.

Rajah bolts into the carpeted room, which is empty other than a pile of pillows in one corner, and a small closet on the other side. The therapist closes the door and gives a ghoulish laugh, "Whooahh!" whereupon Rajah cries out in delight, "Get away from me!" [Presenting a challenge]. The therapist shouts, "I'm coming to get you!" and runs toward Rajah, who runs away from him. They run around the room until Rajah stops, turns around, and puts up his fists: "Stop or I'll punch you!" The therapist replies, "Oh, yeah? With fists? Look what I have, knives!" (He pulls out mimed knives.) Rajah, pumping himself up more, responds by pulling out very big knives or swords. Therapist cries, "Oh, oh, swords is it? Now it's time for you to…" Rajah interrupts him, "Die!" They then fiercely battle each other with their swords. Rajah is quite playful and able to maintain the pretend nature of the battle until the therapist makes a particularly loud and threatening cry. Rajah looks anxious, drops his mimed sword, and kicks the therapist for real in the leg. Therapist replies, "Oh, Rajah, you kicked me for real . . . remember to pretend to hurt me . . . because then you can do *really bad* things…like take your sword and stab me in the chest!" [Strengthening the playspace and supporting mutuality.] Rajah mimes taking his sword and stabs the therapist in the chest, who with ultimate ham acting falls to his knees, writhing on the floor in agony, and dies. "Again!" says Rajah, and the therapist stands up and they resume their battle. Each time Rajah successfully stabs or hits the

therapist, he goes down, dying a torturous death. Several times Rajah shouts out, "Again!" before the therapist has a chance to completely die, whereupon the therapist reminds him that he is not dead yet. Rajah looks disappointed, but waits. Then Rajah pushes the therapist into the small closet and slams the door. The therapist cries out with fear, "Let me out of here, help, help, I'm dying, I can't breathe, I'm hungry!" [Varielation on theme: locked in > dying > can't breathe > hungry] When the therapist says he is hungry, Rajah immediately opens the door of the closet, "Come out! I have some food for you." The therapist eats the food, and quickly grabs food from Rajah, "I want it all, you can't have any." Rajah hesitates a moment and then again pushes the therapist into the closet as punishment. The therapist cries out, "I'm hungry, I have nothing to eat, I'm going to starve!" and Rajah responds, "Shut up! We have nothing to eat." [First reference to real stressor.] The therapist then gags and gurgles, smacking his lips, and plays out dying of starvation. Rajah opens the closet and looks in. "Get up!" The therapist gets up and comes out into the room, "Where's my food?" Rajah shouts, "We don't have any. I'm hungry too!" [Rounding] Therapist replies, "Oh, right, you're hungry too! But you were the one who stole my crackers! Give them back to me!" Rajah smiles, and runs away, "You can't have them!" The therapist runs after him, grabs Rajah, takes the crackers out of his hand, and pushes him into the closet. Rajah shouts, "Help, help, I'm hungry . . . where's the food . . . I'm dying!" He then mimics the therapist's previous portrayal of gags and gurgles. The therapist opens the closet door and pulls him out and offers him food so he won't die. Rajah immediately grabs the food from the therapist and rams it into his mouth. The therapist becomes angry and tells Rajah he cannot eat everything in the house, but Rajah doesn't stop. The therapist again pushes Rajah into the closet, where the dying scene is repeated. This time Rajah writhes and cries and gurgles, fully engaged in dying from starvation. He becomes quiet. [Release] The therapist speaks out loud, "Hmm, I wonder why Rajah is so quiet? That's funny. What a relief! . . . Hmm, Rajah? (no answer) . . . Rajah, are you okay? (no answer) . . . hmmmm." Therapist opens the door and Rajah is laying on the ground, dead, body completely relaxed. Therapist: "Oh my God, Rajah is dead . . . he didn't get enough to eat! Oh, my, what did they do to him? I can't believe this!" He pulls Rajah out of the closet and lays him on the ground. He then pulls his head up and rests it on his lap, supporting his body with his arm. [Proximity. No harm.] "Is he still alive?" Yes, I see something. I must give him some water, some milk (Rajah's eyelids flutter), yes some milk, warm milk (Rajah shifts slightly). The therapist mimes putting a glass of warm milk to Rajah's lips. Rajah barely moves his lips. The therapist says, "He is nearly gone. He can't drink from a cup. I'll need a bottle so he can suck." The therapist then mimes placing a baby bottle of warm milk to Rajah's lips. Rajah opens his mouth and pretends to suck on

the bottle. He shifts his body to couch himself even more comfortably in the therapist's lap. After a minute or two, Rajah opens his eyes and looks directly into the therapist's eyes. There is a long, comfortable silence. The therapist smiles warmly at Rajah. [The Moment] Eventually, the therapist says, "Hi." Rajah smiles, then opens his mouth again, and the therapist feeds him. After another brief silence, the therapist says, "I'm sorry you had to go through all that…but I know you are going to be all right." [Bearing witness. No harm.] With that, the therapist places Rajah down on the carpet and moves to the witnessing circle in the corner of the room and sits quietly. After about five minutes, Rajah "wakes" and sits up. The therapist tells him it is the end of the session and time to put on their shoes, which Rajah does, and they exit the room.

Discussion

This session illustrates the basic process of loosening the adaptive layer, particularly the defense of identification with the aggressor. Notice that the therapist does not bring up any of the trauma material directly, even though it is clearly present in the themes of shouting too loudly (domestic violence), hunger (not enough food), and sucking on a bottle (oral sex by mother's paramour). The main focus of this session was to aid Rajah's transformation from mastery to vulnerability, which was clearly achieved. The rounding occurred when Rajah suddenly expressed being hungry, and the release occurred while he was in the closet the second time, after he died from starvation. The therapist provided a range of responses and when Rajah reacted, even minutely, to the mention of any one of them, the therapist followed up by emphasizing that image, as in the mention of "I'm hungry" and "milk." The therapist kept his focus of attention on Rajah's responses to the therapist's play behaviors, as a guide to forming his next intervention. As Rajah opened his eyes, being simultaneously himself in the arms of a caring therapist and the baby who has yet to be harmed by all that will happen in his life, entangled in time and space and role with the therapist, the Moment of contact occurred in a condition of no harm.

Shaking the Tree: Opening Links to the Traumatic Events

Once the client's avoidant defenses are loosened up, the client becomes more available to work directly on their traumatic memories through the play. The therapist uses the many opportunities available to them to shape the action, characters, and dramatic elements increasingly close to those of the traumatic events. At times, the dramatic play may consist of direct references to, or replays of, the traumatic events. However, in DvT, there

remain elements of other dramatic scenes, so that each moment becomes a double entendre, in which client and therapist know that they are referring to an aspect of the client's trauma narrative, as well as the surface dramatic scene. This intrinsic discrepancy between the real and the imagined provides the client with room to move and transform the various traumatic images. This is important because trauma schemas tend to rigidify and lock in expression, leading to repetition rather than development.

The general principle employed by the therapist is to weave in increasingly direct references to the client's trauma, until the client recognizes the connection. The doubled scene is then played until the client shows greater ease in managing the material, whereupon the therapist proceeds to introduce other, ever more distressing, aspects of the traumatic material. As this process unfolds, it is not uncommon for the client to make these connections also, and to introduce new elements of their traumatic experience not yet described to the therapist. Throughout the process, the therapist uses varielation to destabilize images, ideas, and actions until moments of surprise occur.

The client is encouraged in DvT to follow their impulses, to have fun, and to wander wherever their associations take them. Ironically, on this seemingly random path, the client's play inevitably intersects with reminders of their traumatic experiences, and at each of these crossroads, the therapist notes the overlap. The therapist may note it verbally, by transforming to the here-and-now and telling the client what has been observed, though more often the therapist will note the connection through embodied variations in their character or actions. The therapist always carefully observes the client for signs that they also have registered the link between current play and past trauma. (See Pitre, Sajnani, and Johnson, 2014 for a detailed case that illustrates this process.)

Case Example

This is the fourth session with Rajah. His foster father was present, sitting in the witnessing circle in the corner of the room. He was simply asked to watch the play.

Rajah bolts into the room as usual and he and the therapist play "I'm coming to get you." By this time, both are comfortable with strong physical contact, and Rajah jumps on the therapist, who falls down, Rajah on top of him. The therapist rolls over to get away from Rajah, and then Rajah runs after him, as the therapist transforms into a frightened child being chased by a big, bad man. "Help me, help me!" the therapist cries. Suddenly Rajah enters the closet and closes the door on himself. The therapist then moves around the room, frightened that "He" will jump out of nowhere and grab him. Suddenly, Rajah bursts out of the closet with a growl, and the therapist

runs to the pillows to hide, but Rajah leaps on him and mimes stabbing him with some weapon, probably a sword. The therapist dies majestically. "Again!" shouts Rajah, and he hides in the closet. The therapist moves around the room, expressing fear that the "bad man" will jump out of nowhere and get him. Rajah again bursts out, only this time clearly with a large sword which he brandishes. The therapist falls backward into the pillows and puts up his hands, "Don't kill me, sir, don't kill me, I'll do anything you want!" Rajah shouts, "Shut up!" The therapist closes his mouth, firmly. [Bringing attention to an aspect of Rajah's trauma.] Rajah cries, "You are my slave . . . you will do as I say . . . or else!" The therapist says nothing. Rajah: "Speak! Say yes!" The therapist refuses and shakes his head no. Rajah moves toward him, holding his sword outstretched, aiming toward the therapist's head, "Open your mouth!" The therapist portrays fear, and again shakes his head no. Rajah becomes very energized, and pushes the mimed sword up against the therapist's mouth, as if to open it with the sword. "Open!" Therapist: "I'm scared . . . maybe like you were scared." "Shut up, slave!" Therapist: "Is that what Mr. Sam said to you?" [Direct reference] Rajah nods and then shouts, "Open I say!' Therapist: "Wow, that's bad, scary! . . . Hey, I don't want to open my mouth for you! You're a bad man!" Rajah lunges towards the therapist, who pushes the sword out of the way and grabs Rajah. They then wrestle for a few moments and the therapist pretends to grab the sword from out of Rajah's hands, who lets him, and the positions reverse, with the therapist now standing with the sword to Rajah's head. [Rounding] Rajah is pinned against the pillows, mouth closed. Therapist: "Open your mouth . . . Speak! . . . Now!" Rajah exuberantly shakes his head no. Therapist: "Listen, Mr. Sam was much bigger than you, so he could force you to do this for him. It must have been scary! But here, we are just playing, so *anything* can happen! . . . Now open I say!" [Strengthening the playspace, preparing for direct reenactment.] Rajah gleams, and refuses, mouth as tight as can be. Therapist: (angry) "I am Mr. Sam and I am going to force you to open your mouth for me. I have this big sword and you are a tiny kid! Here I come!" [Using narration to clarify what the therapist will be doing.] He lunges at Rajah, who deftly pushes the sword to the side and jumps out into the room. He grabs the sword, and now the positions reverse again. [Reversibility demonstrating increased flexibility in the adaptive shield.] Rajah, "Open I say!" Therapist: "Oh no. Mr. Sam, I don't want to, I'm scared, I've never seen a sword like that before!" Rajah: "Now, or I will kill you!" Therapist slowly opens his mouth, showing fear. Rajah slowly mimes pushing the sword into the therapist's mouth, who gags and dies. Rajah throws the sword to the side, and the therapist wakes up, and pretends to spit, "Oh, that was terrible, that tasted terrible!" [Direct reference] They look at each other, smiling, and then slow motion, the therapist picks up the sword and chases after Rajah, who then tumbles into the pillows, positions

now reversed again. Therapist: "Open your mouth for me you little worm, you slave!" Rajah shakes his head and says, "I'm scared!" Therapist: "If you don't do it I will kill you. If you tell anyone I will kill you!" Rajah slowly opens his mouth and the therapist pushes the sword into it, Rajah gags and spits and then dies. [Release] The therapist throws the sword to the side, "We're done with that for now!" and comes to sit at Rajah's side. Rajah wakes up and spits. Therapist: "How was that?" Rajah: "That tasted terrible!" Therapist: "I can only imagine. Mr. Sam was a bad man, and he shouldn't have forced you to do that. Here, have a glass of water to wash that out! (He hands Rajah a mimed glass, and he drinks from it and then offers it to the therapist, who takes a drink. They look at each other in silence for several heavy seconds [The Moment]. He then bolts up and runs over to his foster father and leaps into his lap.)

Discussion

Here the emerging links between the play and the traumatic events, in this case the oral sex, rise to the surface as Rajah attempts to have the therapist open his mouth. The therapist makes an initial link by using the term "bad man" and then says, "I'll do anything you want." Rajah's energy remains high, and he mentions "You are my slave" and then "Open your mouth." The therapist then mentions the perpetrator's actual name, and Rajah's energy does not diminish. By reversing positions of power several times and playing out different versions of the scene, Rajah and the therapist allow a gradual process of uncovering the horror of the event. At first, the capacity to resist is played out, with the victim being able to push the sword out of the way. However, once this had been played, the therapist models being victimized by allowing Rajah's sword to enter his mouth, then dying in an intense, interesting way, and spitting out the semen Rajah likely had to endure. Rajah was then able to follow suit and play out a pretend version of his victimization, demonstrating a remarkable desensitization of his fear over this terrible event. Again, once this occurs, a moment of intense contact between them became possible. All of this occurred in only the fourth session, in the presence of Rajah's adoptive father.

Clearing the Forest: Dismantling the Remnants of Illegitimate Power

Once the client has been desensitized to the content of their traumatic experience, and they have understood how the traumatic event has altered their life by constructing an unwieldy, suffocating shield, they can benefit from a deeper awareness of the illegitimacy of the exercise of power that harmed

them. This process requires the play to slow down, so that the nuances of the maltreatment can be identified, mutually, as both client and therapist stand to the side of the horror – in a psychological and sometimes physical embrace – bearing witness to it from a place of safety. The DvT therapist accomplishes this largely through more sophisticated forms of varielation. The therapist utilizes *emergent varielation* by noticing behaviors not entirely in line with the stated scene, which symbolize or contain meanings rising up within the client that are yet to be fully expressed. Using these clues to alter the therapist's own behavior gently transforms the scene toward deeper layers of imagery. The therapist uses *divergent varielation* by introducing challenging, discrepant, or contradictory elements into the play which disrupt the assumptions held by the circumstances of the current scene, offering the client the opportunity to attempt to adapt to, defend against, accept or transform the intruding image. When the client is psychologically open enough, the adaptive shield shifts and the rigid bond between past circumstances and the present self is shaken, and a strong outburst of energy occurs from the client. It is at this moment that the traumatic schemas that had been limiting their freedom are loosened, and the client is able to recognize what happened to them, and more importantly to see who exerted their power over them, as if from a distance.

Case Example

This is from the sixteenth session with Rajah. They are alone.

They enter the room and the therapist plops down on the carpet and lays face down. Rajah walks around the room silently and then sits down on the back of the therapist. They sit in silence for a minute or so.

Therapist:	Are you going to wake me?
Rajah:	No.
	(Silence.)
Therapist:	But aren't you worried about me? I am your mother you know.
Rajah:	You're not my mother.
Therapist:	I thought I was pretending to be your mother, you know, asleep from taking too many drugs.
Rajah:	(Sits up a little and then sits down hard on therapist's back.)
Therapist:	Ummff! What was that for?
Rajah:	Wake up Mommy.
Therapist:	(Groans as if half asleep.) I'm tired.
Rajah:	(Sits up and then down again.)
Therapist:	I can't carry you sweetheart.
Rajah:	(Rolls off therapist's back onto floor with a plop.)

Therapist: Do that again. (Rajah gets up on therapist's back.) I can't carry you!

Rajah: (Rolls off with a plop.)

Therapist: Oh my god, did she drop you? [Picking up from the rolling off his back with a plop after the therapist says he can't carry him.]

Rajah: Yup. A lot of times.

Therapist: When you were really small?

Rajah: Yup.

Therapist: That's bad! Wait, let me see how this worked, get up. (Rajah and therapist get up, therapist picks Rajah up in his arms.) So she was carrying you and then all of a sudden, you dropped? (He drops Rajah into the pillows, Rajah giggles.)

Rajah: Again!

Therapist: All right, let's see, (picks him up), oh hum, I'm taking my baby to the next room and, oops! I drop him (Rajah is dropped), uh, because . . . I'm weak?

Rajah: Not watching.

Therapist: Not watching?

Rajah: Not watching (places hand on the side of his head).

[They are picking apart the event in more and more detail. The issue is: what was in the mind of his mother at the time?]

Therapist: I don't quite have it right, let me try again (picks him up in his arms), let's see, if I was your mom and not watching and carrying you like this, let's see, I guess it would be most likely that, going through a doorway perhaps, I'd, I'd hit your head! (He swings Rajah perilously close to a wall, Rajah tenses up.) Yes, that's it, I hit your head! [Picking up from Rajah putting his hand on his head, being an emergent varielation.]

Rajah: A lot.

Therapist: Wow, cool! So let's try this out some more. (Therapist moves around the room, pretending to have Rajah's head hit the walls or pretend doorways, each time making a lot of noise such as "smack," "phooff," "pow," "ouch," "sorry honey." [The therapist is varielating options to see if any resonate with Rajah.] Rajah is initially quite tense but gradually relaxes and joins in on the sound effects. Rajah reacts with more energy at the sound, "phoof." Therapist then attempts to take Rajah into the small closet, opening the door and squeezing in, purposefully having difficulty, gently brushing his head up against the real doors. Concerned, Rajah grabs hold of the therapist).

Therapist: (Stops, and repeats this action slowly, gently pushing Rajah's head up against the door frame. Rajah again tenses, almost startled, and grabs onto the therapist strongly.)

Therapist: Oh, I see! Were you afraid she would throw you against the . . . wall? (Rajah grabs even harder.)

Rajah: No, my daddy. [Rajah reveals another perpetrator.]

Therapist: (Grabbing Rajah harder) I see, yes, so I am going to become your daddy and *maybe* throw you against the wall! [The therapist communicates a mixed signal by both grabbing harder, and saying he is going to throw Rajah. This is a divergent varielation.]

Rajah: (Grabs very hard.)

Therapist: Don't let go! I am going to throw you . . . maybe . . . away (grabbing Rajah very hard, but lifting him slightly so his abdomen is turned inward toward the therapist's chest.) [This begins a series of emergent and divergent varielations around posture.]

Rajah: (Screams half playfully, half anxiously.)

Therapist: (Moves him back slightly away from therapist's chest.)

Rajah: (Tenses his body.)

Therapist: (Lifts him again, turning him more toward the therapist's chest.)

Rajah: (Responds by molding his body around the therapist's torso, and reaches up to place his hand around the therapist's neck.)

Therapist: (Moves around the room. Once or twice he releases his grip on Rajah ever so slightly, the first time by moving his arms outward, to which Rajah responds by grabbing harder; and the second time by softening the grip of his fingertips, to which Rajah responds by relaxing a bit more. Rajah has now moved to grabbing the therapist around the neck, and legs wrapped around his torso. Both are holding each other very tightly.)

Therapist: Boy, am I going to throw this child away . . . phoof! (makes a move as if to throw him, but does not let go). [Strengthening discrepancy] Ready, on three I am going to throw you against that brick wall! One, two, three!

Both: Phoof! (Therapist jerks his body but both parties hold on very tightly.)

Therapist: Oh, that was bad. Did you see that?

Rajah: Yes, that was very bad! [They are now bearing witness to the event from a psychological distance, together.]

Therapist: I am going to do it again, only worse! (He shifts his hold slightly towards an even more caring, loving embrace, with less of a grabbing feel.)

Rajah: Do it worse! [Rajah gives the therapist the green light to proceed.]
[Mutuality]

Therapist I'll be your mother who doesn't watch your head, and your daddy who gets so angry he might throw you against the wall, at the same time, that's how bad it will be! [Therapist now mixes two roles together, in addition to mixing holding on and throwing away.]

Rajah: (Places his cheek against the therapist's cheek.) [Rajah is no longer in the traumatic event; he is in the arms of a caring and protective adult.] [No harm.]

Therapist: It's going to be bad.

Rajah: Real bad…. Maybe.

Therapist: (Smiles to himself) . . . that's right, maybe . . . (Standing perfectly still in the middle of the room and not moving, Rajah's cheek against the therapist's.) Silence. [The Moment]

Therapist: Here goes!

Both: Phoof! (Neither moves)
Silence [Another Moment]

Therapist: That's how it went. A little boy, scared, not cared for properly.

Rajah: A long time ago. [They are narrating.]

Therapist: A long, long time ago. (Rajah and the therapist slowly release their hold on one another and Rajah slides down to the ground, puts his shoes on, and together they leave the room.)

Discussion

By this point in the treatment, Rajah was very comfortable with the process, and had worked on many of his memories through the play with the therapist. Unlike the beginning, his play was much more spontaneous, open-ended, and relaxed, even with the direct references to his traumatic experiences. In this session, the therapist sensed minor fluctuations in Rajah's responses to the various play elements, then reflected them back to Rajah, sometimes repeating them over several times with additional variations. They had a kind of meditative conversation about Rajah's victimization at the hands of his parents, examining in finer detail both what they did as well as what might have been their motivations. As this process gained clarity, Rajah allowed himself to experience new feelings of being cared for, and held, by a safe adult figure. It is this discrepant pairing of the memories of his parents

with the present interaction with the therapist that helps Rajah differentiate the past from the present. Together they observe what happened to Rajah, and in so doing reveal and label the illegitimate and distorted behavior of his parents.

The therapist uses emergent varielation first when he sensed Rajah rolling off his back after he said, "I will carry you," suggesting Rajah had been dropped. He next notices Rajah putting his hand on his head as a possible signal of having been hit in the head, and then allows time to explore being hit in the head several times before Rajah reveals he was afraid that his father might throw him against the wall. The therapist then varielates around holding/throwing, followed by varying Rajah posturally from turning him outward versus being embraced and held abdomen to abdomen. Additional ironies emerge as they play with the word "maybe" and "phoof" and "this is going to be bad," simultaneously referring to bad outcomes while interacting increasingly lovingly. Creating a tolerable ambiguity around whether the therapist is or is not a perpetrator provides the conditions for Rajah to take his time to come to the comforting distinction that the therapist is a safe and caring adult, while the therapist's dramatic character is a mean and abusive parent. This is the concrete manifestation of separating oneself from one's given circumstances. The aim here was for Rajah to realize that imagining or thinking about his traumatic experiences can happen at the same time that he is safe in the present. This becomes eminently clear when Rajah says, "Do it worse!" which indicates a decrease in fear, followed by the poignant placing of his cheek against the therapist's, and then playfully noting the double entendre of "Real bad . . . maybe," which in acknowledging that things may not turn out all that bad, brings a smile to the therapist. Here the simultaneity of divergent feelings does not disrupt the intimacy of the developing relationship, indeed, perhaps this only deepens their bond. They then say "phoof" together, a magic word reflective of their unique relationship, and hold a silence . . . for much of the struggle for Rajah has ended . . . as he himself notes a second later when he says that it all was "a long time ago."

The treatment went well, and Rajah rapidly acclimated to his adoptive home and flourished there as well as in school.

EVIDENCE

Trauma-centered DvT has been practiced for many years by many different practitioners. Our clinical impression is that a large proportion of both child and adult clients enjoy doing this work, and are significantly helped in the process. Surveys we have conducted with current and previous clients have

shown over 95% rates of client satisfaction. In one study of TC-DvT with 37 severely abused children placed in foster homes through the state youth protection agency, the number of disruptions in placement (e.g., need for hospitalization, residential care, removal from foster home) decreased significantly. In the year prior to treatment, the State of Connecticut paid for 5,254 days of inpatient care for these children. In the year following treatment, the number dropped to only 1,517 days, and in the second year, only 333 days. The estimated cost savings to the State from fewer hospitalization and residential care days was $3.7 million in the first year.

In another study with elementary school children who were provided trauma-centered DvT sessions during the school day, rapid and significant improvements in behavior and symptoms were noted (Johnson, Sajnani, Mayor, & Davis, 2020). Office referrals and incidents of fighting or aggression were reduced by 83%. Students were asked to rate their level of stress before and after each session, and dramatic drops in stress levels occurred, averaging a 90% reduction in one session. In the over 3,000 sessions conducted during one year, in only 14 sessions (or less than 1%) did the student report any increase in distress after their session. Our team has now conducted over 20,000 trauma-centered DvT sessions in the public schools. As a result, we are confident that trauma-centered DvT is an effective and well-tolerated treatment, and that concerns that DvT will lead to unmanaged emotional expression are unfounded.

CONCLUSION

Trauma is an act of severe harm that overwhelms a person's capacity to function, which takes place within a background field of historical and systemic oppression, preserved in the nuances of language, behavior, tradition, architecture, and naming. The person constructs an adaptive shield against these assaults on their integrity which simultaneously mirrors and rebels against these noxious circumstances, both present and past. The shield itself constricts and even suffocates the immutable presence of the person, leaving at times a hollow shell or empty cavern at the heart of being.

Trauma-centered DvT is a form of trauma-centered psychotherapy that follows the principles of immediacy, engagement, and emotionality in helping the client identify and then dismantle the sources of illegitimate power that beset them. This dismantling is achieved by introducing movement and discrepancy (through varielation) into the representations (portrayals) of roles, objects, and images, urging shifts in the adaptive shield that create openings through which the therapist can make contact with the personhood

of the client. As the sources of power that lie behind each piece of reality are revealed and then questioned, the client has the opportunity to discern for themselves what to retain, and what to discard.

Throughout the process, the therapist must demonstrate skill and courage to self-examine their own identifications, assumptions, biases, power and privilege, and to be transparent to the client about their own social group memberships. In the end, it is the warmth, humor, playfulness, and sense of forgiveness for the incompleteness and brokenness of the human adventure that allows the therapist and client to walk together on the path through this forest that we call life.

AUTHOR CONTACT INFORMATION
davidreadjohnson@gmail.com
rebeccalynndavis.msw@gmail.com

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