CHAPTER 4

TRAUMA-CENTERED DEVELOPMENTAL TRANSFORMATIONS

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PRINCIPLES OF TRAUMA-CENTERED PSYCHOTHERAPY

Trauma-centered developmental transformations is embedded within a trauma-centered psychotherapeutic approach (Johnson & Lubin, in press; Lubin & Johnson, 2009). This approach rests on a number of basic assumptions. First, that distortions in cognition, emotion, behavior, and interpersonal relations occur as a result of the impact of fear or horror. Second, that fear schemas are not altered because of deep-seated and pervasive avoidance in the victim and in society. Trauma-centered treatment therefore requires overcoming the avoidance of 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 specifically 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 will 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.

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. Often other methods are 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. Often specific brief desensitization techniques are used as part of the treatment, such as prolonged exposure (Foa & Rothbaum, 1998), Eye Movement Desensitization and Reprocessing (Shapiro, 1995), or the Counting Method (Ochberg, 1996). 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. Recently, the Institute of Medicine reviewed all treatment approaches to PTSD and concluded that trauma-centered (exposure) treatment was, at this time, the only treatment with strong evidence of efficacy (over medication and cognitive-behavioral approaches) (IOM, 2007).

DEVELOPMENTAL TRANSFORMATIONS (DvT) THEORY

Before detailing a trauma-centered DvT, I will review briefly current DvT theory and method (Johnson, 2009). DvT in itself is not trauma-centered, but rather emerges

from an existential perspective. The fundamental assumption in DvT is that Being, or experience, is nonrepeating; that is, each moment is entirely unique, has never been before. We respond to this bewildering possibility by creating repeating forms (images, ideas, concepts, words, labels, identities), through which we attempt to stabilize our experience. The collection of these repeating forms becomes our representation of reality. DvT posits that our representation of reality is never equivalent to reality, because of the presence of a nonrepeating element in every moment. We call this the *prime discrepancy*.

The prime discrepancy can be further elucidated by saying that our representation of experience is always incomplete, inexact, and inaccurate, to some degree. Our map of the world is not the world. In this we follow Moreno's insight: that spontaneity drives living. It also creates anxiety, a deeply felt existential anxiety over the gap between understanding and being. Our response to this fear is to stabilize experience by reducing ambiguity and increasing order. DvT posits that it is this impulse, based on an intolerance of ambiguity and incompleteness, that leads to many maladies in the individual, family, and society. This negative outcome occurs when we place a demand on the environment (that is, others) to alter their behaviors in ways that maintain our stability. We demand that others act a certain way, in an ordered way, so that we feel safe.

DvT suggests another path, which is not to attempt to lower the instability of the environment (if that is ever really possible), but to lower our own fear of instability. In a way, this is consistent with the goal of desensitization, which also attempts to lower people's fears. Thus, the goal is to help our clients feel more comfortable in unstable situations, such as intimate relationships. The approach is not dissimilar to teaching children to ride bicycles, or toddlers to walk, or teenagers to date; that is, we do not

promise total safety, rather we focus on building self-confidence and capacity to remain balanced in unbalanced situations (what is often called being *centered*).

DvT works in this way at several levels: at the level of difference, we work to help our clients not insist on unity and order, but embrace *diversity* and along with it the humility of not being whole. At the level of desire or preference, we help clients not demand that their needs be fulfilled, or deny that they have needs, but replace these sentiments with greater capacities for desire, coupled with the *integrity* that comes from its restraint. At the level of territory, we challenge our clients not to require clarity or purity, or the separation of conflicting aspects, but to embrace a greater sense of *mutuality* and permeability in relationships with others. These traits require a tolerance of unpreferred elements of experience. Finally, at the level of history, we help clients avoid static power relations with others, achieving instead greater *mobility* and sharing in the exercise of power. This allows for greater participation and engagement by everyone in negotiating developing relationships.

DvT attempts to help clients reach a state of readiness to encounter the world, with all its surprises and demands. We encourage clients to let go of their insistence that the world, and others in proximity to them, accommodate their needs. More profoundly, we encourage clients not to fear the incursions and demands of others to accommodate to *their* needs. Without the flexibility, resilience, and tolerance in the boundary region between myself and others, I am left only with the choice of conflict or isolation, fight or flight. Indeed, this is what we see in traumatized youth, who simply cannot tolerate the demands of proximate caregivers, who "cannot take 'no.'" Of course, neither does DvT encourage clients to simply give in to others; rather to engage in negotiation,

process….relationship. The important element is reducing fear of the inevitable: living with a degree of ambiguity, mixture, incompleteness, compromise.

DvT aims to increase the client's self-confidence and capacity in managing life's instabilities, and instead of living life according to the straight lines on the map or grid we describe life by, living life in the intermediate and mixed spaces of the forests, oceans, and fields that actually comprise our world. Thus, DvT takes us into the woods, into the intermediate spaces that Winnicott has written so compellingly about, and that creative arts therapists have relied on so often: transitional spaces that have greater ambiguity, deeper nuances and textures, more fluidity. Out of these intermediate spaces arise creativity, magic, dreams, intimacy, possibility, and indeed, the arts.

Clearly, if in addition to a basic existential anxiety we add anxiety caused by traumatic events, we will predict that a person's needs for clarity and rigid separation will be greater, along with a more intense distaste for intermediate spaces such as intimate relationships. Indeed, we find this! Thus in PTSD the symptom of a flashback is a piece of the past that is confused with the present, missing the intermediate space called memory (a piece of the past arising in the present without losing the distinction between past and present). Similarly, trauma forces us into having no choice but emotional flooding or emotional numbing, instead of an intermediate territory of emotional feeling. Or living in a world sharply separated into Me and You, worried constantly of impending intrusions of You into Me, in comparison to a world that includes Us and the possibility of belonging (the feeling of being with another without losing the distinction between self and other). Or shifting between feeling like one cannot live another second in this body, to complete dissociation where one has exited the body, versus that mixed state of being

we call embodiment, where mind and body interlace and consciousness infuses substance..

Thus, even though DvT is not at base a trauma-centered approach, its aims are consistent with those of trauma treatment: to aid the client in desensitizing themselves to fear-based schemas that are distorting their lives.

Developmental Transformations Method

Playspace

DvT takes place within one of these intermediate spaces, what we call the playspace, which is a mutual agreement among the participants that what goes on is play. Play itself is an unstable concept: to put things into play means to allow them to vary, to change, to be altered, looked at from different perspectives, all things DvT intends to help the client achieve. The playspace by definition is always becoming, and as such is incomplete, inexact, untrue. The playspace is also an intermediate, interpersonal space, meaning that everything that is played with is mutual, no longer owned by one party or the other. Our goal is to begin in whatever playspace the client has, however small, and gradually expand it to include more aspects of their experience.. In trauma treatment, that means ultimately to place their own traumatic experiences within the conditions of the play: to allow them to transform, to be jointly owned, and to be broken into various pieces and recombined in new ways.

Process

The process through which the client and therapist move is called developmental transformations, and consists of *noticing* new behaviors in the other, allowing a *feeling* about that to arise within, *animating* that feeling by associating it with images, ideas, or

forms, and then *expressing* these forms outward in one's own behavior (Johnson, 1999). The other person, in turn, will notice something new in this behavior, and then go through the process of feeling, animating, and expressing themselves. This process is embodied, relational, aesthetic, and developmental. Clients will have difficulties with one or more of these capacities: noticing, feeling, animating, and expressing; and the therapist will attempt to help them learn how to master these skills.

Varielation

Clients who are beset by a great deal of existential anxiety or traumatic fear will greatly restrict their own freedom of movement, and will concretely and rigidly repeat themselves over and over, for anxiety traps the person in the repeating forms, and causes them to avoid the nonrepeating spontaneous elements. The DvT therapist utilizes a technique called *varielation* to gradually open up the degree to which expressions by the client can become spontaneous, fluid, and dynamic. 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. Varielation also implies playing a different variation each time an action is repeated. As the therapy progresses, the client joins in with this process of varielation, and the sense of movement, openness, and mixing things up greatly increases.

Therapist

Due to the relational nature of the playspace, the developmental transformational process, and varielation, effective treatment in DvT can only take place if the therapist is

fully engaged in the play with the client(s). Interventions are subtle and fleeting, occurring in the rapid back-and-forth responses between the players in the improvisational flow. DvT therapists do not intervene by setting up structures or conditions within which the client can then explore; the DvT therapist intervenes within the dramatic action, in the moment, and then notices the response of the client, and then instantly intervenes again. The DvT therapist must have a great deal of experience to achieve the capacities to notice, feel, and respond so rapidly. They must be very familiar with dramatic improvisation to be able to respond with confidence and sensitivity. They must be very comfortable with their own being, especially their limitations, peculiarities, habitual patterns, and conflicts.

Left to their own devices, clients will tend to revert back to their repeating forms of thought and action. Therapy requires clients to be challenged; protective strategies have to be re-examined and re-organized. Having the therapist be so much part of the play allows for much greater latitude and specificity in his/her interventions. DvT in many ways is like learning karate, or tennis or jazz, by playing with a master teacher. These teachers also interact with their clients by varying the degree of demand they place on them, and then noticing whether the client is able to handle it. In these situations, the client does not expect the teacher to only follow them, only support them, only mirror them. Students know, and expect, that these teachers will purposefully push them, challenge them, even demonstrate how to defeat them, all in the service of learning. DvT is no different, except that in DvT what is being learned is not jazz or karate, but remaining centered within an intimate relationship (which is certainly as challenging, as risky!)

Summary

So DvT intends to help clients lower their fears of life's instabilities. In doing so, DvT needs to interfere with their avoidance of unstable situations. This is accomplished by having the therapist, as a caring professional, engage them in the dynamic, spontaneous, creative world of the playspace, and then progressively presenting them with increasingly challenging demands. Client and therapist work as a team, together, to produce wider and deeper intermediate spaces between the client and the other; not where there is only safety and stillness, but where there is *life*, with all its imbalances, risks, and pleasures.

For the traumatized person, engaging in DvT is to embark on a journey of dealing with the impact of their traumatic experiences. As in other desensitization methods, the client has much to gain by no longer avoiding what they fear. What will help them in this journey is an experienced guide who accompanies them at every step, the deep fun that comes with dramatic improvisation, and the physical outlet that the exuberant movement of DvT provides.

TRAUMA-CENTERED DEVELOPMENTAL TRANSFORMATIONS

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 come up 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 & Johnson; 1996; 1997; James, Forrester, and Kim (2005); Landers (2002); and Reynolds (2011).

Reducing Avoidance

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.

Stage 2: Aggressor – Aggressor Struggle

The presentation of this demand will almost always evoke the "warrior" in the client, 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, exuberant.

Stage 3: Perpetrator –Victim Interaction

Once the conflict has begun, the therapist will notice that his/her 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, 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….critically, 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 it. 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 thus suggests, "my turn!" Now 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

Now 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 he/she is 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, have repeated this so many times, they will feel absolutely no reason to hold on any longer, have no reason to maintain their defenses any more, and suddenly, they will relax….usually they lay there, completely dead, 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….ready.

Stage 7: Victim – Comforter Interaction

Once the release has occurred, the therapist now 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 past, 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.

When working with young children under the age of 12, we usually suggest that the caretaker (parent or foster parent) 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 avoidant defenses 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 (2012). Another detailed case example of this process can be found in Renee Pitre's chapter in this book (Chapter 10).

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.

Reducing Avoidance

The following is from Rajah's first DvT session. The therapist (D. J.) 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 room, which is empty, carpeted, with 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!" 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!” 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 very 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!” 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.” 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!" 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, grabbing Rajah, taking 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. 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. "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. 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." 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 our shoes, which Rajah does, and they exit the room.

DISCUSSION. This session illustrates the basic process of loosening 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 wanted to feed the therapist, and the release occurred while he was in the closet the second time, dying of 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."

Deepening the Links to the Trauma

Once the client's avoidant defenses are loosened up, they become 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, usually in DvT, there remain elements of other dramatic scenes, and 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, but not quite. 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 tends 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.

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 actually telling the client what is

observed, but usually 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.

I will provide a brief example below, but a more detailed case that illustrates this process is Pitre, Sajnani, and Johnson (in press).

Case Example

This is from 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 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 backwards 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. 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?" 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. 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!" 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!" 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. 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!” 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 you 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 jabs the sword into it, Rajah gags and spits and then dies. 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. 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 saying “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, Rajah and the therapist allow a gradual process of uncovering of 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.

Deepening the Process of Varielation

At the same time the DvT therapist is deepening the play by highlighting connections to the client's trauma, they are also using the method of varielation with increasing intensity. At the beginning, the karate teacher stays relatively within the bounds of predictable behavior so that the novice student can master basic moves. But as the training proceeds, the karate teacher will move in less predictable ways, purposefully attempting to put the student off balance in order for them to learn how to stay centered and alert under more challenging circumstances. The DvT therapist does the same, by increasing the degree of variation off what is expected in the dramatic play: by shifting elements in his/her character or actions, by varying the timing of responses, or use of space; by disrupting subtly the grammar of speech or the lilt in the accent; by transforming to roles that appear to mix aspects of the client's and therapist's previous roles. There are approximately 26 such interventions used by DvT therapists, organized according to their degree of varielation (Johnson, 2012).

The therapist begins by noticing natural variations in the client's portrayals. No one can repeat an action exactly, each repetition will include a new, nonrepeating element, which is usually ignored in standard interaction. However, by noticing the element that is not "in line" with the presenting character or scene, and then mirroring it within their own portrayal, the therapist will effectively introduce a variation. This is called *emergent varielation.*

The next level is *divergent varielation*. Here, the therapist introduces a variation and then immediately notices whether the client shows awareness of it or reacts energetically to its introduction. If the intervention is too discrepant, traumatized clients will either ignore it and strengthen their previous portrayal by repeating it; or they may react very strongly to it, demanding the therapist undo it. In both cases the therapist will decide how to respond: to retreat temporarily back into the expected repetition, or to develop a playful struggle around the varielation. However, if the intervention is just discrepant enough, a significant increase in energy occurs in the client, followed by accepting the varielation and playing enthusiastically with the transformed images. It is at this moment that the traumatic schemas that had been limiting their freedom are loosened, and the client feels a strong and enjoyable release, leading almost always to something *new* emerging between the client and therapist. It is this acceptance of the new, the nonrepeating, spontaneous act of becoming, that demonstrates their newfound lack of fear of the unknown, and an overcoming of the impact of their traumatic events.

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.

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 his rolling off his back after the therapist says he will 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).

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.]

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." 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.

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.]

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 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, 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). 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!

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.]

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, as well as mixing holding on and throwing away.]

Rajah (Places his cheek against the therapist's cheek.)

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.) Here goes!

Both Phoof! (neither moves)

Silence

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

Rajah A long time ago.

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. The therapist attempted to sense minor fluctuations in Rajah's responses to the various play elements, then reflect them back to Rajah, sometimes repeating them over several times with additional variation. The therapist was also quite forthright in asking Rajah to confirm information about his experiences as they were playing. They had by this point a kind of meditative conversation about Rajah's past, and a highly intimate personal interaction in which Rajah was exploring new feelings of being cared for, and held, by a safe adult figure. It is partly this discrepant pairing of his memories of his parents with the present interaction with the therapist that helps Rajah differentiate the past from the present.

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 would throw him against the wall. The therapist then varielates around holding/throwing, followed by varying Rajah posturally from laying 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,"

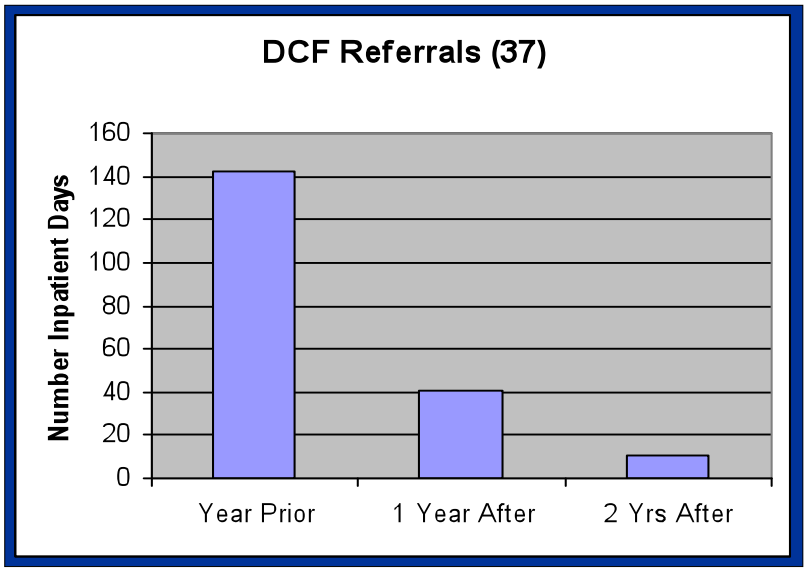
simultaneously referring to bad outcomes while interacting increasingly lovingly. Creating a tolerable ambiguity around whether the therapist is or is not a perpetrator provides the conditions for Rajah to take his time to come to the comforting distinction (that the therapist is a safe and caring adult, while the therapist's *dramatic character* is a mean and abusive parent). The aim here is for Rajah to realize that imagining or thinking about his traumatic experiences can happen at the same time 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 that is what intimacy is. They then say together "phoof," a magic word now 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."

EVIDENCE

Trauma-centered DvT has been practiced for many years by many different practitioners. Our clinical impression is that a large proportion of clients enjoy doing this work, and are significantly helped in the process. Surveys we have conducted with current and previous clients have always shown over 95% rates of client satisfaction. At our Trauma Center, the average drop-out rate within the first month of our clients who are in verbal-only trauma treatment is around 15%; for those clients in DvT trauma treatment is only 4%.

More recently we have focused our work on traumatized children and youth. In one study of severely abused children placed in foster homes through the state youth protection agency, using trauma-centered DvT, we found that there was a very significant drop in disruptions in placement (e.g., need for hospitalization, residential care, removal from foster home) as a result of our treatment. Figure One shows these results.

Figure One



In the year prior to treatment, the State of Connecticut paid for 5,254 days of inpatient care. In the year following treatment, only 1,517 days, and in the second year, only 333 days. We estimated the cost savings to the State from these 37 clients from not needing hospitalization and residential care was $3.7 million in the first year.

In another study with elementary school children who were provided trauma centered DvT sessions during their school day, rapid and significant improvements in behavior and symptoms were noted. (A more detailed description of this program is provided in Chapter 9.) Using an observer who sat in the classroom and rated students on various measures before they received their session and then afterwards, statistically

significant improvements in mood, conformity to social norms, attention, and restlessness were found. Office referrals, and incidents of fighting or aggression were also dramatically reduced, by 83%. Students were also asked to rate their level of stress before and after each session, and dramatic drops in stress levels occurred, averaging 90% reduction. 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. We have now conducted over 12,000 trauma-centered DvT sessions in the public schools. As a result, we are fairly 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-Centered Developmental Transformations follows the principles of a trauma-centered model of psychotherapy in an effort to desensitize clients to their traumatic memories. Though DvT itself is not trauma-centered, several key concepts within DvT overlap with the goals of a trauma-centered approach. These include the goal of lowering clients' fears of the instability of experience, as well as interfering with the rigid boundaries and either/or thinking characteristic of traumatized clients, and expanding their capacity to tolerate intermediate spaces and greater ambiguity in relationships.

The methods of DvT (playspace, developmental transformations cycle, varielation, and therapist as playobject) target key areas of vulnerability in the traumatized client, and can be utilized to relatively quickly decrease symptoms, improve the capacity for intimate relationships, and differentiate past and present. Data from our client's self-

reports as well as objective measurements by observers confirm our perception that trauma-centered DvT is an effective and specific treatment for trauma.

Due to the therapist's participation in the dramatic action with the client, and the immediacy and complexity within which interventions are made, DvT requires a substantial amount of experience, self-confidence, and sophistication in improvisational acting, as well as a minimum of defensiveness regarding one's own deficits, limitations, and biases. With these skills, DvT therapists are well-prepared to work with their traumatized clients toward recovery.

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