

BIRTH STORY:  
A HEURITIC INQUIRY COMBINING NARRADRAMA AND SOMATIC EXPERIENCING  
TO PROCESS TRAUMATIC CHILDBIRTH

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## ABSTRACT

### BIRTH STORY: A HEURISTIC INQUIRY COMBINING NARRADRAMA AND SOMATIC EXPERIENCING TO PROCESS TRAUMATIC CHILDBIRTH

LINDSAY REOCH

This heuristic research project explored the use of Narradrama and Somatic Experiencing (SE) in working with traumatic childbirth. At the time of submission, there hadn't been any publications related to traumatic childbirth in the field of drama therapy. The literature review included the topics of trauma, traumatic childbirth, drama therapy and traumatic childbirth, birth stories, Somatic Experiencing and trauma, the felt sense, Somatic Experiencing and traumatic childbirth, and corrective experiences. The author shared the restorying and renegotiation of her own birth story narrative. She reported on her experiences attending a SE workshop and SE sessions geared toward birth. The author then reported on her experience with a Narradrama process around her traumatic childbirth, using Dunne's (2006) Eight Step frame. She detailed outcomes from nine Narradrama sessions and included photographs of the artwork created. Beneficial aspects from the sessions for this author were reported as: The use of externalization, the use of different art modalities, the option to work non-verbally, and the open choice of interventions. Challenges with the Eight Step frame was reported as the lack of a trauma informed approach with respect to past, present, and future. The SE components of the research reported to be helpful for the author centered around the felt sense in relationship to support, imagination, and corrective experiences. The major challenge reported around the SE process was its focus on the felt sense. The paper looked at theoretical overlap between Narradrama and/or drama therapy and SE, and highlighted theoretical differences that were apparent from this research. The author stated that this research has brought her professional competency and personal gains. She reported that her trauma symptoms were resolved as a result of the work done in the research. The paper suggested that the interventions and theories it outlines could be further researched with a larger population to see if they are helpful for others. In particular, the author was interested in the further development of an externalized, arts-based T-Model as a timeline drawing of birth stories.

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I would like to thank my mama friends, with whom I have shared and listened to birth stories, and who have encouraged me to persevere with this work. Your honesty and insights were invaluable. Finally, to all the mamas out there who have experienced traumatic childbirth:

May you find a way to restory and renegotiate your experience, and live with peace and ease in your role as mother. You are not alone.

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## **Chapter 1. Introduction**

This paper reports on the use of Narradrama and Somatic Experiencing processes during an inquiry into my experience of traumatic childbirth, and how this inquiry has affected my clinical learning as a drama therapist. Traumatic childbirth is an under researched area in the field of drama therapy and the Creative Arts Therapies. Using my own experience of processing traumatic childbirth serves a dual function in terms of my own clinical understanding and personal gains. In completing this research, I have highlighted ways in which Narradrama and Somatic Experiencing were helpful and could potentially be combined when working with mothers who have experienced traumatic childbirth. I present common themes that are particular to women who have survived traumatic childbirth, which may not be well known in the field of Creative Arts Therapy and drama therapy. My hope is for readers to gain insight into the topic of traumatic childbirth, as well as knowledge around interventions that may be helpful in the field of drama therapy.

First, the paper defines the specific interventions and terms used, and discusses assumptions, biases, and limitations of the research. Second, the research question is identified and the methodology of the heuristic process is outlined. Third, a literature review is shared on the major themes at play in this research. Fourth, I share my personal birth story narrative. Fifth, a summary of the data and heuristic process is presented. Sixth is a discussion of learning outcomes and suggested future research. Finally, seventh, a conclusion summarizes an overview of the paper's outcomes.

### **Definitions**

#### Heuristic Research

This research paper follows Moustaka's (1990) heuristic approach, including core concepts and processes, as well as his six-phase model (see Methodology section). Moustaka defines the heuristic process as follows:

...[A] process of internal search through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis. The self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge. Heuristic processes incorporate creative self-processes and self-discoveries. (p. 9)

## Narradrama

Narradrama is a form of drama therapy that often works in a group setting, but is also used in individual sessions. In *The Narrative Therapist and the Arts*, Dr. Pamela Dunne (2006), creator of Narradrama, writes:

Narradrama combines the concepts of narrative therapy with drama therapy and the creative arts. It borrows freely from psychology, sociology, anthropology, experimental theatre, music, dance, and poetry. All of the forms of expression may, at various times, be helpful to the participant in expanding their awareness of their internalized narratives and/or in considering alternatives to a problem as well as possible solutions. (p. 23)

For this research, I used Dunne's (2006) "Eight Step Process" (p. 39) as a guide for my therapeutic process.

## Somatic Experiencing (SE)

SE is an integrative form of therapy that focuses on the nervous system's response to perceived traumatic events (Levine, 2010). It is designed to provide the right conditions for the body to restore itself to proper functioning through developing awareness of the physical body, and allowing for physical and emotional release of built-up tensions that have resulted from trauma (Levine, 2010). It is an exposure model that works in a titrated way, with psychodynamic, humanistic, and biological roots (FHE, 2007). Two of SE's core concepts are pendulation and coupling dynamics. These concepts will be further discussed in the Literature Review.

## Traumatic Childbirth/Birth Trauma

The terms "traumatic childbirth" and "birth trauma" may be used interchangeably in this paper, and refer to the perception of the mother's experience.

## Birth Story

A birth story is the synthesis of the birth narrative, usually from the perspective of the mother.

## **Biases, Assumptions, and Limitations**

I am a Somatic Experiencing Practitioner (SEP), a yoga teacher, and a MA candidate in Creative Arts therapies; I have an inherent bias that there is value in these modalities and their methodologies. I have a large personal and professional investment in showing how the body and the arts can facilitate therapeutic change, as well as a strong desire for my own therapeutic

process to be effective through these modalities. As a survivor of traumatic childbirth, I am likely to point out its prevalence and aspects of traumatic childbirth that are similar to those I experienced. Due to the nature of the heuristic process, this work is inherently personal. While I strive for honesty within myself, it is not possible to be conscious of all of the factors at play in my experience. All of my conclusions are drawn from my own experience and cannot be generalized. However, I do believe that readers may be able to find some new understanding in reading about my personal journey and heuristic research.

My hope in doing this research was to understand more about how Narradrama can be applied to working through birth stories, as well as hold a better sense of what coupling dynamics and pendulation patterns may be at play. I was also hoping to understand more about my experience of birth, and resolve my trauma symptoms. Ultimately, I wanted to become comfortable working with women who have experienced traumatic childbirth, and I had hoped my findings might lead me towards potentially devising a method for working with traumatic childbirth in the future, that includes both drama therapy and SE.

## Chapter 2. Methodology

### Research Question

My research question was: How can a heuristic inquiry into combining Narradrama from drama therapy with coupling dynamics and pendulation from Somatic Experiencing help in exploring the challenges in my own process of resolving traumatic childbirth and add to my clinical understanding around this issue?

However, due to the nature of my heuristic process, the question that I ended up truly answering was, in the end: What is the experience of combining aspects of Narradrama and Somatic Experiencing, focusing on traumatic childbirth, and how can that add to my clinical understanding around this issue?

### Concepts and Processes in Heuristic Research

There are several concepts and processes that Moustakas (1990) lists that are key to heuristic inquiry, which guide a researcher on the use of the self. This research employed each of these processes and concepts throughout. They include “self-dialogue” (p. 16), “tacit knowing” (p. 20), “intuition” (p. 23), “indwelling” (p. 24), “focusing” (p. 25), and “the internal frame of reference” (p. 26). “Self-dialogue” (p. 16) refers to ways in which a researcher converses with themselves in order to explore different perspectives of an experience or issue. “Tacit knowing” (p. 20), is described as a “knowing of the essence” (p. 21). Moustakas refers to Polanyi’s 1964 work which breaks down tacit knowledge into “subsidiary and focal” (p. 21), with elements related to skill, facial recognition, proprioception, and speculation. Moustakas emphasizes the importance of tacit knowledge in heuristics, again quoting Polanyi (1969) who writes “all knowledge is either tacit or rooted in tacit knowledge” (p. 144). Moustakas describes the core concept of “intuition” (p. 23) as “the bridge between... explicit [knowledge] and the tacit [knowledge]”. Of intuition, Moustakas writes, “intuition guides the researcher in discovery of patterns and meanings that will lead to enhanced meanings, and deepened and extended knowledge” (p. 24). The process of “indwelling” (p. 24) is “conscious and deliberate” (p. 24), and “involves a willingness to gaze with unwavering attention and concentration into some facet of human experience in order to understand its constituent qualities and its wholeness” (p. 24). “Focusing” (p. 25) is described by Moustakas as “an inner attention” (p. 25), and refers to Gendlin’s 1978 seminal book, *Focusing* (re-released in 2007). Moustakas outlines:

[T]he steps of focusing as used in heuristic research include the clearing of an inward space to enable one to tap into thoughts and feelings that are essential to clarifying a question; getting a handle on the question; elucidating its constituents; making contact with core themes; and explicating the themes. (p. 25)

It is interesting to note that Moustakas omits Gendlin's (2007) concept of the "felt sense" (p. 11), which is a critical tool to both this research and SE. "The internal frame of reference" (p. 26) is the final core concept referred to by Moustakas as essential to heuristics. He refers to the internal frame of reference as the "medium or base" (p. 26) of knowledge for the heuristic process. He writes "[o]nly the experiencing persons—by looking at their own experiences in perceptions, thoughts, feelings, and sense—can validly provide portrayals of the experience" (p. 26). Here, he does acknowledge the senses.

### **The Six Phases of Heuristic Research**

The six phases of the heuristic process are: "the initial engagement, immersion into the topic and question, incubation, illumination, explication, and culmination of the research in a creative synthesis" (Moustakas, 1990, p. 27). Moustakas (1990) writes, "[d]uring the initial engagement, the investigator reaches inward for tacit awareness and knowledge, permits intuition to run freely, and elucidates the context from which the question takes form and significance" (p. 27). In this research process, the initial engagement phase was the planning of the methodology, which took place in January-February 2016. After coming up with the research question, I spent some time thinking about how to best answer it and created a timeline for that process. I had already done a literature review on drama therapy, SE, and trauma, and decided that researching traumatic birth from an academic standpoint before engaging in my own therapeutic process could influence the therapy outcome, so I decided to delay that part of the literature review.

The immersion phase is when "the researcher lives the question in waking, sleeping, and even dream states" (Moustakas, 1990, p. 28). The immersion phase of this research began in early June 2016, when I attended the Musings from the Womb workshop in Berkeley, California. This workshop looked at birth through the lens of Somatic Experiencing. There, I explored nervous system health in relationship to birth, with a focus on support, corrective experiences, and the power of imagination. I also did individual sessions with Somatic Experiencing Practitioners regarding my birth processes as a child and as a mother. In a second phase of

immersion, from August through October, I actively sought out a Creative Arts Therapist to work through the Narradrama process. In early November, we began weekly sessions, working with my experience of traumatic childbirth through a modification of the Narradrama Eight Step process, meanwhile staying open to integrating SE techniques and theory (which mainly focused on the SE T-Model). Our work concluded in early January 2017.

The incubation phase is when “the researcher retreats from the intense, concentrated focus on the question” (Moustakas, 1990, p. 28). During this time, “the inner workings of the tacit dimension and intuition... continue to clarify and extend understanding on levels outside the immediate awareness” (p. 29). There were several incubation phases in this research, which made it a titrated process (meaning, to alternate between elements – a key concept in SE theory). The longest moments of incubation were February-June 2016, June-August 2016, January-May 2017, with other mini breaks in intensity here and there. Due to life circumstances and realizations from the therapy process, I decided to postpone completion of the research from May 2017 to September 2017.

The illumination phase is when “the researcher is open and receptive to tacit knowledge and intuition” (Moustakas, 1990, p. 29). Illumination “opens the door to a new awareness, a modification of an old understanding, a synthesis of fragmented knowledge, or an altogether new discovery of something that has been present for some time yet beyond immediate awareness” (p. 29). The illumination phase(s) in this research seemed to have occurred both during immersion, after each incubation period, and also while writing this paper. There was a pattern in which I would have insights about my personal journey during the immersion experiences, and insights about the methodologies and therapeutic interventions after a time of incubation. For example, during the SE workshop in Berkeley, I gained a lot of insight about my birth experience, and after some incubation time, I made connections about my childbirth and SE techniques that I hadn’t seen before – which ultimately shifted my focus on which elements of SE I wanted to pay attention to for this research. Similarly, during the Narradrama process, I had insights about my own recovery from my experience of traumatic birth, while after an incubation phase, I gained understandings around what parts of the Narradrama process were and weren’t helpful.

Moustakas (1990) writes, “[t]he purpose of the explication phase is to fully examine what has awakened in consciousness, in order to understand its various layers of meaning” (p. 31). He continues,

“[p]erhaps the most significant concepts in explicating a phenomenon are focusing and indwelling, where concentrated attention is given to creating an inward space and discovering nuances, textures, and constituents of the phenomenon which may then be more fully elucidated through indwelling” (p. 31).

The explication phase in this research has occurred as I have gone over the data and while writing this paper. It has also included expanding my literature review to look more deeply at trauma criteria and related diagnoses, as well as traumatic childbirth, and discovery of Pam England’s (2017) Birth Story information (something someone introduced to me in passing, after hearing about my research). Explication has happened in the spaces where I have sat with the material and tried to get to the essence of what my experience of the research has been.

Finally, a creative synthesis “usually takes the form of a narrative depiction utilizing verbatim material and examples, but it may be expressed as a poem, story, drawing, painting, or by some other creative form” (Moustakas, 1990, p. 32). It is where, once gaining a full grasp of the knowledge gained from the question, the researcher puts “the components and core themes into a creative synthesis” (p. 32). The culmination of this research in a creative synthesis is both the writing of this paper with the exploration of my clinical learning, and the writing of my birth story.

### **Why Heuristic?**

The heuristic process allows for a dual purpose: Both professional and personal gains. I was curious about the interaction between Narradrama and SE in working with *my* birth story on a personal level because I thought I might be able to resolve the trauma that I felt inhabited my body. On a professional level, I felt called to work with women who had similar experiences – who felt unprepared, unseen, unheard, and traumatized by childbirth. But first, for my own competency, and clinical learning as a therapist, I needed to understand what had happened to me during the birth. I needed to reduce, if not eliminate, the anxiety I felt in my daily life from the birth, and reduce, if not eliminate, the activation I felt when thinking about it or telling my birth story. As a researcher, I wanted to report my findings in the hopes of furthering knowledge in the field of drama therapy with respect to traumatic childbirth.

In her known review and critique of heuristics, Sela-Smith (2002) writes about the importance of the inquiry being “exploratory discovery, rather than testing of hypotheses...[t]he inquiry is open-ended with only the initial question as the guide” (p. 58). I needed the research to be heuristic so that I could follow my own path of inquiry, where ever the path took me, until I was truly satisfied. Satisfied not only in academic and clinical knowledge, but also in resolving my trauma physically, emotionally, and cognitively, and left with a sense that I am able to hold a clear space for others, as a drama therapist and Somatic Experiencing Practitioner. This research paper is the final task in completing a clinically focused MA in drama therapy – it was paramount that in completing the degree that I felt ready to work as a clinician.

Finally, the importance that heuristics place on tacit knowledge and intuition made it a strong candidate for researching birth experiences. In my experience, there is something about birth that is incommunicable through words. As well, both Narradrama and SE show a deep respect for non-verbal communication and sensorial experience. A methodology that respects and uses tacit knowledge and intuition was appealing.

### **Validity and Reliability**

The heuristic method is a form of qualitative research that is highly subjective. It relies on the experience and interpretation of the researcher, and cannot be empirically generalizable. The reliability lies in the researcher’s transparency of process and ability to think deeply and self-reflect. The validity lies in both the reader’s perception that the information is valid or helpful to them, and in the act itself of exploring and sharing a personal experience without claiming it to be universal.

Douglass and Moustakas (1985) write, “[a]t the heart of heuristics lies an emphasis on disclosing the self as a way of facilitating disclosure from others – a response to the tacit dimension within oneself sparks a similar call from others” (p. 50). This research is a way to create an account of my experiences and make them available for others to read in the hopes that by sharing my journey and process, it might help others with theirs, or help other therapists working with people who have lived through traumatic childbirth.

### **Data Collection**

Data was collected during each period of immersion, and retrieved from relevant past records. During the Musings from the Womb (SE) workshop I took detailed notes of lectures, and wrote journal reflections, including drawing responses, after each day and personal SE

session. I also took notes from telephone conversations with workshop leader, Ariel Giaretto.

During the process of seeking a Creative Arts Therapist, I took detailed notes of telephone conversation (including drawing responses), wrote journal entries after in-person meetings, and kept a record of emails exchanged.

The Narradrama process produced the most significant amount of data. They include: A life-sized restorative body drawing, two abstract drawings used to explore different visual art media, a large timeline drawing of the birth that was worked on over many sessions, photographs of sand tray work and visual art, photographs from the birth, hospital and birth centre records, and journal entries from after each session, including drawing responses.

I also have a record of detailed notes from a conversation birth educator Pam England.

### **Data Analysis**

I reviewed the data from each period of immersion, going over each item, and deciphering the themes that seemed to speak to me as being the most important in my engagement with the material and healing process. Then, I looked at my experience from a clinical perspective and related my experience to the theories of drama therapy and SE. I have assembled the data in a narrative format, presented in the Data section of this paper.

After reviewing all of the data from the SE workshop, I used the tools of self-dialogue, indwelling and focusing to determine the themes from the workshop that stood out as significant to my personal processing of childbirth. I asked myself the question, “What, from your experience at the workshop, has stayed with you and remains significant?” Through this line of questioning, I realized that pendulation and coupling dynamics were not an outstanding part of my experience (although present and important), but rather the use of imagination, corrective experiences, and support stood out as what remained most significant. I then needed to translate that to my clinical learning and asked myself, “What parts of the theory were helpful or not helpful?”, and began a process of examining via indwelling, focusing, and self-dialogue, how imagination, corrective experiences, and support were used in the SE context at the workshop, and within the literature.

In analyzing the data from the Narradrama section of the research, I, again, primarily used the tools of self-dialogue, indwelling and focusing. In interpreting my own art work – either by photograph or the item itself – I drew upon tacit knowledge and intuition. I would look at the image, recall the experience of creating it, look for visual symbols or meaning, and then touch in

on my felt sense experience of the data item as a whole. I'd note emotions and physical sensations that surfaced. I followed a similar process after reading each journal entry. For each session, I'd ask myself, "From a clinical perspective, what is significant about this work/experience?" I would then continue with indwelling and focusing until I reached a satisfactory answer.

My experience of the Narradrama Steps was often modified, and not necessarily in chronological order, which made it more challenging to decipher the essence of the Narradrama interventions that were most significant to my personal process and clinical understanding. I tried to analyze the work I did through a drama therapy lens in order to be able to stay true to the form of Narradrama. However, likely due to my primary orientation as an SEP (my internal frame of reference), I found it very challenging to separate my experiences from SE theory. I sometimes went through a process of interpreting my experiences first through an SE lens and then translating them to the language of drama therapy. There were moments when the theories from the two modalities were so intertwined that it was not possible to report from a purely drama therapy perspective. It was, however, important that a drama therapy lens remained at the heart of the analysis and reporting on the Narradrama experience.

## Chapter 3. Literature Review

### Trauma

The leading authority on mental health in North America is the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-V; American Psychiatric Association [APA], 2013a). The DSM-V has a category of “Trauma and Stressor Related Disorders” (APA, 2013d, para. 1) which includes the subcategories of “Posttraumatic Stress Disorder (PTSD)” (APA, 2013d, para. 1), “Acute Stress Disorder” (ASD; APA, 2013d, para. 1), and “Adjustment Disorder” (AD; APA, 2013d, para. 1). All of these are “disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion” (APA, 2013d, para. 1), and each has an extensive list of criteria for diagnosis. While PTSD and ASD include the criteria “[e]xposure to actual or threatened death, serious injury, or sexual violation” (APA, 2013d, box 3 & 4), AD does not. These three diagnoses vary in severity of impact of the trauma, and duration of symptoms. ASD frequently develops into PTSD (about 50%); ASD will resolve within one month of the traumatic event, while PTSD is diagnosed after the one month marker (APA, 2013d). One helpful way to distinguish between the disorders is that “[d]epressive or anger responses in an adjustment disorder may involve rumination about the traumatic event, as opposed to involuntary and intrusive distressing memories in acute stress disorder [and PTSD]” (APA, 2013d, para. 80). Adjustment disorder is a very common diagnosis in outpatient settings (5-20% of patients) and hospital psychiatric consultation settings (up to 50% of patients; APA, 2013d).

In the international field of mental health, the concepts regarding the origins and symptoms of trauma have evolved significantly throughout history (Sajjani & Johnson, 2014). Nevertheless, “trauma” is a widely accepted term in mental health, with entire therapies and centres dedicated to helping people who have survived trauma. The founder of The Trauma Center at Justice Resource Institute in Brookline, MA, Bessel van der Kolk, and his team, have written prolifically on body-based research and approaches to working with trauma, and have had a major influence on most modern trauma work, including drama therapy and SE (van der Kolk, 1994; Interlandi, 2014).

A study by the International Society for Traumatic Stress Studies Complex Trauma Task Force regarding best practices for the treatment of PTSD (Cloitre et. al., 2011) looked at how trauma is currently being treated in the USA. They found:

First-line interventions matched to specific symptoms included emotion regulation strategies, narration of trauma memory, cognitive restructuring, anxiety and stress management, and interpersonal skills. Meditation and mindfulness interventions were frequently identified as an effective second-line approach for emotional, attentional, and behavioral (e.g., aggression) disturbances. (p. 615)

They also advised a “phase-based or sequenced therapy” (p. 615), which they describe as follows:

[T]he initial stage of treatment focus on patient safety, symptom stabilization, and improvement in basic life competencies. A second and later stage includes the exploration of traumatic memories for the purposes of first reducing acute emotional distress resulting from the memories and then reappraising their meaning and integrating them into a coherent and positive identity. (p. 616)

### **Traumatic Childbirth/Birth Trauma**

Cheryl Tatano Beck (2015), one of the leading researchers in traumatic childbirth defines birth trauma as follows:

Birth trauma is an event or events that occur at some phase during childbearing that involves the woman being stripped of her dignity and/or an actual or threatened serious injury to the mother or her unborn child. The mother may experience terror, helplessness, loss of control, powerlessness, or horror. Trauma can be psychological or physical. When women speak of their traumatic births they describe them as “feeling abandoned and alone,” “betrayed,” “raped,” “my dignity was taken from me,” “treated like a nothing,” and “terrified to the core of my being.” (p. 4)

A significant factor in precipitating birth trauma is when the mother *perceives* that her own life or the baby’s life is in danger (Beck, 2004; Nicholls & Ayers, 2007; Levine, 2010).

Traumatic childbirth does not receive specific recognition in the DSM-V (APA, 2013a). Even though PTSD and ASD are more common in females than in males (APA, 2013d), traumatic childbirth and/or birth trauma are not included in the examples given of events that may lead to these conditions. Rather, the APA cites examples of “rape and other interpersonal violence” (APA, 2013d, para. 78) as the potential association with gender. Interestingly, the DSM-V cites an example that can lead to AD as “becoming a parent” (APA, 2013d, para. 87), but does not specifically name childbirth. The postpartum period is mentioned briefly under the

DSM-V section on depressive mood disorders (APA, 2013b), as well as genito-pelvic pain/penetration disorder (APA, 2013c), but not with recognition of childbirth (traumatic or otherwise) as a source of the disorder in either case.

While the DSM-V (APA, 2013a) doesn't address traumatic childbirth directly, it does address "[m]edical incidents that qualify as traumatic events [that] involve sudden, catastrophic events (e.g., waking during surgery, anaphylactic shock)" (APA, 2013d, para. 26 & 59), and "witnessing a medical catastrophe (e.g., a life-threatening hemorrhage) involving one's child" (APA, 2013d, para. 61), both examples of incidents fall under the PTSD and ASD diagnoses, and could occur during a traumatic birth. This is helpful, but it does not include experiences in which birth is not medicalized, yet still traumatic. Interestingly, ASD is "especially severe when the stressor is interpersonal and intentional" (APA, 2013d, para. 61), something that is reported that can be a factor in traumatic birth (Beck, 2015; Harris & Ayers, 2012). On a related note, AD is reported to be particularly common in relationship to "medical illness and may be the major psychological response to a medical disorder" (APA, 2013d, p. 100). This may be validating if a woman has been left with a medical disorder after her birth.

There isn't one clear statistic on the prevalence of traumatic childbirth. In 2011, a survey reported that 9% of new mothers in the USA met the criteria for PTSD in the DSM-IV, while 18% met criteria for post traumatic stress symptoms (Beck, Gable, Sakala, & Declercq, 2011). In 2004, a commonly cited study reported 1.5-6% of mothers experienced traumatic childbirth, by one of the same 2011 authors (Beck, 2004). The 2004 study was much smaller, but included women from New Zealand, the USA, Australia, and the United Kingdom. The Prevention and Treatment of Traumatic Childbirth (PATTCh) website, founded by respected childbirth educator and author Penny Simkin, writes "between 25 and 34 per cent of women report that their births were traumatic" (Simkin, 2017, para. 1), and later states that "most women who have had a traumatic birth do not develop PTSD" (para. 5). Other studies report between 20-40% of women perceive that their births were traumatic, some showing symptoms of PTSD (Alcorn, O'Donovan, Patrick, Creedy, & Devilly, 2010; Ayers, Harris, Sawyer, Parfitt, & Ford, 2009). The Canadian Maternity Experiences Survey (Chalmers, Dzakpasu, Heaman & Kaczorowski, 2008) – a first of its' kind – has been criticized by Penny Christensen of Birth Trauma Canada for not reporting on traumatic births, for only screening for depression rather than (or as well as) PTSD, and for overall "positive spin and dishonesty" (BT Canada, n.d., para. 18). Of the 6421

respondents, 3.1% reported a “very negative” (Chalmers, Dzakpasu, Heaman & Kaczorowski, 2008, p. 223) and 6.2% reported a “somewhat negative” (p. 223) experience of “their overall labour and birth” (p. 223). Kalina Christoff (2011a), a psychology professor at the University of British Columbia and the author of the website Vancouver Birth Trauma finds similarities in statistics of women suffering from traumatic birth with veterans who suffer from PTSD after being deployed in the Canadian Forces, and calls for more recognition and treatment of PTSD in Canadian mothers.

Beck (2015) summarized her findings in a meta-analysis of 11 years of her research. Based on her work, she identifies five common “attributes of traumatic birth” (p. 4). “Deprived of caring” (p. 4) refers to a mother not receiving the care she needs from birth attendants. “Stripped of their dignity” (p. 4) refers to feeling “degraded and disrespected” (p. 4), or even “raped” (p. 4). “Terrifying loss of control” (p. 4) is described as the mother not being able to make choices during the birth, due to the intensity of the labour and/or the birth attendant’s actions. “Neglected communication” (p. 4) refers to woman feeling “invisible” (p. 4) and left out of important discussions. Finally, “buried and forgotten” (p. 5) refers to the trauma of the birth going unacknowledged as the baby is healthy and the mother is told to “move on” (p. 5).

Similarly, Elmir, Schmied, Wilkes & Jackson (2010) conducted a meta-analysis of ten studies regarding women’s perceptions and experiences of traumatic birth (including four of Beck’s), and reported six common themes: “‘feeling invisible and out of control’, ‘to be treated humanely’, ‘feeling trapped: the reoccurring nightmare of my childbirth experience’, ‘a rollercoaster of emotions’, ‘disrupted relationships’ and ‘strength of purpose: a way to succeed as a mother’” (p. 2142).

In the same vein, Harris & Ayers (2012) conducted a study to find the most prevalent hotspots of traumatic birth “to examine which events during birth women find particularly traumatic, and the cognitions and emotions most clearly associated with moments of peak distress” (p. 1168). They reported “[t]he largest category of hotspots concerned interpersonal difficulties, with the most frequent subcategory of being ignored. Obstetric events and pain was the next most frequent category, with more non-painful obstetric hotspots reported than acutely painful events” (p. 1170). The third hotspot was “events concerning the baby” (p. 1170). They identified the emotions of “anger, failure and negative affect (sadness and guilt) in addition to DSM-IV Criterion A responses to fear, helplessness and horror” (p. 1172) as predictors for

PTSD. Another “characteristic consistently predictive of re-experiencing and PTSD was intrapartum dissociation” (p. 1172). Anecdotally, in a conversation with Pam England, respected midwife, author, birth educator, and creator of Birth Story Medicine (a form of compassionate listening to traumatic birth stories) this author was told by England that in her experiences of listening to hundreds of birth stories over the past 20 years, the most frequent traumas occurred in the “relational realm” (P. England, personal correspondence, June 22, 2017).

Symptoms of birth trauma can fit with any of the DSM criteria of PTSD, ASD, or AD, but might include, in particular, “uncontrollable flashbacks/nightmares, numbing detachment, increased arousal: seething anger, difficulty sleeping, and retreating from the world of motherhood” (Beck, 2015). In addition to these symptoms, a woman might also experience feeling sad, angry, helpless or guilty about the birth (Christoff, 2011b; Harris & Ayers, 2012), “emotional numbing and dissociation” (Christoff, 2011b, para. 4), and “avoidance of all reminders of the birth” (Christoff, 2011b, para. 7).

Other significant consequences of traumatic childbirth can include difficult birth anniversaries (Beck, 2015; Beck, 2006), breastfeeding complications (Beck, 2015; Beck & Watson, 2008; PATTCh, 2017; Birthtalk.org, 2016), attachment issues (Ayers, Eagle & Waring, 2006; Beck, 2015; PATTCh, 2017; Birth Trauma Association, 2017), and difficulties with partner relationship (Ayers, Eagle & Waring, 2006; PATTCh, 2017; Birth Trauma Association, 2017).

Elmir, Schmied, Wilkes & Jackson (2010) state “[w]omen need to be given the opportunity to talk about their birth experiences and should be assessed in the postnatal period for signs of psychological distress” (p. 2151). Debriefing or talking through the birth experience with birth attendants is not necessarily going to resolve the lasting impacts of traumatic childbirth on a new mother (Elmir, Schmied, Wilkes & Jackson, 2010; Beck, 2015).

Recommended treatment for traumatic birth from the literature is trauma focused psychotherapy, including Cognitive Behavioural Therapy (CBT; Ayres, 2017; Beck 2015; Kendall-Tackett, 2017), and Eye Movement Desensitization and Reprocessing (EMDR; Beck 2015; Beck, Driscoll & Watson, 2013; Kendall-Tackett, 2017; Sandstrom, Wiberg, Wikman, Willman & Hogberg, 2008).

## **Drama Therapy and Trauma**

The North American Drama Therapy Association (NADTA) defines drama therapy as “the intentional use of drama and/or theater processes to achieve therapeutic goals” (NADTA, 2014, para. 1). There are several kinds of drama therapy methods that use theatre in different ways to achieve therapeutic goals, and of those, some are more trauma-informed than others.

Redfern (2014) looked at drama therapy methods that focus on trauma and proposed a “common framework” (p. 369) of three parts: 1. “Preparation: Safety and Resource Building” (p. 366), 2. “Personal Trauma Representation with Facilitated Reintegration” (p. 367), 3. “Moving Forward: Honoring the Loss and Support of the Future” (p. 367). While he gained these insights from a meta-analysis of drama therapy methods, he concludes that they are not necessarily specific to drama therapy. This common framework mirrors the phase-based therapy recommended for best practices for the treatment of PTSD by the International Society for Traumatic Stress Studies Complex Trauma Task Force (Cloitre et. al., 2011), mentioned above.

Sajnani & Johnson (2014) in their book *Trauma-Informed Drama Therapy* identify unique qualities that they believe DT brings to trauma work: “[V]ividness of recall” (p. 16), “cognitive distance” (p. 17), “reversing roles” (p. 17), and “humour and pleasure” (p. 17). Vividness of recall is discussed as a form of “imaginal exposure...through the engagement of the physical body and the entire sensory system” (p. 16-17), rather than simply in one’s mind. Sajnani & Johnson cite Foa, Hembree, & Rothbaum’s 2007 work that empirically shows vividness of recall “to be the most important element in successful desensitization” (p. 17). Cognitive distance in drama therapy can be achieved through a variety of “stylistic and structuring maneuvers that can shift the client’s state of mind from deeply cathartic emotional release to highly observant and reflective stance toward their experience” (p. 17). The commonly used drama therapy terminology of “aesthetic distance” (Landy, 1983, p.178) helps the drama therapist and client determine if the material is “underdistance[d]” (p. 178; meaning, too much intensity) or “overdistance[d]” (p. 178; meaning, not enough intensity), and work to find “aesthetic distance” (p. 178; the right amount of intensity) for effective therapy. Sajnani & Johnson discuss the appropriateness for “reversing roles between victim and perpetrator” due to the unique nature of the structure and tools that DT offers. They state that this particular role reversal technique provides “an opportunity to process the traumatic experience with far greater depth and complexity, evoking hidden attachments to the perpetrator, and deepening the

engagement with the therapeutic work” (p. 17). Humour and pleasure, according to Sajnani & Johnson, is a result of “spontaneous play” (p. 17) in most drama therapy, something they say “may provide greater acceptance of the treatment” (p. 17). These unique qualities can be seen in many writings on drama therapy for people who have experienced trauma.

### **Narradrama and Trauma**

While there is no stated trauma-informed approach to Narradrama, Dunne’s (2006) “Eight Step Process” (p. 39) does generally follow the three-phase framework for working with trauma in drama therapy, identified by Redfern (2014) above. However, the “Eight Step Process” (p. 39) is generally geared towards focusing on the present moment, rather than processing a past traumatic experience.

At the core of Narradrama are action-oriented methods, consisting of “projective, psychodramatic, and externalizing” (Dunne, 2006, p. 23) techniques, which are often used together. Projective techniques, such as using a sand tray with figures, allows the client to tell their story through objects (or roles) outside of themselves. Psychodramatic techniques, such as “living sculptures” (Dunne, 2006, p. 24), allows the client to enact parts of their story through “dramatic action” (Dunne, 2006, p. 24). Externalization helps the client separate their identity from the problem, proposing that “the person isn’t the problem; the problem is the problem” (Dunne, 2006, p. 24). In Narradrama, externalizing techniques allow clients to “identify their problems with objects and people different of themselves” (Dunne, 2006, p. 25). Through externalization, projection and psychodramatization, clients gain new perspectives, or “unique outcomes” (Dunne, 2006, p. 24), around their “problem saturated story” (Dunne, 2006, p. 24), leading to an experience where they can “re-story a life experience” (Dunne, 2006, p. 26) – ultimately shifting the client’s perspective around past events, current circumstances, or even their identity. The process of taking apart and analyzing a situation is called “deconstruction” (Dunne, 2006, p. 35), and the process of restorying and putting the pieces back together in a way that serves the clients is called “reconstruction” (Dunne, 2006, p. 35).

Dunne’s (2006) “Eight Step Process” (p. 39) is as follows: “Step One: Warming up to New Descriptions of Self Identity and Environment” (p. 39) involves interventions that create a sense of safety in the environment and an exploration of personal identity. “Step Two: Externalizing the Problem” (p. 43) involves interventions that allow the client to separate the problem from their identity and see the problem outside of themselves. Dunne states “the basis of

narradrama is the externalization of the problem” (p. 43). “Step Three: Possibility Extension” (p. 45) allows that client to “try on something new” (p. 45) and works in the imaginal realm of desired life experiences. “Step Four: Externalizing Choices” (p. 51) involves interventions that allow a client to use externalized methods to project into the future both the continuation of the path they are on, as well as try out new choices related to the externalized problem. “Step Five: Invite Personal Agency” (p. 54) uses interventions that reflect upon and externalize personal agency in the client’s personal journey. “Step Six: Alternative Stories and Unique Outcomes” (p. 55) provides interventions that lead to “an alternative way a problem might be solved” (p. 55) and looks at “an exception to the problem saturated story” (p. 55). “Step Seven: Restory Life Scene” (p. 56) offers interventions for clients to create and explore their preferred narrative around their personal journey or a specific situation. “Step Eight: Closure, Reflection, and Rituals” (p. 58) happens in the last session with the therapist and offers interventions that help the therapeutic process terminate, while aiding the client to move forward in life.

### **Drama Therapy and Traumatic Childbirth**

A literature review on traumatic childbirth and drama therapy or creative art therapy, produces sparse results. A search of the database PsychInfo, as well as the specific journal sites of *Dramatherapy* and *The Drama Therapy Review* with the terms “drama therapy” or “dramatherapy” with “birth trauma”, “traumatic childbirth”, “childbirth” and/or “birth”, produces a total of three articles. One match focuses on the development of the child and is therefore not applicable. Another briefly mentions the author’s experience as an anthropologist witnessing childbirth in Malaysia (Jennings, 2008). The third article is applicable; it is regarding a case study of a woman working through grief related to stillbirth (Bar-Yitzchak, 2002). This article views the case through the lens of “complicated grief” (p. 9) rather than trauma, although it did mention the client meeting DSM-IV criteria for PTSD. The article does not discuss the birth itself in any detail, and focuses on the grief related to the loss of the child and motherhood, as well as difficulties around subsequent failed IVF treatment.

A wider search on PsychInfo using the terms “creative art therapy”, “art therapy”, and/or “dance movement therapy” with “birth trauma”, “traumatic childbirth”, “childbirth” and/or “birth” yields nine results. However, none of them are directly relevant to traumatic childbirth.

A database search of the journal *The Arts and Psychotherapy* with the term “childbirth” yields seven results, two of which are relevant, only in that they mention childbirth as a unique

issue that creative art therapists should be aware of under the wider umbrella of working with women (Hogan, 2013; Johnson, 1989).

### **Birth Stories**

A birth story is the synthesis of the birth narrative, usually from the perspective of the mother. It is a large part of popular birth culture in English speaking countries (and perhaps beyond). Bonnie Gibbs Vengrow, a blogger on Parents.com, writes that swapping birth stories is a “new-mom rite of passage” (Gibbs Vengrow, 2017, para. 1). Popular pregnancy and parenting website Babycenter.com (2017) has a section dedicated to birth stories, including 28 articles with different women’s birth stories, and different takes on what a birth story might look like, usually with a positive spin. The Birth Trauma Association (2017) and Birth Trauma Canada (n.d.) both have dozens of traumatic birth stories shared on their websites.

Nicole Tricarico (2017), birth educator and Birth Story Medicine listener writes:

Sharing our stories and scaring others, or even smugly recounting how blissful our birth was, is often, at least in part, an attempt to process what was an incredibly intense experience. It helps us to process the magnitude of the experience. We *do* need to process our birth stories, good or bad—but in a healthy way. (para. 16)

Birth stories can be a way to process the birth, a way to share wisdom with other expecting mothers, and may become part of family folklore. One study suggests that how a daughter hears about her own birth story contributes to her self-esteem and attachment with her mother (Hayden, Singer & Chrisler, 2006). Sharing a birth story can be extremely vulnerable, and could lead to triggering memories and sensations similar to those experienced at the birth. The details of a birth story might only be reserved for an exclusive, intimate audience, or might be “sugar coated” (Gibbs Vengrow, 2017 para. 1) for a more general audience.

Pam England (2017), creator of Birth Story Medicine, writes in her book *Ancient Map for Modern Birth* about the “nine modifications of birth stories” (p. 375), and frames them through the myth of Inana, who returns from the underworld through seven gates. England observes that a woman’s relationship with her birth story changes over time, particularly over the first year postpartum. She modifies the gates from the myth, adding two more, showing the path of a “modern woman... complet[ing] her rite of passage to motherhood” (p. 375). The theory is that as a woman goes through each gate, she processes her birth story in a new way, helping her to come to terms with what transpired; once finished the process, she is able to step more fully into

her role as mother. The first gate is called “No Birth Story” (p. 376), the second gate is called “Relief and Gratitude Story” (p. 377), the third gate is called “Relationship Story” (p. 377), the fourth gate is called “Social Birth Story” (p. 378), the fifth gate is called “Medical Birth Story” (p. 378), the sixth gate is called “Victim and Judge Story” (p. 378), the seventh gate is called “New Meaning Story” (p. 379), the eighth gate is called “Huntress Story” (p. 380), and the ninth gate is called “Wise Woman’s Story” (p. 380).

### **Somatic Experiencing and Trauma**

The Foundation for Human Enrichment (FHF; 2017), the organization that runs The Somatic Experiencing Trauma Institute and manages the training and membership of Somatic Experiencing Practitioners, defines SE as follows:

Somatic Experiencing is a body-oriented approach to the healing of trauma and other stress disorders. It is the life’s work of Dr. Peter A. Levine, resulting from his multidisciplinary study of stress physiology, psychology, ethology, biology, neuroscience, indigenous healing practices, and medical biophysics, together with over 45 years of successful clinical application. The SE approach releases traumatic shock, which is key to transforming PTSD and the wounds of emotional and early developmental attachment trauma. (para 1)

According to SE founder, Peter Levine, trauma “is in the nervous systems, not in the event” (Levine, as cited by FHE, 2007, B1.4). Levine refers to trauma as the “debilitating symptoms that many people suffer from in the aftermath of *perceived* life-threatening experiences” (Levine, 2005, p. 7). The SE teaching manual (FHE, 2007) breaks down trauma into the following categories, taking into consideration typical symptoms that occur after typical traumatic events: “global high intensity activation” (p. I1.12) – including pre- and peri-natal trauma, anesthesia, high fevers, and suffocation, choking and drowning; “high impact/failure of physical defense” (p. I1.22) – including falls, head injuries, and motor vehicular accidents; “inescapable attack” (p. I1.26) – including animal attacks and sexual assault; “physical injury” (p. I2.8) – including surgery, poisoning, and burns; “natural and man made disasters” (p. I3.3) – including horror, survivor guilt, and torture, ritual and war; and “emotional trauma” (I3.10) – including shame.

Central to SE’s nervous system approach is Porges (2011) polyvagal theory. Porges looks at how the fight, flight, and freeze responses are connected to the vagus nerve, and

discusses how the nervous system will self-regulate (or not) after perceived trauma. Essentially, SE works to bring a client out of a freeze state, into a sympathetic nervous system state (the high activation of fight or flight), allowing them to complete incomplete self-protected motor programs that have been thwarted, returning the nervous system to homeostasis (Levine, 2010; FHE, 2007). However, the way in which a SE practitioner approaches this is sophisticated enough to meet the complex needs of differing and individual nervous systems.

At the time of writing this paper, the first randomized controlled outcome study looking at SE's efficacy was recently published (Brom, Stokar, Lawi, Nuriel-Porat, Ziv, Lerner & Ross, 2017). The study, looking at people with PTSD in Israel, shows that people with PTSD significantly benefited from SE treatment; of course, further research is suggested. Other studies show SE to be an effective treatment for trauma, however without control groups (Parker, Doctor & Selvam, 2008; Leitch, 2007; Leitch, Vanslyke & Marisa, 2009), or with a very small sample size (Changaris, 2010). The single research study found that involves both SE and DT is Lahad, Farhi, Leykin and Kaplansky's (2010) SEE FAR CBT. This study combines SE, "fantastic reality" (p. 392) – metaphoric therapeutic cards that allowed for story making – and cognitive behavioural therapy; it shows positive results when working with PTSD. Despite the lack of published empirical studies, SE has developed into a respected form of trauma treatment, dating back to 1972, with over 120,000 professionals who have attended trainings on six continents (Somatic Experiencing Trauma Institute, 2017).

There are many core concepts that make up an SE practice, each acting as a guiding principle that can be applied to each unique nervous system. However, concepts particularly pertinent to this research will be introduced below. These are "pendulation" (FHE, 2007, p. B1.19, B1.20, A1.7), "coupling dynamics" (FHE, 2007, p. B1.27, B3.17), and "Movement Through Time" (FHE, 2007, p. B1.22), also known as "The T-Model" (S. Hoskinson, personal communication, April 28, 2012). "Pendulation" (B1.19, B1.20, A1.7) is described as "the inherent rhythm of the nervous system" (B1.19), which can be mechanical and learned, but is eventually "automatic" and "involuntary" (B1.19). It is described as "the natural oscillation between opposing forces of contraction and expansion... [and used] to help a client experience a sense of flow" (FHF, 2017, para. 4). According to SE theory, the rhythm of the nervous system is disrupted during trauma and in therapy returned to its' natural rhythm. "Coupling dynamics" (FHF, 2007, p. B1.27, B3.17) are "an association between a stimulus and a response" (p. B1.27)

within the elements of the acronym “SIBAM”– sensation, image, behaviour, affect, and meaning (p. B1.27). The implication is that the coupling creates difficulties in the present moment, as perceptions become tied (consciously or not) to the trauma experience. As a traumatic event is evoked (by retelling, sensing, or otherwise), particular stimuli and responses can be either uncoupled or recoupled, as appropriate. The T-Model is an intervention used for event-based trauma, based on a time scale (FHF, 2007; Levine, 2010). Working through the time sequence of the traumatic event helps re-establish the continuity of the experience (especially if there is dissociation), which is often disrupted in trauma (Levine, 2010). The model breaks down time into “experiences that happen prior to the primary traumatic event” (e.g. T -2, T-1; p. B1.22), “the primary event itself (e.g. T -0; p. B1.22), and “experiences that follow the primary event” (e.g. T +1, T +2; p. B1.22). As a timeline, it can be seen as: “T -1, T -2, T -0, T +1, T +2” (p. B1.22). The model does not have to be worked chronologically, but the client does need to realize that they have survived the trauma and made it through to T +2, as well as maintain a titrated awareness of the present moment in therapy (FHF, 2007; Levine, 2010).

### **The Felt Sense**

Psychologist and philosopher, Dr. Eugene Gendlin coined the term “felt sense” in the 1960’s, in development of Focusing therapy (Allison, 1999). Gendlin (2007) calls the felt sense “an internal bodily awareness” (p.11), and further describes it as a “body-sense of meaning” (p. 11) that is non-verbal, and can take time to find. Levine and Frederick (1997) call the felt sense “internal body sensations” (p. 66) and write that “the felt sense...[is]...the medium through which we experience the totality of sensation” (p. 68). SE uses the felt sense as “a portal through which we find the symptoms, or reflections of trauma” (p. 66). However, by the same token, it can also be said that the felt sense can be used to know when safety and pleasure are present, and trauma symptoms have been resolved.

### **Somatic Experiencing and Traumatic Childbirth**

At the time of writing this paper, there were no relevant scholarly articles found through database searches on PsychInfo or ProQuest with the terms “somatic experiencing” and “childbirth” or “birth”. The most relevant results of a google search with these terms leads to websites of Somatic Experiencing Practitioners (SEPs) who include working with traumatic childbirth in their practice.

While Levine (2005) does list “[b]irth stress for both mother and infant” (p. 15) under “less obvious potential causes of trauma” (p. 14) in his book *Healing Trauma*, the SE teaching manual (FHE, 2007) does not name traumatic childbirth as a specific category of trauma. However, depending on what has happened during the birth, conceivable traumatic events could include one of, or a combination of, “global high intensity activation” (p. I1.12) from anesthesia or high fever; “inescapable attack” (p. I1.26) similar to sexual assault; “physical injury” (p. I2.8) including surgery (cesarean section, episiotomy, forceps or vacuum injury, etc.) or naturally occurring injuries (organ prolapse, tearing, hemorrhoids, anal fissures, urine and fecal incontinence, etc.); “natural and man made disasters” (p. I3.3) includes the categories of horror, survivor guilt, and torture – all conceivable experiences of traumatic birth; and “emotional trauma” (I3.10), for example, birth attendants emotionally abusing the mother causing shame, anger, fear, grief, etc.

### **Corrective Experience**

Hill et al. (2012), in their book *Transformation in Psychotherapy: Corrective Experiences Across Cognitive Behavioral, Humanistic, and Psychodynamic Approaches*, outline two types of corrective experiences. “Type 1 [corrective experiences] are new or unexpected thoughts, emotions, sensations, behaviors, or feelings about one’s self that result from the client encountering an event that is different from (and thus disconfirming of) his or her frame of reference” (p. 356). These new experiences can happen in therapy with the therapist and/or group, or in vivo. In “Type 2 [corrective experiences], the client actively does something different in situations that typically have triggered apprehension and negative emotion, leading to a new outcome” (p. 356).

This paper refers to Type 1 corrective experiences, particularly in relationship to encountering events during therapy itself, and in relationship with a therapist and/or intervention.

## **Chapter 4. My Birth Story Narrative**

The reader may notice certain elements in My Birth Story that I have worked on through my own therapeutic process – certain hind sights and wishes for different choices, and celebrations of personal empowerment and joyful moments. I will go into my process regarding these moments in more detail later in the paper as I describe my therapeutic process. This is how I conceive of my birth story after doing the research and therapy that I set out to do for this paper. However, as England (2017) points out, a woman's perception of her birth story continues to change over time.

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### **Part One: Contractions for a Month**

My pregnancy had gone without a hiccup. Two weeks before my due date, I started having contractions that seemed pretty serious. I was elated that the baby might come a little early, and I felt ready. It didn't amount to labour, but I was on alert that the baby could come at any time. She didn't, though. I had a few other incidents that weren't as intense, and no baby. The due date came and went, and our daughter wasn't actually born until 11 days after. It was an excruciating time – patience was not a virtue that I possessed. It was February in Montreal – the coldest winter on record in 111 years. It wasn't possible to go for long walks outside at -33°C. I was beginning to get very uncomfortable in my body, experiencing cabin fever, and generally losing it. I wanted to meet my baby as soon as possible. If I could do it again, I would try to summon more patience, if only for the sake of bringing my nervous system down from a high-alert state.

### **Part Two: It's Go Time**

At around 1am on February 15<sup>th</sup> I started experiencing contractions that felt pretty serious. At around 2:30am we texted the midwife and she suggested we meet at the birth house. In retrospect, we should have stayed home and waited for the contractions to become more regular, but that's not what we did.

It was a Sunday, so the birth house was very quiet and empty. The midwife confirmed that the baby's position and heart beat seemed fine, and that I wasn't very dilated. For the first few hours, my husband and I were excited. He played ukulele and we sang, we had a playlist of music from a friend and I danced through some of the contractions. It was fun, funny, and empowering.

But after 12hrs, the whole process started to feel long, and I didn't feel like I was progressing at all. I tried out the birthing tub, and when I would get in the warm water, my contractions would slow down. I took that to be a bad thing, because it stopped any progression. Since the birth I have learned that the bath is often used to slow things down to give the mother a break. I felt ashamed when the contractions slowed down, like I did something wrong. I wish my midwife had guided me better through the understanding of what was happening at that time, and I wish I had better communicated my anxieties and feelings of shame.

### **Part Three: It's Go Home Time**

At around 3pm, the midwife strongly suggested that it would be a good idea to go home. She said that because I was progressing slowly, I might be more relaxed at home, which could speed up the process. Her other reason was that the longer the birth happened under care, the more likely it would be that interventions would be used. I really didn't want to go home. I didn't want to take a taxi ride and leave the sanctuary space that we had created, or break the breathing, vocal work, and eye contact that my husband and I were doing with each contraction. I cried, just at the idea of leaving, but I agreed in the end, trusting in the midwife's advice and experience. In retrospect, I think this was a mistake.

It is possible that the baby shifted position to be posterior on the car ride home, because the pain in my sacrum and back intensified significantly upon arrival. At home, I took a Gravol (as suggested by the midwife) to see if I could sleep, but wasn't able to. I tried the bath at home, but after a few hours there was little relief. At around 7:30pm, I wanted to go back to the birth house.

### **Part Four: Am Going to Die?**

Between arriving at the birth house for the second time at around 8pm on February 15th, and 5am on February 16<sup>th</sup>, my contractions increased in intensity, my back pain increased in intensity, and I became incredibly tired. I think I was passing out in between contractions – this is the haziest and most dissociated part of the birth experience. The position that worked best for contractions was standing with my arms around my husband's neck while he supported my entire weight. There was a moment in the bath, a much-needed break (although filled with shame for slowing down the process), when I felt like I couldn't go on and thought I would need to be transferred and get a caesarean. But, no one made that suggestion. I dug deep within myself and came up with a new plan. I asked my husband to repeat the mantra "you can do it" in one ear,

and I asked my mother to repeat the mantra “it’s for the baby” in the other, during every contraction. I believe we did this together for over 5 hours. It definitely helped, but my energy and ability to cope with the pain was getting worse and worse. It was during this portion of the birth that I thought I was going to die. I never voiced this fear, and pushed the thought down. I wish I had voiced it. Speaking with them later, my husband and mother both had similar thoughts, but none of us expressed them at the time.

Meanwhile, another family came into one of the other birthing suites and gave birth in what seemed like three loud pushes. That was slightly demoralizing, although it was their third child. I now find this part of the story mostly funny.

At around 4 am the midwife checked me again and there had been almost no progress in dilation. She guessed that the baby’s head had rotated and proposed that the reason I was in so much pain was because I was in “back labour”. I had never heard that term before. I now know that a nickname for back labour is “the labour from hell” (England, 2017, p. 249). The midwife suggested positions that could help rotate the baby, but they were excruciatingly painful and I couldn’t hold them for more than a second. She then suggested sterilized water injections. I had never heard of them. Sterilized water is injected into the skin in four spots around the sacrum. They are momentarily painful to receive for about 20-30 seconds, the pain relief lasts for about 90 minutes, the shots can only be taken twice due to skin damage (according to my midwife), and work for about 50% of the people who receive them (also, according to my midwife). Fortunately, they worked really well with me. A few seconds after receiving them, I felt extreme relief. I could move, I had energy, I was ready to go. For 90 minutes, we did everything the midwife said to do to turn the baby. This included different positions, and using a scarf to physically shift the baby’s position from the outside. It didn’t work. The water shots wore off and the pain came back as strong as ever. It was 6 am and we sat on the bed for a conversation on how to proceed. The options the midwife presented were to do stay the course, or take the shots again, break my waters (which she said could speed things up, but also make things more intense) and continue to try and turn the baby.

I didn’t realize it yet, but I had lost my trust in the midwife after being sent home. I asked why no one was talking about transferring to the hospital to get an epidural. I said that it was clear that I did much better with pain relief and that if I still wanted to deliver the baby vaginally, getting pain relief for more than 90 minutes seemed essential to me. I made the decision that I

wanted the sterilized shots once more, and hopefully that would tide me over until I could get an epidural. I have since learned the term “compassionate epidural” (England, 2017, p. 254) used after long and painful back labour. England writes, “[d]o what needs to be done next and know that your baby’s position or having back labor is not your fault” (p. 255). After another round of sterilized water shots, we started packing up, I felt energized and angry – at the midwife and the birth house. My thought was, “Get me out of here!” I could barely look at the midwife in the taxi ride that was 10 blocks to the hospital. I was relieved when she left, after I had been checked in and her shift was over.

### **Part Five: Hospital and Pushing**

From the moment of making the choice to go to the hospital, I felt empowered and more in control of my experience. We arrived at around 7am, which was when they were doing a shift change. I had to wait a while for the epidural. When the anesthesiologist came, I was in disbelief that I was supposed to hold still during the injection. I used my residual feistiness to make sure that we did it between contractions. I told the doctors that I didn’t want interns checking me all the time and I didn’t want interventions, except the epidural. I didn’t realize that when you get an epidural, you need to get a catheter. I was upset about this, but agreed. I didn’t want the child’s heart monitor on my stomach, but agreed when it seemed like I didn’t have a choice. Later, I refused the internal head monitor. There was so much I wasn’t prepared for at the hospital.

After the epidural was working, I was able to sleep for a couple hours. It was sweet relief. Then, the doctor tried to convince me to let him break my waters, but I said no. Two hours later, he checked me again and I agreed on the basis that it would move things along. It was remarkably uneventful. I slept for another two hours and when he checked me again, he asked if I was pushing (I wasn’t). He said I was fully dilated and ready to go – I couldn’t believe it and I was thrilled. Reviewing the narrative of this, it does seem like he was trying to move things quicker than my body’s natural rhythm. I didn’t mind it at the time, but his actions do speak to a certain agenda to keep things going. I wonder if there was a medical reason for this that I’m not aware of? Perhaps knowing that I was in labour for so long, he wanted to make sure there was no meconium. I’m not sure I’ll ever have the answer to this.

My husband called my mother (who had gone home to rest after the hospital transfer) and the head midwife, who were supposed to join us for the pushing. I really liked the hospital nurse – she was very gentle and kind, and had a calm and empathetic approach that was helpful. I felt a

trust in her and felt my body relax around her. When the midwife arrived, she saw that we had already started. She threw her jacket down, ran to my side, and in her Belgian accent said, “Alright, Lindsay, I need you to puuuush into your bum”. It is a phrase that my husband and I recount to each other with a twinkle in our eyes.

The pushing was blissful. I felt calm, in control, supported, and able to control the pace. I knew the baby was coming and that I would meet her soon. The pushing lasted about 1h45min, and I tried very hard to tune into my body, and listen to the guidance of my team –making requests for how I wanted them to support me (e.g. quieter, less intense, more physical guidance). I was able to feel the contractions, and control the epidural drip with a button – I stopped pressing it during the pushing in order to feel the contractions better. I pushed at my own intensity, not wanting to bare down too hard, slightly less than what some were encouraging me to do. I could feel that the resident doctor felt the pushing was taking longer than he had hoped, and I (privately and defiantly) refused to rush the process to please him. However, in the last few minutes, the baby’s heart rate would lower during contractions, so I gave it my all and she was soon out. When the baby finally emerged, the head obstetrics doctor was in the room and she instructed the resident (who was about to hand the baby to the nurse) to give me my baby right away. I will never forget grabbing her under her slippery armpits and pulling her up my body to my belly, and then my chest. She was a little blue at first and then bright pink. She had a full head of very dark hair, her nose was a little squashed, she had a bit of vernix and blood on her. She was amazing. She stayed on my chest for a while and the midwife helped her breastfeed for a short moment.

I had requested delayed umbilical cord cutting, but it seemed like there was some potential hemorrhaging and the doctor wanted to get the placenta out. Delivering the placenta was a bit of a haze – it seemed to happen quickly and without much effort on my part. I remember the doctor tugging it at one point. They gave me some synthetic oxytocin to prevent the small hemorrhaging that had begun. I had five stitches. The nurse showed the placenta to me, which was an impressive organ to behold. But none these details seemed important or dangerous; I was so enamoured with the baby, and in disbelief over her head of dark hair and the fact that she was actually here (see Figure 1).



*Figure 1.* The baby is born. February 16, 2015.

### **Part Six: Aftermath**

Eventually I was wheeled to my room, and my husband and baby went to do some quick routine tests and then joined me. The next hours, days, weeks, and months were a mixture of heart opening joy, and extreme stress. When I let myself think about the birth, I was in shock and disbelief that it had been so awful. Without ever being raped in my life, I felt like I had been violently raped for hours. I tried to focus on the baby and what needed to be done to take care of her. In my hospital room, I wanted to get back on track for our plan to head home within 24hrs of the birth, like at the birth house, not readjusting to the reality of the epidural or difficulty of the birth. We had a photo shoot scheduled for 9 am the next morning that I didn't want to miss (see Figure 2). While the pictures are beautiful, I wish we had rescheduled! In retrospect, not acknowledging this shift in situation caused me a lot of struggle. Had I stayed in the hospital longer (as the nurses politely suggested), we could have received more help, I might have rested better, and we might have figured out the breastfeeding issues sooner. I did not want to admit to myself that the birth was not at all what I hoped it would be, or even more so, that I needed to take actions to care for myself in ways that I hadn't prepared for as a result of it. I may have come around to that sooner, if we hadn't had the breastfeeding issues that we did. But as I have discovered, breastfeeding issues can be linked to traumatic births and epidurals.



*Figure 2.* Our new family. February 18, 2015.

### **Part Seven: Conception of this Research Paper and Finding Help**

The year after my daughter’s birth was a very challenging one, and the process of living that year brought me to the decision to write this paper.

Up until this point in my life, I had investigated the subtleties of physical sensation with great sensitivity. It was part of my profession and, in some ways, my identity. I was proud of my ability to track the smallest changes in my body, and relied on my ability to say “that’s enough for now” rather than push through physical pain. It was a life philosophy that I subscribed to that goes against the fast-paced, go-go-go, harder-faster-more-ness that I perceive brings a lot of pain to our society. When anything happened that was upsetting – for example a bike accident – I was always able to seek the help I needed, and take time to myself to rest and recuperate. I remember

thinking that if I didn't have a baby to take care of, I would spend the next month in bed sleeping, and visiting with therapists of different sorts.

I probably could have done that, more or less, if my daughter hadn't had lip and tongue ties, preventing her from properly transferring milk from my breasts to her mouth. To say this was stressful is an understatement. Eventually, she endured a surgery where a laser severed her tongue and lip ties three weeks after she was born. It wasn't an easy entry to parenthood.

I never received the recovery from the birth that I needed, and avoided thinking about it as I navigated life as a new, anxious, mother. I was constantly hoping that things would calm down and become easier. The combination of the birth and the breastfeeding aftermath were too much and I believe I developed, although undiagnosed, Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD) with dissociative symptoms.

My anxiety peaked at around five months postpartum during a holiday visiting family and friends in my home town. My daughter had been waking every hour of the night to feed for a third night in a row, and it was becoming impossible for me to fall back asleep in between feedings. My thoughts circled around whether it was good or not to feed her on demand and if she was developing terrible sleeping habits because of this, or if it was a growth spurt and was the best thing for her. I also worried about whether or not I was moving too much in the bed and keeping my husband awake or if I might wake her up again. I fretted about how I was going to make it to the big picnic the next day, and wondered why were we planning so many activities that required sleeping in new places every three days.

Lying in bed, my body began to tremble. My heart was beating fast and I began gasping for air. I felt overwhelmed and guessed I was having a panic attack. I recognized the trembling movements as releasing tension – something I am familiar with from my work with SE – and decided to allow it to continue to happen, albeit in an inhibited way. My husband, who has done some SE training, woke up and offered some supportive touch. After talking a little, I realized that what my body wanted to do was bigger and louder than I was willing to let happen because I was scared that I would wake the baby. My husband and I went into the living room and I lay on a yoga mat and let myself tremble and cry while my husband stayed with me and calmly offered supportive touch and reflections of my sparse words. The trembling happened mostly in my legs. I held a happy-baby-like pose and knew on an intuitive level – particularly because of the physical position that I was in – that this release was related to the birth. The trembling also

moved up and down my spine and into my arms. What was vivid was the experience of anxiety and panic, followed by emotional relief and physical release as I finally listened to my own body's needs. The supportive touch and gaze of my partner also seemed crucial. There weren't many words for what was happening, it was so completely physical – what I believe was physical and neurological processing of the birth. My body demanding to be heard. I had ignored and pushed-through for too long.

This was a turning point. Before this I had been stuck in my anxiety, not acknowledging the grip it had on me. After this night, I realized that I had a problem, that I needed help, and that I needed to take care of myself. I admitted that the birth was traumatic – something I had avoided and suppressed to this point – and that I needed to process, on a physical and emotional level, what had happened.

As I began to make links between what had happened and what was happening, I became angry with “the system” in not preparing me or supporting me enough through the process of birth and early motherhood. My inner social-justice/activist role thought it would be a good idea to investigate my experience in order to normalize it for myself, and share it so that it might be helpful for others. My inner researcher role got very interested in how birth stories live in the body, and how traumatic birth stories get stuck in the body and need to be released. I thought about my previous proposal for a research project – to compare core elements of drama therapy and SE – and got excited about being more specific. Eventually, I would like to create a program to help women process their birth traumas, but I knew that in order to do that, I needed to process my own first. The unfortunate part about this was, that with deciding to use myself as a subject for research, I delayed seeking help in order to work within the academic frame. My return to academic life was five months away, and I think I suffered for putting my healing off in order to make it part of my research.

One difficulty that stood out was that I was unable to tell my birth story without becoming emotionally overwhelmed. So, while my anxiety began to feel under control due to some stabilizing self-care, I knew I still had work to do and thought that being able to tell my birth story without becoming overwhelmed would be one way to see if I had worked through the birth trauma. I looked to Narradrama because it works directly with the narrative of experiences and is flexible in its' artistic approach. I felt that combining an externally focused Narradrama process with the physically-in-tune process of SE (similar to what I had experienced on the night

of my panic attack) could be a potent mixture for processing my birth story, and wanted to test it out.

At 11-months postpartum, in January 2016, I went back to school part-time, resubmitted my proposal for this research paper, and created a plan to document my therapeutic process as a heuristic inquiry.

## Chapter 5. Data/Process

### **Musings from the Womb: Somatic Experiencing and Birth**

From June 3-5, 2016, I attended a workshop entitled *Musings from the Womb* lead by Ariel Giarretto in Berkeley, California. Giarretto is, among many things, senior faculty of the Somatic Experiencing Trauma Institute, a Marriage and Family therapist, and began her early work as a doula. I heard about her workshop through the online SE community and it peaked my interest. I wondered, how is traumatic childbirth approached from an SE perspective? I wanted to know more and thought this would be a good opportunity.

The short answer to the above question is: Just like any other trauma. As discussed in earlier in this paper, SE has guiding principles, and practitioners take cues from what the client is presenting as they follow those guidelines.

However, there are three major learnings that I took from this workshop that seem particularly important to birth processing, and can be viewed through both SE and drama therapy lenses. These are the importance of support, the usefulness of the imagination, and, in particular, how they work in corrective experiences.

#### **A corrective experience in group using support and imagination.**

Support is such a foundational concept of SE (Levine & Frederick, 1997). An SEP's practice could be framed as providing support for a client's nervous system to re-establish equilibrium. Similarly, doulas, midwives, and medical teams support the birthing process, hopefully toward equilibrium as well. Yet, many women report that their traumatic childbirth was connected with lack of support – or “deprived of caring” (Beck, 2015, p. 4) – during the birth. The workshop proposed ways of imagining and experiencing support, and it was key that the client integrated the support in a present, felt sense way.

Chanti Smith, a midwife, SEP, and assistant instructor at the workshop, introduced an embodied and enrolled exercise around support at birth, based on the work of Ray Castellino. Dr. Castellino, has a background in craniosacral therapy, and is “an internationally known trainer, clinical researcher and author in the field of prenatal and birth therapy” (Birth Psychology. n.d., para. 1). The exercise enrolls people as baby, mother, birth partner, midwife, grandmother, or any other vital role that may be necessary at a particular birth. The group of people stand in a line with the baby in the centre, the mother on one side, touching the baby, and the midwife on the other side, touching baby. The birth partner/father stands next to the mother and touches her, and

the grandmother stands next to the birth partner/father and touches him. Other roles can be added as desired. The idea is for the outside people to touch the person they are next to, energetically offering them support.

I watched a demonstration of this exercise and knew immediately that I needed to experience this exercise in the role of the mother. When I did, I was completely overwhelmed by the feeling of support that I experienced and began to sob. My tears were, in part, an acknowledgement that I didn't receive what I needed during the birth and that it could have been a better experience. Standing in the role of the mother, I imagined a scenario in which my midwife was Smith and not my actual midwife. I requested even more support and Smith invited another midwife to support her. I felt physically bolstered by my supportive team and I got to imagine what it might have been like to have felt supported in the way that I had needed during the birth. I got to do the exercise a few times. Once again as the mother, and once as the birth partner. In my second time being the mother, I was much less overwhelmed by emotion, and was able to stand and silently receive the supportive intention that all of the others were sending to me, so that I could then send my support to the baby. In my first experience, I was so overwhelmed by the difference of feeling from my actual birth, that I wasn't very conscious of being able to send support to the baby – which actually paralleled the birth experience.

The exercise was done in silence and evoked for me an experience of nervous system pendulation. I had a chance to ride the waves of feeling overwhelmed or close to overwhelm, and then open to the support and receive the support and feel my body calm down. I could feel my awareness contract to my experience of discomfort and grief, and then expand to take in the people who were supporting me and eventually the person playing the role of my baby. No words were necessary and no words came. As I received the support, I could feel my nervous system regulate – my vision, heart rate, and body temperature return to normal. The moment was about allowing the grief to be expressed, and then realizing that support was there for me, receiving the support, and allowing myself to focus on the task at hand: Connecting with my baby, feeling safe, and entering a process of welcoming my baby into the world. I got to redo a part of my birth story, in a supported way; a kind of “re-negotiation” (Levine & Frederick, 1997, p. 187).

### **A corrective experience in an individual session using support and imagination.**

Up until this point, I had understood SE to be mostly exposure therapy integrated with a strong focus on the body (or felt sense). While SIBAM contains the concept of working with image, my understanding was that keeping the work based in images from real events produces better results. However, Giarretto put forward that re-enacting certain images and events may not always be the most helpful intervention.

One form of corrective experience is the words used by the therapist, guiding the client to imagine a different experience than the traumatic experience, in a felt sense way. I had the opportunity to work individually with SEP and midwife, Smith. She was the first therapist I told my birth story to – the first person who held a space for me to grieve and experience my feelings around what had happened, and I expressed a lot of pent-up emotion and overwhelm. What I remember most from our session was that she validated my experience that the midwife who was attending to me was not helpful. She proposed a scenario suggesting what she would have done had she been at my birth, “I would ask your midwife to leave to take a nap, and I would suggest we try a few things. I would make a plan with you. I would try to give you the road map and guidance that you felt were missing” (C. Smith, personal communications, June 4, 2016). She got me to imagine her at the birth, helping me, and to take in, in my body, how that felt different from what I had actually experienced. She told me techniques she would have used. She told me to imagine that we had found out the baby had turned much earlier. She told me to imagine that I had never been sent home, but had stayed at the birth house to rest. I felt a sense of calm and gratitude flood over me. Having her acknowledge that how my midwife had worked with me did not serve me well and that she was not attuned to my needs gave me permission to experience the anger and pain that my midwife’s miss-attunement had caused me. I had repressed these feelings because up until the birth I had really liked my midwife, trusted her, and I didn’t want to be angry with her or feel disillusionment with midwifery in general or the birth house. However, imagining and integrating a felt sense of how the birth could have been better, with a different midwife, gave me a sense of peace, and made the whole idea of birth less terrifying.

### **Anxiety Returns: Trauma Symptoms**

While I don’t have data of this time, per se, my recollection of it is vivid and it seems like an important part of my process to note. In late August of 2016, our family began to integrate my

daughter into daycare. She was clearly not happy with this transition, and I was feeling extremely guilty for thrusting it upon her. In retrospect, I believe we could have done a gentler and more gradual transition. However, family obligations requiring travel and the beginning of a new semester made the schedule seemingly impossible to work out differently. For the first time since before the birth, I was back to a demanding schedule of practicum and class, while my husband was back to work full time. A few weeks in, my anxiety began to spike to levels similar to the summer before. My symptoms included insomnia and irritability, and when I took the time to tune into my body, it felt like what I was experiencing was a re-emergence of trauma related to the birth. I knew I needed to deal with my birth experience directly, in depth, and with help. I had put it off too long and was suffering. It felt like I was bursting to tell my story and process what had happened with some qualified support.

### **Seeking a Therapist**

The search for a therapist was more challenging than anticipated and I have pages of detailed notes from this search. A colleague pointed out, “Lindsay, you are essentially looking for yourself”. I couldn’t find any drama therapists who are also Somatic Experiencing Practitioners who weren’t my professors. I considered 13 different therapists over two months – emailing with them, talking on the phone, and trying a first session that didn’t feel quite right.

My criteria for working with someone were specific:

- I needed a creative arts therapist willing to work with some Narradrama techniques. After some thought and speaking with a SEP, I realized that I needed a creative arts therapist, preferably a drama therapist, to help guide the Narradrama process. Because my degree is in the creative arts, this felt like a better fit for my research. For the sake of the therapy, I did not want to be teaching a SEP how to do Narradrama. Since I am a SEP, I decided that I would keep my awareness attuned to the elements that were part of my research question, and that I could consult with an SEP outside of the creative arts therapy sessions. I opened my criteria up to creative arts therapist over a drama therapist, because of the small pool of drama therapists in Montreal, and the dual roles I had with most of the ones that met the rest of my criteria.
- I needed a creative arts therapist with respect for the somatic; ideally someone familiar with Somatic Experiencing, and bonus points if they were familiar with

the concepts of "pendulation" and "coupling dynamics". Somatic Experiencing is fairly new in Montreal. At the time of my search, only one cohort had finished the three-year training program.

- I wanted to work with a woman who has either given birth, or who has attended many births. This clearly limited my options of people to work with. Ideally, I was looking for a woman who had experienced vaginal birth. It was important to me to work with a person who understood the physical/non-verbal qualities of birth.
- I needed a therapist that I won't come into contact socially or professionally, or cause problematic dual roles. This became a big challenge and felt like it limited my search. My supervisor advised me to think about the drama therapy and creative arts community in Montreal as though we live in a small town. She suggested that dual roles may be unavoidable, and that it might be possible to address this within the therapy to find a way to work together, if I found someone I wanted to work with who met the rest of the criteria.
- I needed a therapist who is more experienced than I am. I wanted to feel held in my process, and not like I needed to hold the process by myself. I wanted someone who could challenge me when necessary. I wanted to learn from them.

I ended up working with S, who met the criteria well enough. She is an art therapist who is also a Kundalini yoga instructor. She has a profound respect for the somatic, and is familiar with Somatic Experiencing. She has given birth, twice. There are some dual roles (she is good friends with one of my professors, and she regularly attends a local drama therapy event that I have been to once), but we were able to negotiate a comfort level for the work. We agreed upon working together for this project and reassessing afterward if we would shift into a regular therapist-client relationship – a shift that has not happened. Finally, S has a greater depth of experience as a therapist than I do. Perhaps most importantly, I felt drawn to her. She showed a temperament and presence that was soft and supportive, and gave me space for my own process to unfold rather than directing it. In hindsight, I see S's involvement in the drama therapy community as an asset for our work together as she displayed a comfort with embodiment and role, and incorporated the Narradrama approach with grace. To my knowledge, she was the best possible collaborator for the task at hand.

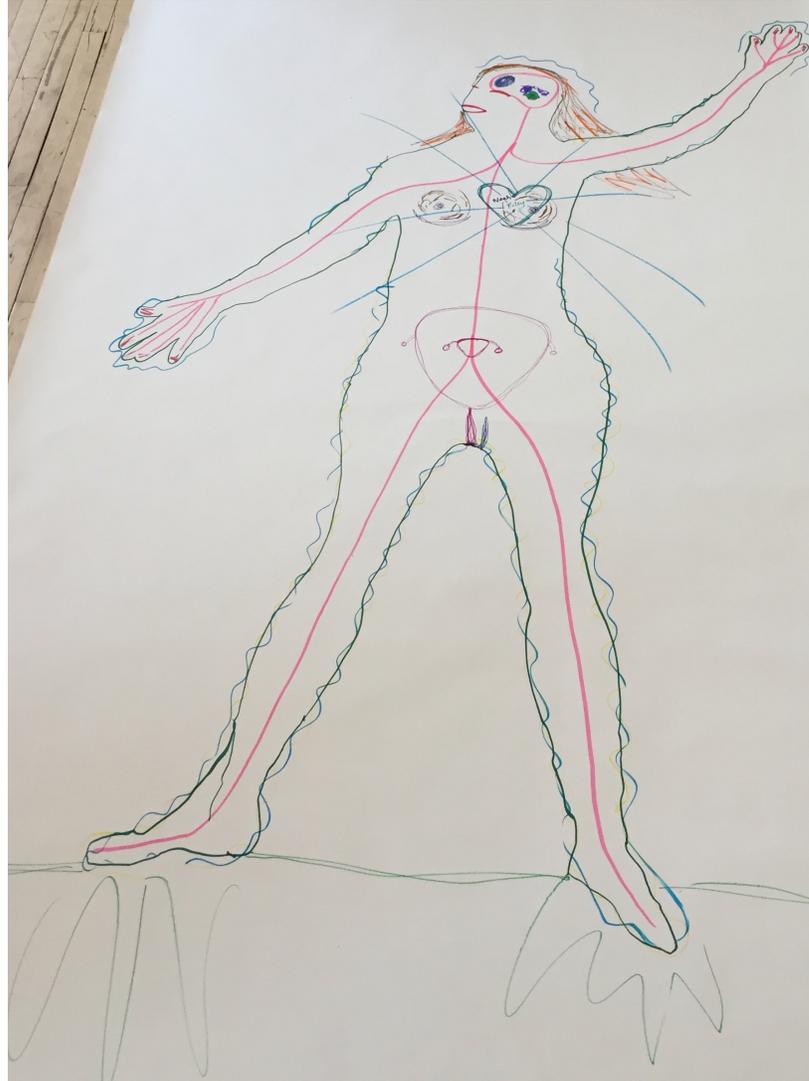
## **Narradrama in Therapy**

I met with S, over 9 sessions, from November 3, 2016, through January 5, 2017. Most sessions were 90 minutes long. We agreed to use Dunne's (2006) "The Eight Step Process" (p. 39) as a guideline for our work, while paying attention to coupling dynamics and pendulation from SE. In practice, we did not always follow the Narradrama steps in chronological order, and some steps needed modification to work within a trauma frame.

Below, I summarize each session based on journal entries, along with photographs of work created, photographs from the birth that were reviewed, and my memory of the sessions. I also outline interventions used or modified.

The first session included telling my birth story, and the impact that the birth and postpartum period has had on my mental health since. The story was difficult to tell, and I felt like I was rushing through moments that were overwhelming, and inhibiting my emotional reaction in order to get the entire story out. Telling the birth story verbally was not helpful, and felt too under-distanced. In the session, I had an idea to create an externalized timeline for the birth and surrounding events, and link it to SE's T-Model, so that I could process each moment more slowly. I decided to retrieve the birth records from the hospital and birthing house in order to aid in the timeline.

In the second session, we began the Narradrama process with "Step One: Warming up to New Descriptions of Self Identity and Environment" (Dunne, 2006, p. 39). I chose to do a "body drawing" (Dunne, 2006, p. 41), focusing on my perception of my current body (see Figure 3). S traced my body on a large piece of paper, and I drew in the centre of it and around it. The creative process of drawing allowed a sense of safety in the space and with the therapist. As I drew, I followed my own rhythm, shifting between focus on the art making, and inclusion of the therapist and processing. I had thought that I would want to do a second drawing centered on what I would like my body to become (as suggested in the intervention), but in the moment I was happy with one drawing of what I am. I didn't want to be something else, I just wanted more ease with what I already was.



*Figure 3.* Restorative body drawing. November 10, 2016.

At the third session, I arrived agitated. We worked with the sand tray, as in “Step Two: Externalizing the Problem” (Dunne, 2006, p. 43; Figure 4). Choosing the figures and setting them up allowed me the control to set the pace and decide how much I wanted to verbalize – negotiating my own aesthetic distance. Externalizing and deconstructing my cycling anxious thoughts helped me better understand them, and gave me a sense that my worries are manageable. In the middle of the tray was the ghost of the birth trauma (represented by a white alligator), faced by my desire and faith that I will overcome the effects of the trauma (represented by a unicorn; Figure 5).



*Figure 4.* (Left). Sand tray from session three. November 17, 2016.



*Figure 5.* (Right). Detail of sand tray from session three. November 17, 2016.

In the fourth session, we continued with “Step Two: Externalizing the Problem” (Dunne, 2006, p. 43), focusing directly on my birth story through drawing. I began the visual timeline that I had wanted to create after the first session (Figures 6 and 7), a 15ft x 15in scroll of paper using pencil, pastels, and markers. Combining the T-model concept from SE with the idea of externalizing the problem from Narradrama, I took the long scroll of paper and lay it out on the floor and wrote in pencil Giaretto’s proposed birth timeline of preconception, conception, birth, and first year of life. Then, in the space of birth, I used oil pastels to represent my general experience of the birth. I used different colours to represent negative and positive emotions I felt about the birth, deconstructing my experience into externalized parts. I was able to vary my pace, and work quickly and forcefully with the pastels to help express emotion. As I worked I remembered more details about the birth, and added them in representation on the page and through my quality of movement. I came to a stunning realization – I was so scared during the birth because I thought I was going to die. I knew that this is a factor for developing PTSD (APA, 2013d). I felt like I had found a ‘why’ to my personal wondering of why the birth was so

difficult for me to get over. At the end of my session, I stood back to look at the timeline. I hated the aesthetic of what I had created and barely wanted to look at it. It was a huge black, ugly blob. I had wanted to create an intricate image of the birth story, depicting all of the details and feelings describing the journey. In hindsight, the image was a perfect metaphor for my overall experience. The trauma of being afraid I was going to die had overtaken my ability to articulate or appreciate the details. Fear of death was so huge that it had taken over the rest of my experience – like the big black blob that is was – but it took me a few more sessions to appreciate this fully. In the creative act of externalizing and deconstructing the problem story, I stumbled upon new information, touching on elements of restorying – a significant part of Step Seven.



*Figure 6.* (Left). Birth story timeline drawing from session four. November 24, 2016.

*Figure 7.* (Right). Detail of birth story timeline drawing from session four. November 24, 2016.

The fifth session used modified versions of both “Step Four: Externalizing Choices” (Dunne, 2006, p. 51), and Step Six “Alternative Stories and Unique Outcomes” (Dunne, 2006, p. 55). However, rather than exploring these “what ifs” through a strictly Narradrama exercise, I listed all of the “what ifs” that were nagging at me through discussion – exploring alternate choices and stories that could have happened during the birth. Then, I ended up doing a blend of SE sensation tracking with free-movement that looked somewhat like a “living sculpture” (p. 29). I acknowledged all the ways that the birth could have been better, different, or worse, and how those differences might affect me in the present. In my earlier SE session with Smith, I got to experience, in a felt sense way, what it might have been like to live some of those experiences,

and the memory of that session was strong in this one. Most importantly, after exploring the “what ifs”, I could sit more easily with “what is” without denying or suppressing my emotions. While it was uncomfortable, it wasn’t as uncomfortable as I had feared it would be. There was a sense of wholeness as I acknowledged the narrative of what had happened during the birth, along with the invisible narratives of what didn’t happen.

My therapist guided me to take the time to sit with the emotions that I was feeling after exploring these different choices and outcomes from the birth. A flow of emotions went through me. I identified: Denial – that it went wrong and I am not well; then anger – at the midwife and “the system” for not supporting or preparing me enough; then fear – for my own life; followed by grief – for the loss of the ideal birth I had planned for; and finally, shame – for not adjusting better to everything that had transpired.

We continued to shift away from verbal processing and the Narradrama frame as I began to track sensation in my body in more of an SE exploration. I made this shift for two reasons: First, to enter a more embodied experience as we had spent the session to this point in a verbal dialogue and I had a strong desire to move, and second, because at this point in my process I was still committed to specifically exploring pendulation and coupling dynamics and wanted to bring those concepts more directly into the Narradrama space. It wasn’t until later that I understood that these concepts can be used to view any intervention, including those in Narradrama. In retrospect, interventions like “Possibility Map” (p. 53) and “Journey Map” (p. 53), or a “unique outcome scene” (p. 55) could have been modified to work with the past, and could have been helpful and more embodied than discussion.

Nevertheless, I will continue to report what happened during the session. Two big physical movements followed. One was a strong push through my upper back and arms, with the feeling of saying “no” combined with a collapse in my spine, reminiscent of depression. This transformed into a kneeling position in which I held my arms tenderly and slowly rocked back and forth, sometimes touching my forehead to the ground. The movement continued until it reached a natural completion. I later called the movement sequence “a prayer for integration” (see Figure 8, a sketch from my notes after the session). I was left with a feeling of hope that I could and would be able to heal and move on from what had happened, and live my life in a more present way.

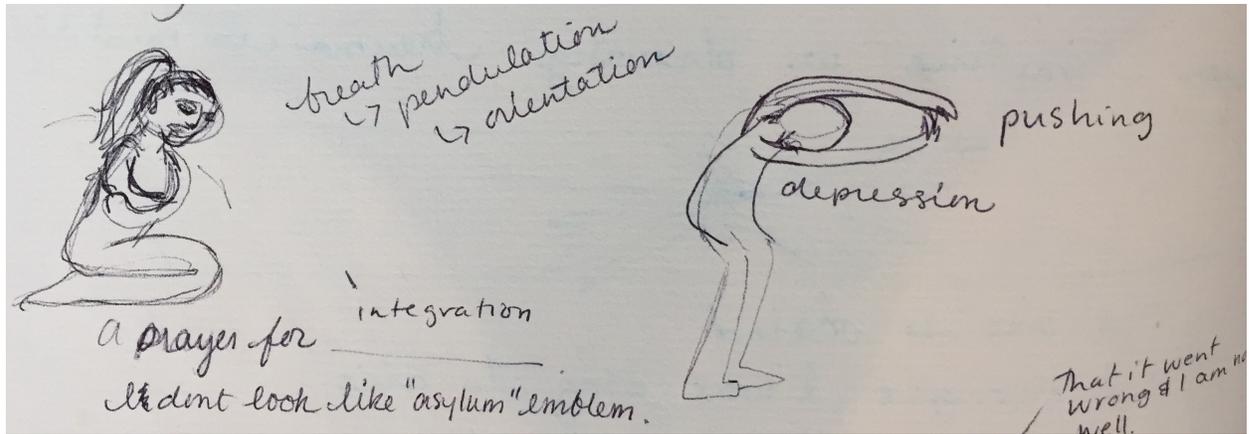


Figure 8. Sketches of movement sequences from session five. December 1, 2016.

This process was an authentic and fully embodied movement sequence that contained a lot of repetition. I worked within an aesthetic distance that allowed for an internal experience of change, edging towards under-distance, but not quite getting there. The embodiment and movement sequence evoked an image of an archetype or role of depression that transformed into one of prayer. Both archetypes/roles felt personal and universal; both felt meaningful. All the while, S held the role of audience and witness to my vulnerable and physical expression, allowing me to feel both seen and safe. Rather than deconstructing and externalizing the birth story as the problem story, this movement sequence deconstructed and externalized my current relationship to the birth experience as the problem story. Rather than working with the past, I was working in the present.

Between the fifth and sixth sessions I reviewed all of the photographs from the birth with the hope that they would help my memory. This could be seen as a form of externalization (with objects), because I was looking for evidence that the birth experience was the problem, rather than who I am a person as the problem. I needed so see something outside of myself. It was also an attempt at restorying – I had avoided looking at these photos for over a year, and it felt like a way of looking through external evidence for the birth story, with the best outcome being that there was a narrative available in the photographs that wasn't part of my problem saturated story. Most of the photos were taken while at the hospital, just as the pushing began, and right after the baby was born. My favorite is one that I took from the bed during the early pushing process. It shows my husband, the nurse, the resident doctor, my mother, the attending doctor, the head midwife, and my right big toe in the bottom corner. They are all looking at me with big smiles;

my mother and husband wear a look of weary endurance and love. I was surprised by how joyful it was to look through the photos. I had anticipated a potentially painful reliving of the experience. My problem saturated story had been challenged and an alternate story was emerging. My biggest surprise was when I saw how much weight I had gained around my face from water retention – something that I hadn't realized at the time. I laughed at my own ignorance and vanity. I thought that if that was my biggest surprise from looking at the photographs, maybe I had processed more of the birth than I thought I had. That said, the photos were of a happier and more integrated part of the birth. Regardless, I had found an alternate narrative – not all of the birth was traumatic. In fact, parts of it were immensely joyful and sometimes funny.

I brought the medical records that I had requested from the birth centre and the hospital to the sixth session, thinking that I could include some events to the externalized timeline – a continuation of “Step Two: Externalizing the Problem” (Dunne, 2006, p. 43). The envelopes carried a certain emotional “charge” and I was nervous about what they contained. It was a big relief to know that my perception of events was not so different from what was documented. I had worried that reading the documents would be overwhelming, but in fact it was more of a cognitive experience. I was thankful to go over them with the therapist in a safe space where I could experience any reaction I needed to have, and not in my own home where I had lived the experience and not processed it well.

The session ended by touching on “Step Seven: Restory Life Scene” (p. 56), as I developed new insights into the problem story. The therapist invited a creative expression of the experience of reviewing the documents and I decided to add to my birth story timeline. Again, combining SE theory with Narradrama's “Step Two: Externalizing the Problem” (p. 43), I immediately remembered the emphasis SE theory places on the client knowing when they are OK in their timeline (i.e. T +2). Translating that to the Narradrama frame, I took the action to draw my own T +2 moment. This action of drawing continued the deconstruction process of understanding what had happened during the birth and the reconstruction process of including alternate narratives and unique outcomes in the restorying. I drew a vertical line delineating that the birth was over at the end of the birth section. I wrote “I am no longer giving birth”, “I am no longer in labour”, “the baby is here”, and “the birth is over”. I sketched a picture on the other side of the line – a quiet moment in the recovery room with my husband, baby, and mother – it

was the closest moment I had to knowing I was OK. I then drew another long line, extending from the black trauma blob representing the birth all the way to the space representing the present moment to show how the trauma has stayed with me until now (Figures 9 and 10). The therapist invited me to stand back and look at my work. In my journal I wrote, *It showed so clearly how my fear from the birth has been living with me ever since* (personal communication, December 9, 2016). The line extending from the birth didn't overwhelm the space, but was undeniably present. In that moment, I gained a new understanding that I was truly OK, and that the birth was over. My externalization of the problem story was restored to reflect change in perspective and traumatic growth.

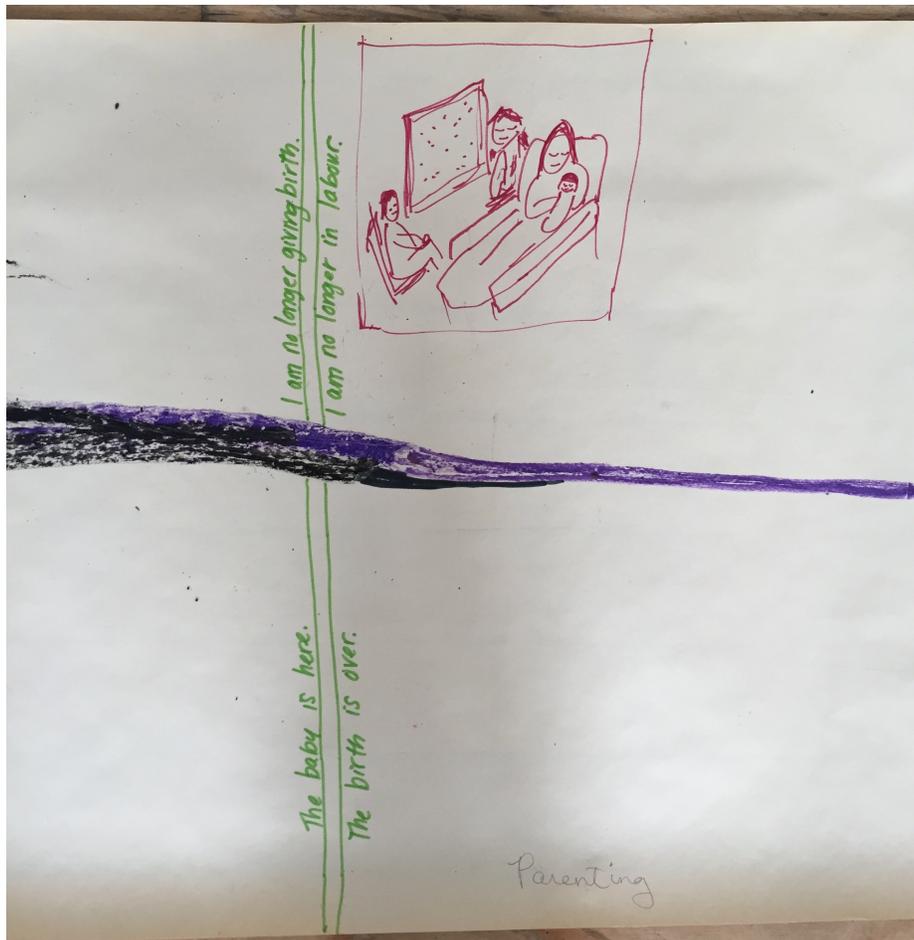


Figure 9. Detail of birth story timeline drawing additions from session six. December 9, 2016.

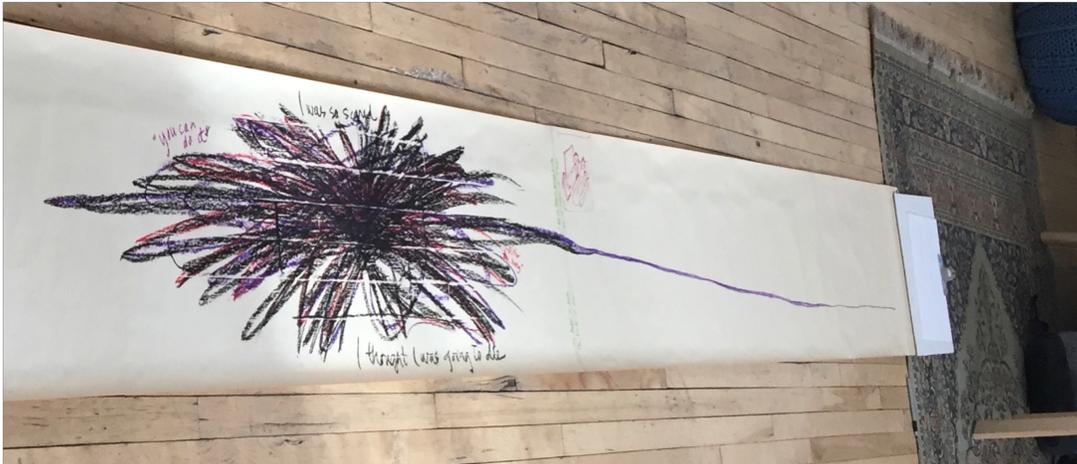


Figure 10. Birth story timeline drawing additions from session six. December 9, 2016.

The seventh session modified “Step Four: Externalizing Choices” (p. 51) as we spent the time mostly in discussion around themes regarding time, parenting, and choice. Notably, these choices were focused on the present, rather than imaginings around what could have been done in the past. My main takeaway was the idea that, as I wrote in my journal, *There is no going back* (personal communication, December 15, 2016). I don’t totally agree with this statement – in many ways the entire therapy process has been about going back (deconstruction), in order to move forward (reconstruction). What I believe I meant by this statement is that it is not actually possible to take an action – outside of the imaginative realm – about the past. Therefore, what actions can I actually take? In the present moment, I can make choices and take actions about what is important to me – how I want to parent and how I want to live my life. That said, I don’t think it would be possible to take this viewpoint unless some of the restorying process had not begun, and I was not on my way to finding peace with the events and experiences of the birth.

Reflecting on this session, it was as if I was stepping more fully into my role as mother (and away from the role of the maiden), which echoes drama therapy’s take on role expansion (Dunne, 2006; Landy, 1991), as well as England’s (2017) birth story gates. Interestingly, England discusses the moment when a woman feels like she is going to die during childbirth as a metaphor for the death of her role as a maiden, and the moment she realizes she will live as a metaphor for the birth of her role as a mother. Metaphorically, I believe I got partially stuck during the death of my maiden role. It was from this discussion that I made the choice to postpone finishing this paper in order to be a more fully present parent.



naïve, excited, and cheering as we felt ready to meet our baby – this was our attitude before going into labour, and in the first few hours when things were still fun. The second scene was at the birth house (Figure 13) – although I was there before and after being sent home, I only depicted it once in this sand tray. I am represented by an axe-wielding warrior, who is screaming and angry. I imagined it being the moment when I decided to leave the birth house and go to the hospital – a moment of empowerment and rage. My husband is a protective gorilla, my mother is a kind and loyal sheep, and the midwife is represented both as a rat and a playmobile girl scout. The third scene represents when we went home (Figure 14). There is a small house, a bathtub, and pylons and an askew fence to represent that there was something wrong. A large hand is emerging from the sand nearby, representing that I needed help during the second and third scenes. The fourth scene represents being at the hospital (Figure 15), a time when I felt I was receiving the help that I needed and had a sense of being in more control of my experience. I am represented by a cat who is lying on her back as though she is giving birth. Around the cat are characters that represent the people in the photo that I took during the beginning of the pushing phase. The fifth scene is in the recovery room (Figure 16). A gorilla mother holds her infant and looks into its’ eyes, while a gorilla father looks on. There is also a small human baby in a crib next to the bed that the gorillas are on, to help represent the space of the room and a more human quality. Finally, in one corner, there is a unicorn with its’ wings spread wide (Figure 17). With lines in the sand, I connected the unicorn to each scene. The unicorn represents a connection to faith that I will be able to live through and overcome whatever challenges are in front of me.



Figure 12. *Detail 1 of sand tray of the birth story from session eight. December 27, 2016.*



*Figure 13.* Detail 2 of sand tray of the birth story from session eight. December 27, 2016.



*Figure 14.* Detail 3 of sand tray of the birth story from session eight. December 27, 2016.



*Figure 15.* Detail 4 of sand tray of the birth story from session eight. December 27, 2016.



*Figure 16.* Detail 5 of sand tray of the birth story from session eight. December 27, 2016.



*Figure 17.* Detail 6 of sand tray of the birth story from session eight. December 27, 2016.

It was a relief to finally get the whole story out. The aesthetic distance was perfect for me. I really liked not having to speak, but rather used figures and spacial relationships to represent how I felt. While I talked a bit about what I was creating during the process, there was no pressure to, and I could work at my own pace. With some distance, and reviewing the photographs of the sand tray, I am pleased with how they represent the birth. I take a lot of joy in the humour that underlies some of the characters, images, and choices that I made.

The ninth session was based on “Step Eight: Closure, Reflection, and Rituals” (p. 58), and, in reflecting on the therapy process, I again touched on “Step Seven: Restory Life Scene” (p. 56). We reviewed all of the work we had done, adding some finishing touches to some art work. I had a chance to hang the restorative body drawing on the wall and explore an embodied dialogue with it. After reflecting on the entire process, I was able to identify a new experience of knowing that the birth was over. I added a final drawing to my birth story timeline, marking a new line that symbolized the end of the trauma seeping through to the present (Figure 18). I then sketched myself, my husband, and daughter holding hands, representing us being present and

moving forward together. There was a sense of closure in that I felt done with exploring the birth itself. I was now curious about the present moment, themes around parenting and partnership, and how to take action to resolve physical postpartum symptoms.



Figure 18. Detail 7 of birth story timeline drawing from session nine. January 5, 2017.

### **The eight steps in chronological order.**

To summarize this section, I will review my process with Narradrama by presenting the Narradrama Steps in chronological order. Step One is “Warming up to New Descriptions of Self Identity and Environment” (p. 39.), and I chose the intervention of a “restorative body drawing” (p. 40) in the second session. I also revisited this drawing during the review in the ninth session, and entered deeper into the intervention with an embodied dialogue, revisiting my identity at the

end or the process. Step Two is “Externalizing the Problem” (p. 43). In the third session, I slightly modified the intervention “Sandplay Problem” (p.45) and created a scene of my life at the moment, with the birth trauma in the centre of it. In the fourth session, I looked more directly at the problem story by modifying the intervention “Problem Drawings” (p. 44) and creating a timeline drawing of the birth experience. Between the fifth and sixth sessions, I reviewed all of the photographs from the birth, focusing on the experience of the birth being the problem rather than myself as a person. In the sixth session, we reviewed the medical records of the birth and then I added to the timeline drawing - this addition is a bit of a hybrid with Step Seven. I didn’t seem to encounter “Step Three: Possibility Extension” (p. 45). This step works with the imaginal realm of desired life experiences, and I believe that I was too interested in processing the past trauma experience and was not yet interested in future experiences other than gaining new understanding around the birth. Or perhaps my vision of a future that was not affected by the traumatic childbirth was already very clear to me. “Step Four: Externalizing Choices” (p. 51) was modified to look at past choices I could have made during the birth, and done through discussion in the fifth session. It was also modified to be used in discussion about present choice making in session seven. I did not feel that a specific intervention around “Step Five: Invite Personal Agency” (p. 54) was necessary in my process. However, it was important to highlight moments of personal agency during the birth story, and give importance to experiences of personal agency during sessions as they arose, or as I looked to the future. Personal agency was particularly important in the eighth session during the restorying of the birth. “Step Six: Alternative Stories and Unique Outcomes” (p. 55), was modified, like Step Four, to look at different ways the birth story could have gone, and done via discussion in the fifth session. Small parts of alternative stories were found in looking at the birth photos, and in developing the birth story timeline, which contributed to restorying. “Step Seven: Restory Life Scene” (p. 56) was particularly touched upon in the sixth and ninth sessions, as I made new discoveries around the birth story, and externalized these discoveries in the birth story timeline. As mentioned above, these instances were a bit of a hybrid with Step Two, and also Step Six. Not following a specific intervention from Step Seven (although harkening back to an intervention from Step Two), I decided to come back to the sand tray in the eighth session in order to reconstruct the full birth story, integrating new insights and alternate stories around my birth experience from previous sessions. “Step Eight: Closure, Reflection, and Rituals” (p. 58) occurred in the ninth and last

session, where I was able to review and reflect upon the work that we had done during the entire process. Unfortunately, there wasn't time to choose a specific ritual intervention. However, there was a sense of closure and desire to move forward and away from the birth story to the present moment.

## **Chapter 6. Discussion**

### **Reviewing the Research Question**

After living with the original research question for some time, I realized it didn't reflect what I wanted to explore. The original research question was: How can a heuristic inquiry into combining Narradrama from drama therapy with coupling dynamics and pendulation from Somatic Experiencing help in exploring the challenges in my own process of resolving traumatic childbirth and add to my clinical understanding around this issue? The problem with the question is that it proposes looking at a system of interventions (Narradrama) through conceptual lenses that belong to SE (coupling dynamics and pendulation). While there isn't anything inherently wrong with that, I was more interested in looking at interventions and concepts from both modalities, with the potential to combine them, if appropriate. What I ended up doing in the research was looking at what parts of the interventions and the theories that worked and didn't work in my personal process regarding traumatic childbirth. I realized that, because they are a conceptual theory, coupling dynamics and pendulation are always in play during a therapeutic process that works with trauma, no matter what the intervention is; elements of SIMAB and nervous system pendulation are inherently part of trauma resolution, as viewed through an SE lens. What I really set out to find from the world of SE, and Narradrama, was what concepts and interventions are most helpful in relationship to traumatic childbirth, and how might they be complimentary or counter indicated. To review, my final research question was: What is the experience of combining aspects of Narradrama and Somatic Experiencing, focusing on traumatic childbirth, and how that can add to my clinical understanding around this issue?

### **Outcomes**

Based on my heuristic inquiry with Narradrama and SE, I will summarize the outcomes through a theoretical standpoint of what worked well and what didn't. The most beneficial aspects from the Narradrama process in working with traumatic childbirth during this research were: The use of externalization, the use of different art modalities, the option to work non-verbally, and the open choice of the plethora of interventions. The main challenge with the Eight Step frame was the lack of trauma informed approach with respect to past, present, and future, particularly in relationship to the interventions. The framework generally approaches the problem story as something that can be changed or fixed with solutions and actions in the present, rather than first focusing on accepting and integrating events around the traumatic

experience. Externalizing the problem story by being able to look at the traumatic childbirth outside of physiological and verbal experiences through art media, can be extremely helpful in understanding what happened during a traumatic childbirth. Because the client is working with something that has happened in the past that they have not been able to integrate and move forward with in a way that is tolerable or satisfying to them, the externalization could be where most of the work on acceptance and restorying will happen, and might be where most of the time is spent in therapy. An externalization of a traumatic childbirth can slow down or create a freeze frame of the event(s), people, and locations involved, giving the time needed to process what happened. Externalization creates room to play with metaphor and scale to allow for representation of the emotional experience around the events. The externalization can change over time, as a client makes discoveries and adds to or detracts from the narrative, creating documentation of the client's progress in therapy. The externalization can serve as a reminder to the client of new thoughts, discoveries, and narratives. It is an extremely powerful tool that allows for aesthetic distance, especially due to the physical nature of traumatic childbirth that may bring about dissociation. As a result, a client may not be able or ready to process their experience in their body strictly via the felt sense, but may be able to later, after having externalized their trauma narrative. On a similar note, the use of different art modalities (various forms of visual art, sand tray, improvised scenes and monologues, movement, poetry, etc.) is another strength of Narradrama in this research. Choice is important when working with traumatic childbirth because "terrifying loss of control" (Beck, 2015, p. 4) is reported as one of its' contributing factors. The different art modalities also allow control around aesthetic distance, as some art modalities offer more distance (e.g. sand tray objects), while others offer less (e.g. pastels). In addition, the modalities themselves offer different experiences, which offer different insights and perspectives into whatever topic is being explored. For example, drawing the timeline of the birth story is a different experience to creating a sand tray of the birth story, and both offer valuable and differing perspectives and insights. Dunne (2006) writes, "expressive activity in one of the arts stimulates and nurtures expressive activity in the other" (p. 25). Using different art modalities also offers a number of ways to work non-verbally. When it comes to trauma, working verbally can be overwhelming and too under-distanced, or it can create disconnection from affect and be too over-distanced. It is also possible that working non-verbally may be particularly helpful in working with traumatic childbirth because there is so much of the

birth experience that is non-verbal and that lives in the implicit and intuitive realm. There may be physical experiences from childbirth that need expressing that are difficult for the client to find (or may not have a vocabulary for), but can be expressed through an art modality. Seeing an externalization of the experience may then allow for words and cognitive comprehension to come after creation, leading to integration and moving forward. Finally, the plethora of interventions to choose from allows the therapeutic process to follow its own organic course. Straying from the Narradrama specific interventions, as was done in this research, may occur, but it is possible to maintain the spirit of the steps and process when exploring outside the proposed chronology. Each step has a guiding framework that can be modified relatively easily. Having the freedom to choose what to do when, allows for natural modifications that honours the individual process and narrative of the client. Dunne (2006) writes, the “therapist/facilitator... collaboratively interacts with an individual or a group of participants, instead of acting in a privileged, authoritative position” (p. 23). While Dunne does not state this explicitly, the spirit of Narradrama seems to imply that if a specific intervention does not work for the client, it is appropriate to modify it to meet the client’s needs, as long as the heart of the step is at the core of the modified intervention.

Straying from the Eight Steps and modifying the Narradrama interventions when working with traumatic childbirth may occur because Narradrama is not specifically designed for trauma narratives. It seems that, as proposed in the Eight Steps, the problem story is about the symptoms of trauma and how they currently manifest (e.g. anxiety), rather than the story of the traumatic childbirth that caused the symptoms. Perhaps it could be both. However, the interventions that are proposed do not necessarily acknowledge this difference. A traumatic childbirth is not a problem story that can be retroactively fixed through choices and action in the present. However, the client can restory their experience. They can gain new perspective, integrate moments of empowerment, gain acceptance, and discover ways to move forward. It is possible to restory the narrative to include threads around resilience, strength, help, relinquishing or accepting guilt and responsibility where appropriate, validating emotional reactions, and gaining new insights around events.

Below I will look more specifically at what modification can be made to certain steps. During “Step Two: Externalizing the Problem” (p. 43), it could be helpful to determine if the problem saturated story is the traumatic birth story or the current symptoms from the trauma, or

if there are two problem saturated stories. It could also be helpful to look at how they relate to each other. Perhaps, like me, some clients may not be interested in “Step Three: Possibility Extension” (p. 45) at the beginning of their work because they already have a clear vision that in the future they want to be free of trauma symptoms, or perhaps they are not ready to look to the future before processing the past. Others may find this step helpful as a way to motivate them to confront the difficulty that sometimes arises in therapy, or may want to return to this step after feeling more at peace from restorying the traumatic childbirth. Related to what is discussed above, how “Step Four: Externalizing Choices” (p. 51) is presented in the Eight Steps, is problematic in its’ focus on present events. The client who is seeking help after a traumatic childbirth usually comes to therapy because they are feeling stuck around what happened in the past. The interventions proposed in Step Four may seem frustrating to the client because they are geared toward solving a current problem (e.g. anxiety). From a trauma informed perspective, this means looking at symptoms of the problem (e.g. anxiety) rather than the root (e.g. the trauma). If the current problem is that the client is suffering with symptoms of PTSD, the current externalized choices may be as simple as to deal with the trauma or not deal with the trauma (or to deal with individual symptoms rather than the root of the symptoms). Some clients may be satisfied with this. Of course, making choices around current problems like anxiety can be helpful, but my point is that if the root of the anxiety stems from the traumatic childbirth, the Eight Steps does not specifically frame “Externalizing Choices” (p. 51) as something a client can do about events in the past. Fortunately, this step can be easily modified to explore how events may have gone differently during the birth. It could be very helpful to explore different choices that could have been made by the mother or others who attended the birth with the intention of better understanding what did happen, or the intention of experiencing a more healing childbirth. Exploring potential choices can create the opportunity to mourn the loss of a desired birth plan, or experience gratitude that the birth wasn’t worse. It could also be very beneficial to reenact a desired scenario for how the mother would have wanted the birth to go, so that she can experience what it might have been like to live it differently. However, ultimately, the desired outcome is that the client comes to accept what happened with new perspective, and to move forward in life. Perhaps after the client feels satisfied and has gained new acceptance and understanding around their birth narrative, they may then benefit from repeating Step Four, oriented to the present moment. “Step Five: Invite Personal Agency” (p. 54) can be applied as

indicated, but a client working with a traumatic childbirth would benefit, in particular, in identifying moments of personal agency within the childbirth narrative as well as the present moment. “Step Six: Alternative Stories and Unique Outcomes” (p. 55) can be slightly reframed to include looking at moments that did go well during the birth, as well as moments where the client has dealt with trauma symptoms well. Other modifications occur because Narradrama is often done in a group setting, and therefore many of the interventions need to be omitted or modified for an individual.

The SE components of the research that felt significantly helpful centered around the felt sense in relationship to support, imagination, and corrective experiences. Support is a particularly important component when working with traumatic childbirth because the trauma is often reported as being in relationship to a lack of support during the birth. In particular, a therapist can offer support both through the therapy process, and through a felt sense corrective experience of what better support might have felt like during the birth. The intervention of re-creating a felt sense experience of a supportive birth team is an example of offering support in a group therapy setting that was particularly helpful in this research. This intervention shares exciting central qualities with drama therapy – including “dramatic reality” (Pendzik (2012, p. 198), “projection” (Jones, 2007, p. 83), “embodiment” (Jones, 2007, p. 112), and “role” (Jones, 2007, p. 94; Landy, 1991). The use of the imagination in conjunction with the felt sense is another powerful tool for the nervous system to experience something new and helpful. Imagining what might have been, in a felt sense integrated way, allows the client to experience what they needed and didn’t receive, resulting in a new frame of reference both cognitively and neurologically. This is very similar to what I have proposed for the modification of Narradrama’s “Step Four: Externalizing Choices” (p. 51), except the experience happens in the imagination and felt sense realm rather than via an art medium. This research explored corrective experiences through imagined support at the time of the birth, and through the helping relationship with the therapist and the group. Corrective experiences may be helpful in validating what did not happen that was needed, thereby facilitating a grieving or emotional activation process, as well as knowledge for how to better prepare for future births, should they be desired.

The major challenge around the SE process is its focus on the felt sense. It can be difficult to keep awareness on the body and stay present, particularly when dissociation is being

renegotiated. A certain amount of familiarity and skill with the felt sense and embodiment could be necessary, or time may be needed to learn it.

The pairing of the externalization process from Narradrama with the felt sense process from SE is complementary. Moving back and forth between external and internal experiences creates another format for titration and aesthetic distance. In particular, externalizing the T-Model through visual art documents the narrative of the birth story while allowing for an unfolding experience of trauma processing. The externalized T-Model provides a concrete place to return to over several therapy sessions, allowing changes in narrative to be created in art form, alongside physiological and emotional changes which can sometimes feel fleeting and ephemeral.

There were many areas of theoretical overlap between Narradrama and/or drama therapy and SE. For example, both modalities generally follow open processes that are client centered, letting the client's experience lead the way toward interventions, with the potential to offer choice of interventions to the client. Another similarity is that both SE and Narradrama allow for non-verbal processing, giving space to elicit vivid recall through implicit and intuitive knowledge; Narradrama does this with its' use of different art modalities, while SE uses the felt sense. Both modalities seek to gain new insights around what has happened in the past and offer the client an opportunity to re-do an experience so that they live with its' memory in a more tolerable or satisfying way. While there are differences in these terms and how they are applied, Narradrama looks at restorying a narrative while SE looks at re-negotiating trauma. Similarly, SE's concept of titration and drama therapy's concept of aesthetic distance share core attributes: Both look to find the right amount of distance or space from intensity of experience in order for the client to process their experience in a way that is helpful and not harmful. Another area of overlap is the importance of and possibility for humour and pleasure; in drama therapy theory, humour is stated as a unique key to working with trauma through play, while in SE theory, pleasure is stated as a way to ensure the client is resourced enough to delve into trauma material and a key part of polyvagal theory. Both modalities try to ensure that the client is enjoying themselves, at least part of the time.

It is difficult to write about how Narradrama and SE don't work well together in this research, because they were only paired when it felt appropriate or inspired. Unfortunately, a full theoretical analysis of differences in the theories is beyond the scope of this paper. However, I

will highlight a few theoretical differences that were apparent from this research. One moment where the approaches conflicted was in the first session where, under a creative arts therapy lens, I was asked to share my full birth story – as I have mentioned, it was an overwhelming experience for me. An SE approach would request that a client slow down the story telling to process arousal as it arises, so that the client doesn't re-experience or reinforce the overwhelm associated with the story. In contrast, the creative arts therapy approach wanted the information of the story, despite overwhelm, in order to create a context for working. In general, the tracking of emotional arousal is different in the two modalities: SE is focused on the titrated release of emotional arousal and plays close attention to it, while the Eight Steps in Narradrama do not indicate what to do when a client is having an emotional experience. Drama therapy as a whole holds the concept of aesthetic distance, which works well with choosing an art form or intervention to work with, but doesn't provide the moment to moment guidance on emotional arousal that SE offers. Similarly, some drama therapists may look for an emotional catharsis, which, through an SE lens, would be considered a reinforcement of a pattern of overwhelm followed by collapse – something that is not desired. Rather than catharsis, SE theory proposes manageable emotional experience that can be fully integrated and leave the client with a sense of capacity (as opposed to the emptiness often associated with catharsis). On another note of contrast, theoretically speaking, an SE lens would encourage the externalization to eventually be transformed into a felt sense experience, so that the process ends up being embodied and experienced in a present way, through the nervous system. In contrast, a Narradrama lens might argue that the art creation in itself is enough, and the felt sense embodiment is not necessary because a similar experience takes place during art creation and subsequent analysis. In my experience with this research, I found both helpful – in the end, the felt sense experience informed the art making, and vice versa.

Outside of the above theoretical understandings, which can also be interpreted as clinical learnings, I believe my biggest clinical gain from doing this research is a sense of competency as I move forward with my clinical practice. In resolving my traumatic childbirth experience, I now feel capable and competent to hold a space for others to do so. I have always been drawn to supporting women's health, and working with clients who have experienced traumatic childbirth feels like something I would like to pursue. This research has also opened my awareness to the multiple complex issues around fertility in general, which has not only given me more empathy

and knowledge, but also a desire to research further in this field. Finally, I feel a gain in clinical competency with both drama therapy and SE, and a confidence in when and how to mix the two. In my future work, I imagine titrating between externalization and the felt sense, and between the drama therapy and SE, in order to help my clients find an aesthetic distance and renegotiation that feels good to them.

My process with this research has brought many personal insights and outcomes. Perhaps most significantly, I have experienced a general reduction in anxiety, with better moods, and minimal arousal when recalling the birth. I have also gained a capacity to share the part of my birth story that will help others, rather than a need to process it or show my wounds – England's (2017) ninth gate. This is particularly significant for professional reasons, as I now feel able to hold a therapeutic space for a client who has experienced traumatic childbirth. Another aspect worth noting is that at the end of this process, I have a restored desire to consider birthing another child with much less fear and a sensibility that I am better equipped and prepared for a future birth.

### **Future Research**

Working with an externalized, arts-based T-Model in the processing of traumatic birth stories would be an interesting intervention to further develop with a bigger population. It could also be interesting to look at other people's experiences of the felt sense integration of imagined support as part of a corrective experience around traumatic childbirth. I'm curious about what the differences would be between imagined support while seated and imagined support while enrolled within a group setting. Because Narradrama and SE are so open in form, it would be very challenging to design a study that respects their flexibility, and measure how a large group of people respond to these methods.

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It should be noted that, in this research, there was no exploration of self-protective motor programs in individual SE sessions – something that is usually associated with trauma resolution in SE. It could be interesting to explore how self-protective motor programs around childbirth may emerge and what creative expression might take place in conjunction with them.

### **Validity**

The widely studied and empirically tested forms for treating trauma exist in CBT and EMDR. Why create a different way of treating PTSD, ASD, AD, and trauma? Narradrama and SE offer a way of working with a trauma narrative that engages tacit knowledge, felt sense, and

artistic expression. It is not conventional, and it is not medicalized. If a person has had a medicalized birth with traumatic interventions, there might be fear around following a medicalized and conventional form of trauma treatment. There may be personal preferences for those who do not respond well to conventional methods and prefer a less verbal and more expressive form of processing. This form of combined therapy might also work well in conjunction with CBT and/or medication, allowing for a more creative and physical processing of the trauma material to compliment the traditional models.

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## **Implications**

This is a heuristic research project that explores the use of Narradrama and SE in working with traumatic childbirth. It outlines specific interventions that were helpful for me as I worked to resolve my experience of birth trauma. The interventions and theories proposed in this paper could be further researched to see if they are helpful for others. Since there haven't been any publications related to traumatic childbirth in the field of drama therapy to date, this research offers information about what issues may be at play. In particular, it shares the ways I modified Narradrama's Eight Steps in order to help process my birth story. This research is also one of the first to integrate drama therapy and SE, and offers theoretical suggestions, based on my experiences, regarding what parts of drama therapy and SE are and aren't compatible.

There are a large number of people in the world that suffer from the effects of traumatic childbirth. In some cases, it can affect attachment with the child. Normalizing and acknowledging traumatic childbirth will likely encourage new mothers and their communities to get the help they need. It is important for therapists to understand that there are particular elements to a birth story narrative that can cause trauma, and particular symptoms that can be caused by traumatic childbirth. Using a combination of Narradrama and SE gave me an opportunity to tell my birth story without having to re-enact it, use non-verbal processing and communication, and work with the same tacit knowledge and intuition that is called upon in birth. The externalization of my birth story helped titrate the physical processing of SE sensation tracking, and aided in slowing down and seeing important moments in my narrative. The externalized T-Model was a concrete symbol and working-document of processing the birth. By exploring alternate narratives of support, my nervous system experienced what it might have been like if I had been better supported during the birth. As a result, I have the knowledge of

what a supported birth could feel like in the future, and had the opportunity to grieve what did not occur.

This study shows that there are potentially alternative ways to treat and process traumatic childbirth. In reading this study, drama therapists might gain insight into some issues related to working with traumatic childbirth, and potential ideas on how to approach it with their clients. In reading this study, SEPs might gain insight into some specific issues around traumatic childbirth, and perhaps gain some ideas around externalization of the trauma story through arts-based media. This study was significant to me in that it was an impetus to integrate my birth story, resolve my trauma symptoms, and become comfortable working with women who have experienced traumatic childbirth. In working through my birth story, I believe that I am a better therapist. I also believe I am now a better mother, wife, friend, and daughter.

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## Chapter 7. Conclusion

“A connection has been made that will remain forever unbroken and that will serve as a reminder of a lifelong process of knowing and being” (Moustakas, 1990, p. 55-56).

In February 2015, I gave birth to my daughter. It was a long, painful “labour from hell” (England, 2017, p. 249), that left me traumatized. Coupled with significant breastfeeding issues, I believe I suffered from ASD and PTSD. The anxiety, insomnia, and avoidance that I experienced in the months to come, and specifically a panic attack that led to some SE style release, led me to question how SE might be paired with the telling of birth stories in order to process traumatic childbirth. I created a plan to investigate this curiosity, with a huge invested interest – my own mental health was at stake, as was my ability to work professionally with other women who have experienced traumatic childbirth. I also felt compelled to share my story, as I felt like traumatic childbirth was an under-discussed issue in preparing to give birth. Perhaps sharing my story could be helpful for someone else.

The literature reviewed includes trauma, traumatic childbirth, drama therapy and trauma, drama therapy and traumatic childbirth, Narradrama and trauma, birth stories, and Somatic Experiencing and trauma, the felt sense, Somatic Experiencing and traumatic childbirth, and corrective experiences. It seems that traumatic childbirth, as a subject and how to work with it, is under-represented (i.e. not represented) in the DSM-V, drama therapy, and Somatic Experiencing literature. While birth stories are part of popular birth culture, England’s (2017) *Birth Story Medicine* is the only found form of processing that addresses birth stories directly, as well as her *Birth Story Gates*, which serve as a helpful guide.

The methodology of this research was heuristic and served a double purpose of professional and personal gains and insights. The process followed Moustakas (1990) six-phases of initial engagement, immersion, incubation, illumination, explication, and creative synthesis. While I set out to answer one question, the nature of this inquiry led me to answer another. I was able to study with SEP trainers who are experts in the realm of birth, and do private sessions with them. I was also able to do a nine-session Narradrama process with an art therapist, and integrate parts of SE, notably an externalized arts-based T-model. I was also able to make contact with Pam England and discuss my process and her work. My creative synthesis is both this paper, and the new narrative of my birth story with elements from the therapy integrated.

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From the Narradrama process, my experience was that the use of externalization, the use of different art modalities, the option to work non-verbally, and the open choice of interventions were particularly helpful in working with traumatic childbirth. I found that the Eight Steps were challenging in working with a trauma story from the past, and needed modification. From the SE process, I found interventions related to the felt sense in relationship to support, imagination, and corrective experiences to be most helpful. However, the felt sense has a potential to be overwhelming, especially if unfamiliar or dissociation is part of the trauma experience. Narradrama and SE worked well together in an intervention that externalized the T-Model through the creative arts. It is possible that this intervention could be further developed in future studies. Due to the nature of this study, and although some theories are proposed, there wasn't a true opportunity to discover how Narradrama and SE do not complement each other. This research is heuristic, and cannot be generalizable. However, it offers specific insights and experience that may be helpful in informing practitioners, researchers, and survivors of traumatic childbirth.

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This research has changed my life. I have experienced myself break, and I have experienced my own resiliency coming back stronger and wiser than before. As a therapist, and as a mother, this seems like an important thing to know is possible and to be able to convey. My birth story transformed from one that signified trauma and horror, to one that has traumatic moments and beautiful moments. It is possible that this re-storying could change my relationship with my daughter, and potentially her relationship with herself. It could change how many children I have. I recognize that this is *my* story, and that others undergoing the same process may come to different conclusions. I am not trying to create a prescription for the masses. I feel like I understand what happened during my birth, and I am no longer afraid of it. That is invaluable to me. It is my hope that I may be able to help others through their own process of knowing what they need in order to be at peace with their own birth stories. In the words of Esther Gallagher, a doula and co-host of the podcast *Fourth Trimester*, “[n]o matter what, these things [i.e. what happens during birth] will be with us for the rest of our life. The question is how?” (Trott & Gallagher, 2017).

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