Sana Loue *Editor*

Expressive Therapies for Sexual Issues

A Social Work Perspective

Springer

Expressive Therapies for Sexual Issues

Sana Loue
Editor

Expressive Therapies for Sexual Issues

A Social Work Perspective

Springer

Editor
Sana Loue
Department of Epidemiology and Biostatistics
Case Western Reserve University
Cleveland, OH, USA

ISBN 978-1-4614-3980-6 ISBN 978-1-4614-3981-3 (eBook)
DOI 10.1007/978-1-4614-3981-3
Springer New York Heidelberg Dordrecht London

Library of Congress Control Number: 2012942185

Printed on acid-free paper

Springer is part of Springer Science+Business Media (www.springer.com)

Contents

About the Contributors

Mechelle Chestnut, MA, MT-BC, LCAT
Works with middle school-aged children in the Jersey City, NJ, public school system and children and adults with developmental traumas in private practice in New York City. She has worked in public and private hospitals, residential facilities, and community-based programs in and around New York City. She is a nationally board certified music therapist as well as a New York State licensed creative arts therapist. She cofounded MAR Passages, a music therapy conference for students and new professionals. Mechelle has presented locally, regionally, and nationally and has published music therapy articles and reviews. She performs her own compositions on vocals and viola in the New York metropolitan area. Mechelle studied music and psychology at Barnard College before pursuing the master's degree of music therapy at New York University, where she wrote her thesis Family Music Therapy: Family Work in Music Therapy from a Feminist Perspective. She also completed the Advanced Vocal Psychotherapy Training at the Music Psychotherapy Center of New York.

Haley Fox, PhD, REAT, ATR-BC, MT-BC
Is a registered expressive arts therapist (REAT), board-certified art therapist (ATR-BC) and music therapist (MT-BC), and licensed professional clinical counselor (LPCC) with a PhD in clinical psychology. She currently holds a position as the Clinical Director for the Minnesota Sex Offender Program, an intensive, residential treatment program for adults who have been civilly committed as sexually dangerous persons (SDP) or sexually psychopathic personalities (SPP). She has spearheaded arts-based programming with this population in Minnesota; the effort has been a springboard from earlier clinical work in community-based treatment programs for sexual abusers and corrections-based programming. Dr. Fox currently serves as one of three executive cochairs for the International Expressive Arts Therapy Association (IEATA).

Cynthia Blomquist Gustavson, MSW, ACSW, LCSW
Graduated from Boston University, earned a master's degree in social work from Louisiana State University, and did graduate work in theology at United Seminary of the Twin Cities and doctoral work in education at Oklahoma State University. An award-winning poet, psychotherapist, and leader in the field of poetry therapy, Gustavson is the author of *In-Versing Your Life* (2006), an acclaimed series of six poetry therapy guidebooks. Her latest publication is *Bully! The Big Book for Bullies and the Bullied* (Sept. 2011, *Blooming Twig Books*). She has won awards in recent years for her children's book *Ballad of the Rag Man* (2009) and her poetry collection *Please Use This for Children and Not for War and Guns* (2010). Her poetry and articles have been printed in magazines and journals, such as *The Christian Century*, *Sojourners, The Journal of Poetry Therapy*, and *Families in Society*. She has been an invited lecturer internationally and domestically, giving readings, workshops, and speaking on the use of poetry in therapy. She has taught graduate-level courses at Louisiana State University and Northeastern State University in Oklahoma, as well as lecturing at psychiatric grand rounds at the Oklahoma University School of Medicine. Gustavson has a private psychotherapy practice in Tulsa, OK, and is on the editorial board of *Nimrod International Literary Magazine.*

M. **Eve Hanan, MA, R-DMT**
Is a dance/movement therapist with a master's degree in creative arts therapy from Drexel University. Her master's thesis, *Embodying identity: A qualitative case study of dance/movement therapy for people transitioning genders*, is the first study of expressive movement and transgender embodiment. Through her training as a creative arts therapist, she has led group and individual therapy sessions that blend somatic and verbal techniques for people throughout the age spectrum in a variety of life circumstances and settings. Eve is also an attorney who practiced criminal law in the trial and appellate courts of Boston and Washington, DC, for 8 years. She currently facilitates restorative justice circle processes for youth and their communities in Baltimore, Maryland.

Meghan Hinman, MA, MT-BC, LCAT
Is a licensed creative arts therapist and board-certified music therapist with a private psychotherapy practice in New York City, specializing in trauma, sexuality, and the experience of terminal illness and grief. Meghan's undergraduate music therapy training from Duquesne University in Pittsburgh was grounded in existential phenomenology; she studied music therapy as part of the graduate program for creative arts therapists at Drexel University in Philadelphia. She also has advanced music therapy training in vocal psychotherapy from the Music Psychotherapy Center of New York and is currently pursuing doctoral studies in Jungian psychology at Pacifica Graduate Institute in Carpinteria, CA. Meghan has lectured and presented her work on the topics of end-of-life care, grieving children, sexual transference, and spirituality.

Lydia S. Lennihan, LPCC
Is a clinical counselor, writer, mythologist, artist, and continuing education provider in Albuquerque, New Mexico, where she has had a private practice for over 12 years. She has a graduate degree in mythological studies from Pacifica Graduate Institute, as well as an MA degree in counseling psychology from Regis University. She writes about film and psychology, and her articles have appeared in several edited collections and various psychological journals.

Sana Loue, JD, PhD, MPH, MSSA, MA
Is a professor at Case Western Reserve University. She holds a primary appointment in epidemiology and biostatistics in the School of Medicine, with secondary appointments in the departments of bioethics, psychiatry, and global health and at the Mandel School of Applied Social Sciences, the university's school of social work. Dr. Loue is a licensed social worker whose clinical focus is with emerging adults and whose research focuses on gender, sexuality, HIV risk, mental illness, and family violence. She is currently pursuing certification in sandplay therapy. Dr. Loue is a member of the American Association of Pastoral Counselors and the Sandplay Therapists of America. Dr. Loue has presented her work nationally and internationally and has contributed to many journals, including the *Journal of Sandplay Therapy.* She is the author or editor of more than 25 books, including *"My Nerves Are Bad" ("Mis Nervios Estan Malos"): Puerto Rican Women Managing Mental Illness and HIV Risk* (2011) and *The Transformative Power of Metaphor in Therapy* (2008)

Judy D. Zappacosta, MFT, CST-T
Is a teaching member of Sandplay Therapists of America (STA) and the International Society of Sandplay Therapy (ISST). She offers psychotherapy and sandplay for individuals seeking to experience their own personal process, as well as consultation and training in Jungian studies. Ms. Zappacosta uses integrative dream work, sandplay, and body awareness in both individual psychotherapy and interior rhythm seminars. She hosts an international Sandplay in Switzerland training program with Caring for the Soul Conferences and has been published both nationally and internationally. In addition, she has a strong background working with children, basing her theoretical work in Jungian child studies and developmental psychology. Ms. Zappacosta presently serves on the Marion Woodman Foundation Board of Trustees and on the board for the International Society of Sandplay Therapy (ISST). She is a past president of Sandplay Therapists of America

Introduction

Sexuality is clearly one of the most challenging and demanding areas of social work; issues of sexuality, encompassing gender identity, gender role, sexual orientation, and sexual identity, go to the very core of who we are as individuals, exposing our vulnerabilities (Logan, 2001). Nevertheless, most social workers are ill-prepared to address issues relating to sexuality and sexual behavior (Ballan, 2008; Speziale, 1997), having received relatively little, if any, training in their professional preparation programs (Ballan, 2008; Roberts, 1986). Indeed, when training is received, it frequently problematizes various aspects of sexuality. This occurs, for example, by focusing on traumatic aspects of sexuality such as childhood sexual abuse and partner violence (Jeyasingham, 2008; Trotter & Leech, 2003); by "defining 'sexuality' as an essential identity with a fixed set of characteristics and social welfare 'needs'," thereby transforming individuals into "objects of knowledge" (Hicks, 2008, pp. 65, 68); or by framing categories of individuals and their sexuality in the context of oppression and discrimination (Logan, 2001; Trotter & Leech, 2003). Any of these pathways may implicitly, however unintentionally, lead to a perception of clients as unidimensional embodiments of only that one facet of themselves whose needs and visions for their lives are assumed based upon that single dimension; victims of experiences beyond their control who subsequently internalize their diminution by others; or anomalies from what is perceived to be otherwise "normal" or "usual" expressions of sexuality (Hicks, 2008; Jeyasingham, 2008).

Social work as a profession and ethic challenges us to move beyond the assumptions that unwittingly may frame our approach to working with clients and issues of sexuality. "Social workers who are thoroughly familiar with the various components of human sexuality … can be highly instrumental in optimizing their clients' choices of sexual expression" (Goldsmith, 1979, p. 3). Accordingly, we as social workers are challenged to move beyond the binary categorization of sex and gender, and the tripartite classification of sexual orientation, to understand that the constructs of sex, gender, gender role, gender presentation, and sexual orientation exist along a spectrum (Loue, 1999, 2006) and that sexuality and all of its various dimensions encompass the discovery of pleasure as well as the experience of pain.

This text is intended to help social work practitioners move beyond both these often-accepted constructions of sexuality and the range of methods that are available to social workers in their clinical practice. Various themes are apparent throughout each of the chapters in this volume: the range of sexual experience and expression that exists across individuals; a recognition of our society's responses to expressions of sexuality, including the social, attitudinal, and cultural barriers that inhibit the expression of healthy sexuality and that constrain our approaches to assisting individuals with their recovery from trauma; the need to consistently and painstakingly examine our own assumptions relating to sexuality in order to be more effective with our clients; and the delicate balance that is often required when working with clients around issues of sexuality in the context of institutions, community, and societal structures. Importantly, we see as well the tremendous vitality and strength that allow our clients to explore, negotiate, and integrate both the positive and more disturbing aspects of their sexual lives and the positive growth that is possible for clients who, together with a skilled practitioner, are able to make use of any one or more of these expressive therapies in their journeys.

In the first chapter, Hanan introduces the use of movement therapy as a vehicle to help clients transitioning to live as other than their birth sex to become one with their new bodies, both physically and psychically. The focus on gender identity is continued in Loue's chapter, which discusses the use of both writing and identity performance together as a means of self-discovery and self-presentation to others. Writing as a means of healing is further examined by Gustavson, as she details the therapeutic benefits of reading and writing poetry to overcome and move beyond the trauma that clients suffered as the result of sexual abuse.

Fox also addresses the treatment of sexual abuse, using art, and specifically masks, as a therapeutic intervention with sex offenders. Loue's chapter that follows explains how art in the form of photography can be used to explore issues of gender identity and gender presentation with young African American men who have sex with men. Hinman discusses how music can be used therapeutically with clients to understand alternative expressions of sexuality, including fetish and dominance and submission behaviors.

The final three chapters focus on interventions for trauma resulting from sexual abuse. Chestnut demonstrates how music can be used with adolescents who have experienced sexual abuse to move beyond the abuse and rediscover themselves. Similarly, Zappacosta and Lennihan explain in each of their chapters how sandplay can be used with clients to assist them to integrate their sexually abusive experiences and move beyond them and, in Zappacosta's words, to "rediscover inner wisdom in the body and psyche."

Each of the expressive therapies presented in this volume—music, art, writing, performance, sandplay—can be utilized across a wide range of issues that fall within the broad scope of sexuality. The integration of any of these methods into a clinical practice with clients requires the acquisition of knowledge and the development of skills that are often not contained within the usual social work education program. Each author has provided suggestions for how a social worker might best prepare

him- or herself to utilize these modalities with clients and has highlighted the ethical issues that may arise.

The following words, attributed to the Sufi poet Rumi, are apropos here. Although clearly not used in reference to social work, they nevertheless remind us as social workers of the role that we may play for our clients on their journeys toward self-discovery and wholeness and how expressive therapies might be of help to them on their way:

Be a lamp, or a lifeboat, or a ladder.
Help someone's soul heal.
Walk out of your house like a shepherd.

January 2012 Sana Loue

References

Ballan, M.S. (2008). Disability and sexuality within social work education in the USA and Canada: The social model of disability as a lens for practice. *Social Work Education*, *27*(2), 194–202.

Goldsmith, L. (1979). Sexuality and the physically disabled: The social work role. *Sexuality and Disability, 2*(1), 33–37.

Hicks, S. (2008). Thinking through sexuality. *Journal of Social Work, 8*(1), 65–82.

Jeyasingham, D. (2008). Knowledge/ignorance and the construction of sexuality in social work education. *Social Work Education, 27*(2), 138–151.

Logan, J. (2001). Sexuality, child care, and social work education. *Social Work Education, 20*(5), 563–575.

Loue, S. (2006). *Assessing Race, Ethnicity, and Gender in Health*. New York: Springer.

Loue, S. (1999). *Gender, Ethnicity, and Health Research*. New York: Plenum Publishing.

Roberts, R. (1986). Results of a survey of Australian schools of social work on the teaching of human sexuality in their undergraduate programmes. *Australian Social Work, 39*(3), 24–28.

Rumi, M. *The divan of Shams of Tabriz*, 3090.

Speziale, B. (1997). Introducing sexual diversity into social work education: A humanistic group approach. *Journal of Teaching in Social Work, 15*(1/2), 51–61.

Trotter, J., & Leech, N. (2003). Linking research, theory and practice in personal and professional development: Gender and sexuality issues in social work education. *Social Work Education, 22*(2), 203–214.

Chapter 1
Embodied Therapy for Clients Expressing Gender Variation: Using Creative Movement to Explore and Express Body Image Concerns

M. Eve Hanan

Introduction

Although the terms gender and sex are often used interchangeably, they are different concepts. The term sex is used to refer to the biological indicators that are associated with male or female sex designation, such as genitals and the XX or XY chromosome patterns. The term gender refers to the social presentation of identity that is associated with or attributed to the biological indicators of sex. Gender presentation includes clothing choice, first names, and cultural roles associated with men and women.

At birth gender is assigned based on the apparent biological sex of the baby, but it now seems clear that some percent of the population in virtually all world cultures have the persistent feeling that their assigned gender identity does not accurately reflect their interior experience of gender (Callender & Kochems, 1983; Nanda, 1985; Poasa, 1992; Totman, 2008; Wilson, 1996). Terminology for this experience varies. Within the United States, the term *transsexual* has been used to refer to "individuals with a cross-sex identity" (Bolin, 1992, p. 14). The term *transgender* has been used as a broader term to describe the gender experience of people who identify as transsexual as well as those who do not identify as transsexual, but who nevertheless live, or wish to live, outside of the gender identity associated with their biological sex (Raj, 2002; Newfield, Hart, Dibble, & Kohler, 2006). A person who identifies as transgender may see gender as a choice between identifying as a man and as a woman, but he or she may also see gender identity as shifting and contextual, or as including other options such as androgyny or third gender roles (Bockting, Knudson, & Goldberg, 2006; Etkins & King, 1997). More recently, the term *gender variation* has been used to broadly describe this experience of living or wishing to

M.E. Hanan, M.A., R-DMT (✉)
e-mail: evehanan@gmail.com

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3_1, © Springer Science+Business Media New York 2013

live outside of the gender identity associated with one's biological sex (Hausman, 2001). This chapter will use the terms *transgender* and *people expressing gender variation* interchangeably.

Issues of gender variation necessarily involve the body. The feeling that one's assigned gender identity is inaccurate may initiate a long process of searching for a way to embody the internal experience of gender. Embodying a different gender identity may include changes in clothing, hairstyles, hormone treatment, and surgical interventions (Barrett, 1998; Dozier, 2005; Gagne & Tewksbury, 1999; Rubin, 2003). The medical transition into a new physical representation of gender can be long and full of many possible delays (*The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders & 6th,* 2001). The feeling that one's body does not adequately reflect one's true identity may persist through all of the phases of transition, and perhaps even after medical intervention if secondary sex characteristics have not been completely eradicated (Barrett, 1998; Johnson, 2007; Mason-Schrock, 1996). Supporting transgender people who are in the midst of this transition requires addressing how identity is experienced and expressed in the body and how physical changes to the body can be integrated into an involving, holistic sense of self (Bockting et al., 2006; Raj, 2002).

In order to better understand this aspect of working therapeutically with people expressing gender variation, I conducted a qualitative study using dance/movement therapy with a small group of adults who described themselves as "transgender" and "in transition." What emerged from the study were six common themes of body image that may be applicable to other transgender people who identify as in transition. In this chapter, I will provide a brief description of dance/movement therapy and the theories regarding the development and maintenance of body image that influence my work. I will then discuss the study and its clinical implications. This chapter seeks to provide health care providers who are *not* trained in dance/movement therapy with a better understanding of the role of the body in expressing and experiencing gender and a more nuanced understanding of the body image issues that may emerge during the process of transition. I will also provide some suggestions and parameters for mental health care providers who would like to incorporate some somatic or movement-based interventions into the care that they provide to clients expressing gender variation.

Understanding Dance/Movement Therapy

Definition of Dance/Movement Therapy

Dance/movement therapy (DMT) is an expressive psychotherapeutic technique that uses the relationship between the mind and body to help clients who are working on issues that include body image, the expression and modulation of emotion, and interpersonal comfort (Chaiklin & Schmais, 1993). The primary mode of expression, interpretation, and conflict resolution in dance/movement therapy is nonverbal,

but participants are also encouraged to discuss what is occurring in the session in order to create a cognitive link between their bodily experiences and their feelings (Stark & Lohn, 1993). By engaging the body in the therapeutic process, the dance/movement therapist is able to assist the client in understanding the somatic impact of experiences and emotions, and also help the client become active agent in healing, to literally begin *moving* toward greater integration of mind and body.

While an increasing number of mental health care providers are using some somatic techniques in their practice, the ability to assess mental health and emotional states through movement analysis is part of the unique and extensive training of dance/movement therapists. Movement is meaningful and communicates both the conscious and unconscious. The connection between emotions and the somatic and kinesthetic experiences and expressions of the body was articulated early on in Darwin's study of the physical expression of emotions (1872/1998). He wrote, "Most of our emotions are so closely connected with their expression, that they hardly exist if the body remains passive…" (p. 234). The quality of movement, in addition to the content of movement and its symbolic meaning, reflects the mover's experiences and inner world (Bartenieff & Lewis, 1980; Fischer & Chaiklin, 1993; Kestenberg-Amighi, Loman, Lewis, & Sossin, 1999; Lamb, 1992; North, 1972).

How Dance/Movement Therapy Interventions Complement Talk Therapy

Dance/movement therapy can serve as the primary therapy for people expressing gender variation because dance/movement therapists are trained as counselors in "talking therapy" as well as in movement-based interventions. Dance/movement therapy can also be used as a complementary or adjunct therapy. I have identified three particular features of dance/movement therapy that are particularly helpful to people who identify as transgender and in transition.

Improving Self-Expression and Self-Agency Through Facilitated Creativity

First, dance/movement therapy allows people expressing gender variation to use creative movement to explore and express a sense of self. After clients participating in a dance/movement therapy session have developed a sense of comfort and confidence in movement, the therapist will invite them to make creative movement choices, such as coming up with a movement that represents how they are feeling. The movements that develop may be symbolic or serve as metaphors for important experiences and feelings. The personal meanings of the metaphors can be explored within the session through words as well as through developing and sharing the movements that emerge. In this process, the active body affirms a sense of self, and the movements chosen by the active body affirm self-agency (Meekums, 2005).

Fostering Interpersonal Support and Validation

Second, dance/movement therapy fosters a unique form of interpersonal support and, in a group setting, supports the development of community based on shared movement and kinesthetic empathy. The dance/movement therapist responds to the client on a movement level in addition to a verbal level. Through a process called "empathic reflection," the therapist "incorporates clients' spontaneous expressions into the ongoing movement experience and responds to those expressions in an empathic way" (Sandel, 1993b, p. 98). This may include mirroring the movements or movement qualities of the clients, but it is usually much more than that. The therapist might elaborate on the client's movements or introduce a different action to modulate movement expressions that no longer feel safe for the clients. In the group dance/movement therapy setting, group members gradually take on the role of empathic reflection of one another's movements. A sense of interpersonal support and cohesion develops through synchronized movement, mirroring of movements, and, eventually, empathic reflection among group members (Sandel, 1993b; Schmais, 1998).

Why should nonverbal mirroring be so powerful? As the literature suggests, it harkens back to our preverbal relationships with caregivers. Sensory and motor attunement of the caregiver to the infant gives the child a sense of body (Krueger, 2002b). Without the responsive attunement of the caregiver in movement interactions, the infant will have difficulty integrating his or her bodily experiences into a coherent whole from which to begin building a unified image of the body and sense of self (Stern, 1985). As the therapist nonverbally attunes to the client through mirroring and reciprocating nonverbal cues, he or she recreates the synchrony and reciprocity of the early caregiver-infant bond (Pallaro, 1996; Sandel, 1993a). This can function as a corrective emotional experience, and it can serve to assist the person being mirrored in seeing himself or herself more clearly (Chace, 1993; Fischer & Chaiklin, 1993; Pallaro, 1996; see also Krueger, 2002a; Stern, 1985).

Increasing Somatic Awareness After Body Modification

Third, dance/movement therapy increases somatic awareness, allowing gender variant clients to explore the changing sensations in their bodies during the process of physical transformation, which include not only hormone therapy and surgical interventions but also changes to gait, posture and clothing that affect movement. The usefulness of expressive movement in the context of transgender body image has been presaged by both dance/movement therapy and body image literature that suggest the value of kinesthetic sensations to the creation and maintenance of body image. The integration of sensory modalities, including kinesthetic sensations, may result in a multidimensional and flexible body image. Kinsbourne (2002) notes that coordinated regions of the somatosensory maps, including the tactile, kinesthetic, and vestibular regions, are simultaneously activated to create the experience of body image. As we integrate our sensory experiences into our awareness, we form an image of our body. "Awareness and experience of the body are the original anchors

of our developing sense of self" (Kinsbourne, p. 27). "[M]otion influences body image" (Chace, 1993, p. 357). It "heightens sensation, kinesthesia, and proprioceptive functions in such a way as to make body image a dynamic, rather than static, aspect of self-concept" (Goodill & Morningstar, 1993). In this way, the dance/movement therapy sessions can become part of the discursive process as participants use conscious, expressive movement to reconnect their subjectivity to their changing bodies.

Body Image and Sensory/Motor Awareness

Defining Body Image

Body image has traditionally been defined as the psychological experience or mental representation that one holds of one's own body (Fisher & Cleveland, 1968; Schilder, 1950). In determining whether a person has a healthy body image or poor body image, researchers generally assess the person's perceptual, evaluative, and affective response to his or her body (Thompson & Van Den Berg, 2002). Tests that assess the perceptual component of body image measure the accuracy of a person's internal image of his or her body (Thompson & Gardner, 2002). Tests that assess the evaluative component of body image measure the degree of satisfaction that a person feels with his or her body, and tests of the affective response to body image measure the degree of dysphoria that a person feels due to a lack of satisfaction with his or her body (Thompson & Van Den Berg, 2002). Some quantitative assessment instruments also measure the effect of context on body image (Cash, 2002).

Quantitative tests and surveys have made it possible to measure some aspects of body image. Body image tests can quantify the degree of body image distortion and dissatisfaction, but the tests do not illuminate the nuances of the lived, day-to-day experience of embodiment. In contrast, questions posed by qualitative studies of body image, and by body image theorists, are as follows: How is body image experienced on a day-to-day basis? What factors influence body image formation? What are the meanings that each person assigns to aspects of his or her body? (Dosamantes, 1992; Krueger, 2002a; Pylvanainen, 2006; Rubin, 2003).

A Tripartite Framework for Thinking About Body Image

Dance/movement therapist researcher Pylvanainen (2003) developed a model for thinking about body image that is helpful in conceptualizing body image in qualitative terms. Body image, according to Pylvanainen, is comprised of three elements:

- Image properties: How do you see your body?
- Body-self: How do you inhabit your body as an agent that represents you?
- Body-memories: What experiences are stored in your body?

The first component, image properties, consists of the way in which a person sees his or her body and may incorporate objects such as clothing or jewelry. We gather data about the image properties of our bodies through our vision and also through our somatic and kinesthetic experiences of living in our bodies. Pylvanainen (2006) suggests that image properties are susceptible to coercive social pressures and ideals.

The second element of body image is the "body-self," which is the "core of the self that experiences and interacts" (Pylvanainen, 2003, p. 50). It develops through early, preverbal object relations with one's mother or caregiver, as elaborated upon by Pallaro (1996); it senses, emotes and acts, and develops in relation to others, as elaborated upon by Dosamantes-Alperson (1981). While image properties consist of the mental representation of the body, and any thoughts or feelings that we attach to that image, the body-self is nothing less than the self that moves and creates and relates to other people. Pylvanainen (2006) describes the body-self as holding a "double role" as a "sensing agent" and an "acting agent" (p. 44).

The third element of body image is "body-memory," which consists of memories of all bodily sensations, whether experienced as pleasurable, painful, or routine (Pylvanainen, 2003). It is the "container of past experiences in the body," memories that are "wordless and independent of conscious will" (Pylvanainen, 2006, p. 44). The body-memory dimension of body image is receptive to the external environment and explains how a pleasurable physical experience, or a painful one, can change our overall body image.

This tripartite model of body image allows for the organization of the experience of body image into meaningful and distinct categories, which, in turn, facilitates verbal identification and clarification of bodily experiences and impressions that may otherwise be unnamed or unconscious. In other words, we can work with clients on understanding their body image in these three categories.

Neurological Indicators, Movement-Based Techniques, and Body Image Concerns

While the image properties of body image are largely shaped by our ability to see and visualize our bodies, our total experience of body image is formed by other senses as well. In his theoretical writing on body image, Kinsbourne stated that, on a neurological level, coordinated regions of the somatosensory maps, including the tactile, kinesthetic, and vestibular regions, are simultaneously activated to create the experience of body image. As we integrate our sensory experiences into our awareness, we form an image of our body. "Awareness and experience of the body are the original anchors of our developing sense of self" (Kinsbourne, 2002, p. 27). The view that body image is partially derived from kinesthetic sensations has been adopted by dance/movement therapists. Chace (1993), often considered to be the mother of dance/movement therapy, wrote that "motion influences body image"

(p. 357). Elaborating on this concept, Goodill and Morningstar (1993, p. 25) stated, "Movement heightens sensation, kinesthesia, and proprioceptive functions in such a way as to make body image a dynamic, rather than static, aspect of self-concept." Put differently, the integration of sensory modalities, including kinesthetic sensations, results in a multidimensional and flexible body image, rather than a static, unchanging body image that is equivalent to a photographic representation of the external body.

Theorists have also suggested that kinesthetic sensations alter body image by focusing attention on the subjective experiences of the body and the volitional aspects of the self. In discussing appropriate therapeutic techniques for people overcoming body image disturbances related to prior sexual abuse, Fallon and Ackard (2002) noted that somatic therapies, including dance/movement therapy, may help clients articulate the damage done to their bodies, experience their bodies in a different way, and, in so doing, reclaim their bodies after the abuse. The source of this new experience of the body is not limited to kinesthetic experience. Rabinor and Bilich (2002) suggested that experiential techniques such as dance/movement therapy change body image because the expressive movement increases awareness of emotions that are stored within the body. Likewise, dance/movement therapy increases awareness of somatically felt emotions by directing the client's attention to consciously performed movements and any accompanying thoughts and feelings (Dosamantes-Alperson, 1979). As Kinsbourne (2002) stated in his chapter on the neurological aspects of body image, "Attention amplifies the previously unconscious somatosensory signals" (p. 25). This awareness of somatosensory signals "anchors our developing sense of self" (p. 27). To use Pylvanainen's tripartite framework, the kinesthetic and somatic sensations experienced in the body when we make volitional movements help to form the body-self aspect of body image, in addition to the image properties of body image. Awareness of kinesthetic and somatic sensations also alerts us to body-memories stored within our body.

The Interactive Nature of Body Image Development and Maintenance

Research and theoretical work suggest that body image is formed through the interaction between one's own multisensory perception of one's body and interaction with others within social contexts, beginning with the infant-caregiver relationship (Kinsbourne, 2002; Stern, 1985). In his theoretical exploration of the psychodynamic roots of body image, Krueger (2002b) notes that Freud saw the ego as first and foremost a body ego because the core sense of self begins with the sensation of physical needs (Freud, 1923). Transposing Freud's body ego to object relations theory, Krueger discusses the manner in which caregivers engage in sensory and motor attunement with infants. It is through this attunement that the infant develops an understanding of its body and its boundaries. If the caregiver fails to attune, it is as if the infant is looking into a "foggy mirror," resulting

in body image disturbances (p. 32). According to Stern (1985), an original sense of self develops in the preverbal infant through his or her bodily experiences in movement interactions with the caregiver. Without the responsive attunement of the caregiver in movement interactions, the infant will have difficulty integrating his or her bodily experiences into a coherent whole from which to begin building a unified image of the body or sense of the self. This theoretical framework is partially supported by studies that show that body image dissatisfaction is inversely related to secure attachment styles (Cash & Fleming, 2002).

Several authors and researchers suggest that social interaction continues to be an important factor in the development and maintenance of body image throughout life. Tantleff-Dunn and Gokee (2002) suggest three interpersonal processes that affect body image. First, the internal representation of the body is shaped in part by the verbal and nonverbal feedback that an individual receives from others. Second, the individual also makes social comparisons between his or her body and the bodies of others. Finally, the individual makes assumptions about how others perceive his or her body, a process the authors call reflective appraisal. These three interpersonal processes influence how the individual conceptualizes his or her body image.

The interactive nature of body image has led some researchers and authors to explore the effect of cultural disapproval of a person's body or movement style on the person's development of body image. Dosamantes (1992) notes that a culture may view the bodies and movements of another social group as ugly or unacceptable as a symbolic projection of what the culture most fears or disavows. Members of the marginalized social group may, in response, strive to have the dominant culture see their bodies as acceptable and even desirable. McKinley (2002) developed three 8-item scales designed to measure the degree to which a woman may be affected by the dominant culture's standards of bodily acceptability and desirability. She hypothesized that women develop what she termed "objectified body consciousness (OBC)," which is comprised of three measurable phenomena. First, women conduct varying degrees of self-surveillance by seeing themselves as others see them rather than focusing on their internal experiences. Second, women have varying degrees of acceptance of cultural standards of beauty and varying levels of desire to achieve the cultural standard. Finally, women vary in the degree to which they believe that the beauty ideal is achievable through body modifications and adornment. In a pilot test, she found that high scores in all three areas of OBC were positively correlated with body image dissatisfaction in women. This suggests that body image is directly affected by the internalization of cultural values surrounding the human body and its presentation, but that the degree of influence varies based on several internal variables.

Perhaps due to explicit or tacit acknowledgment of the importance of social interaction in shaping body image, some authors suggest that a supportive therapist-patient interaction can improve body image. Krueger (2002a) hypothesizes that the empathy generated within the therapeutic relationship could provide the client with an intimate relationship in which he or she can experience the bodily sensations associated with body image satisfication. Dance/movement therapists have largely adopted the view that body image is generated through bodily experiences that are

experienced and integrated through interactions with others, with particular focus on the early infant-caregiver interactions (Pallaro, 1996; see also, Dosamantes, 1992; Pylvanainen, 2006). Dosamantes contends that the infant-caregiver relationship gives the child the sense that he or she has a body with boundaries. Chace (1993) believed that body image is a social creation, stating, "We have a normal tendency to elaborate our body images according to the experiences we obtain through the actions and attitudes of others" (p. 363). If others do not exhibit a "meaningful awareness" of a person, that person is likely to develop a "receding body image," which is visible in movement when a person appears to be pulling back or attempting to disappear (p. 352). She suggested that she could generate a sense of bodily integrity and awareness in patients within the group dance/movement therapy session by clarifying, amplifying, and mirroring their movements. Likewise, Pallaro (1996) utilizes an object relations framework to suggest that the dance/movement therapist's use of her body in interaction with her client's body allows the client to rework his or her early object relations, resulting in a more integrated body image.

Transgender Body Image

That transgender people experience some dissatisfaction with their bodies is axiomatic of a circumstance in which the body does not convey the inner experience of the gendered self. Only a few studies address transgender body image per se, but studies exploring satisfaction, self-esteem, and quality of life for transgender people in relation to body modifications and other variables illuminate aspects of transgender body image.

Studies of the effectiveness of sex reassignment surgery cast some light on the question of body image satisfaction (Barrett, 1998; Kraemer, Delsignore, Schnyder, & Hepp, 2008; Pauley, 1981; Snaith, Tarsh, & Reid, 1993; Wolfradt & Neumann, 2001). Kraemer et al. measured body image in pre- and postoperative transgender women using a German body image measure, called the FBeK, and an operational definition of body image that included perceptions, attitudes, and experiences pertaining to one's physical appearance based on self-observation and the reactions of others. The researchers found that preoperative transgender women scored higher than the postoperative transgender women in the areas of insecurity and concern over their physical appearance and lower in the areas of perceived attractiveness and self-confidence.

Wolfradt and Neumann (2001) studied personality variables that included, for example, depersonalization, self-esteem, and body image in 30 postoperative male-to-female transgender women, comparing them to 30 biological women and 30 biological men. All 90 participants filled out questionnaires for (a) the Scale of Depersonalization Experiences (SDPE), (b) Self-Esteem Scale (SES), (c) the Body Image Questionnaire (BIQ), (d) the Gender Identity Trait Scale (GIS), and (e) a question about whether they were generally satisfied with their lives. The researchers found that transgender women did not have higher rates of depersonalization

than biological men and women and that biological males and transgender women scored significantly higher in self-esteem and dynamic body image measures than biological women. No significant differences were found in rejected body image or in general satisfaction with life. This study suggests that sex reassignment surgery for transgender women is associated with body image satisfaction and self-esteem comparable to that of non-transgender people.

With regard to transgender men, Barrett (1998) assessed the benefits of phalloplasty by comparing a group that had undergone the surgery to a group on a waiting list for the surgery. Dependant variables were measured with general health questionnaires, a symptom checklist, a sex role inventory, and the social role performance schedule, as well as information on income, employment, drug use, and self-reported ratings of satisfaction in the areas of genital appearance, sexual function, urinary function, and current relationship status. The post-phalloplasty group showed slightly higher satisfaction with genital experience and in the area of sex roles, and they endorsed more androgynous behaviors than the pre-phalloplasty group. The implications of this study are that phalloplasty does no harm, and that it does some good for some people, but that it is not as successful as male-to-female sex reassignment surgery in improving body image, quality of life, and overall satisfaction with gender experience.

With regard to other medical interventions for transgender men, Newfield, Hart, Dibble, and Kohler (2006) conducted an internet survey of 376 transgender men and found that they reported a significantly lower quality of life than the general population, but that transgender men who received hormone replacement therapy and chest reconstruction surgery reported a significantly higher quality of life than those transgender men who received no medical intervention. This suggests that hormone therapy and chest reconstruction can result in positive changes in quality of life, due perhaps in part to a concomitant change in body image and in the way the transgender man's body is perceived by others.

Qualitative studies involving in-depth interviews, as opposed to questionnaires and surveys, yield richer data about the individual experiences of body image during transition. Wasserug et al. (2007) interviewed 12 transgender women who presented for treatment with antiandrogen and estrogen therapy. Many of the transgender women described starting hormone therapy as a milestone, regardless of the outcome. It dislocated artifacts of masculine gender in an important way, bringing emotional relief even if the results were less than dramatic. Participants noticed changes in face shape, skin softness, fatness of hips, and breast enlargement and reported being highly attuned to each change in their bodies. They also reported a change in sexual stimulation from genital focused to "whole body" (Wasserug et al., p. 114). One participant talked about transition as being "a newborn baby" neither male nor female, but, rather, existing just at the beginning of gender development (p. 116). The intensity and depth of the feelings surrounding hormone therapy described by participants in the Wasserug et al. study highlight an aspect of the subjective experience of transition that is sometimes overlooked: Hormone therapy changes the body in ways that are not predictable. Gherovici (2010) notes that it is impossible to predict what preadolescents will look and sound

like after the hormone changes of puberty and, likewise, transgender people cannot know precisely how hormone therapy will change their bodies. "The sex change decision entails a plunge into the unknown for the transformation keeps a part of mystery" (Gherovici, 2010, p. 239).

Another study that aimed at gathering in-depth details about the experience of transgender women during transition was conducted by Schrock, Reid, and Boyd (2005). Borrowing from the philosophical work of Simone de Beauvoir (1989), the authors adopt the position that the body is a "situation," and that subjectivity is always embodied (Schrock et al., 2005, p. 318). The results of their interviews with nine transgender participants revealed that they saw their bodies not exclusively as a problem but as a resource. They used their bodies to take actions to modify their gender presentation in the areas of "retraining," "redecorating," and "remaking" the body (p. 321). The transgender women labored to change their bodies and described "harvesting the emotional rewards" of that labor (p. 320). In terms of "retraining" the body, participants disclosed that they worked diligently on their speech and movements, practicing emotional expression, role taking, changing their tone of voice, and studying and emulating biological women's postures and gestures. "Redecorating" consisted of changes to clothing, hairstyles, and makeup. Wearing cosmetics, for example, was reported to create a paradox because, on the one hand, it is a mask and, on the other hand, it leads to greater feelings of authenticity because society is more likely to respond to the transgender women as women when they wear it. In terms of "remaking" the body, the transgender women interviewed by Schrock et al. described nonmedical interventions, such as electrolysis to remove hair, losing weight, and allowing upper body musculature to atrophy, as well as hormone therapy and surgical interventions. These modifications required discipline and effort to enact and maintain.

According to Schrock et al., the retraining, redecorating, and remaking processes initially felt like inauthentic expressions of self, rather than a more authentic expression of gender. One noted, for example, that it felt false to change her voice around people who had known her for a long time. Feelings of authenticity and naturalness developed over time as the transgender women developed body-memories of the new ways of moving and vocalizing. Schrock et al. suggest that this transition from feeling inauthentic to authentic implies that, as the body is changed and shaped, it must be re-wed to subjectivity. The labor and practice that this required reconnected their subjectivity to their bodies. The bodywork thus reflected two aspects of the body-self, the body that takes action in the world on behalf of the self and the body that subjectively experiences itself and the world through sensations.

Johnson (2007) interviewed transgender men and transgender women in order to gain a better understanding of how embodiment manifest in their narratives. Johnson found four ways in which changing or modifying the body affects the embodied subjectivity of the transgender participants in the study. First, participants described experiencing new and altered bodily sensations over the course of a long period of time, particularly as estrogen increased feelings of softness and fleshiness or testosterone increased feelings of strength. Second, participants described studying and learning movements that reflect the cultural practice of gender. Third, participants

experienced an inability to completely undo the evidence of their genetic sex. As for the parts of them that indicated their genetic sex, one participant stated, "'I hate those bits'" (Johnson, 2007, p. 65). Finally, participants experienced an inability to completely undo movement and vocal patterns that suggested their genetic sex, after having spent childhood and adolescence learning them. Johnson suggests that postural and gestural practices leave their mark on the body and are difficult to completely reverse. Gender is "displayed and read … through … embodied practices," and the experience of embodiment changes as transgender people work to alter the gender that their bodies and movements display (Johnson, 2007, p. 67).

If body image is shaped in part through our interactions with others throughout our lives, then transgender people find themselves in a uniquely difficult dilemma regarding the formation and maintenance of body image. Body image can be undermined or constricted by others who fail to acknowledge the internal experience of gender identity and, instead, focus on the external presentation of biological sex. As the research on objectified body consciousness discussed above suggests (McKinley, 2002), the cultural context and the verbal and nonverbal responses of others to one's body can alter one's subjective experience of the body. I found no studies surveying the types of verbal and nonverbal feedback transgender and gender variant people receive in contemporary Western culture. Some sense of the feedback that transgender people receive can be found in a short film made by Alexander (2008), which creates an audio-visual collage of samples from over 80 films in which the issue of gender variance is raised and documents the verbal and nonverbal responses of characters to gender variance. Most of the films sampled in Alexander's short film involve a plot in which one of the characters is gender variant and other characters respond to this discovery.

The most common facial expression made in response to a gender variant person is one of contempt or disgust, with the nose wrinkled and the mouth open and drawn downward. Although an open mouth sometimes suggests surprise or astonishment when accompanied by wide eyes and raised eyebrows, in these scenes, the actors furrow their brows and narrow their eyes, facial movements that Darwin (1872/1998) suggests are indicative of contempt, disgust, or anger. Even when the scene is meant to be funny and the actor is laughing at the gender variant person, the nose is wrinkled and the brow is wrinkled in disgust. Some of the faces show anger and the stirrings of rage, with the eyebrows narrowed and the nostrils flared (Darwin, p. 142). With regard to movements in the rest of the body, many of the scenes feature actors who, upon seeing a gender variant person, move with rigidity, cringing or jumping backward. According to Darwin (1872/1998), muscular contractions often manifest fear or horror. In the few scenes where the actors show surprise, it is exaggerated so that they are raising both arms in astonishment, doubling over or stepping back quickly. In several frames, the actors act as if they are about to vomit, or actually vomit. In one scene, the actor burns his clothes and jumps in the shower in response to contact with the transgender person. Another passes out. In other scenes, the actor hits, slaps, or throws something at the transgender character. In others, the gender variant character is strangled, shot, or beaten with a stick.

What Alexander's film so aptly depicts is the disparity between the gender variant person's experience of his or her own body and the feedback the gender variant person gets from a surprised other person. A severe disparity between how others see a person and how the person sees himself or herself can lead to what Rubin (2003) describes in his phenomenological study as alienation. According to Rubin, body image is the product of social interaction, but it is not static. Rather, one's sense of one's body image vacillates between three different points of view. The first point of view is the "body-for-itself," which regards the body from the point of view of the particular, subjective experience of the person. The second point of view is the "body-for-others," which attempts to regard the body as it is seen, touched, and interacted with by others (Rubin, 2003, pp. 26–27). The interaction of the first and second point of view, the "body-for-itself" and the "body-for-others," can be a healthy process, and one that begins infancy, as discussed by object relations theorists such as Dosamantes (1992), Krueger (2002b), Pallaro (1996), and Stern (1985). The third point of view involves regarding one's body as alienated from oneself. Rubin (2003, p. 27) explains that the "alienated body" results from situations in which "the *I* is coerced into taking a viewpoint of the other on its own body." This occurs when one experiences discord between one's subjective experience of one's body and the way in which others see one's body. If this discord is pervasive and intense, a sense of being completely alienated from one's own bodily experiences can develop.

In his interviews with transgender men, Rubin found a pervasive experience of alienation from the body that was partially remedied by body modifications, such as clothing, hormone therapy, and breast removal. A commonality among the participants was that they experienced puberty as a pivotal time when the "bodies they inhabited disfigured their essential male selves" (Rubin, 2003, p. 89). Rubin calls this phenomenon "expressive failure" because their "bodies are failed representations of their core selves." "Expressive failure," he explains, "makes it difficult to achieve intersubjective recognition" (p. 181). By modifying their bodies, they "are repairing the link between their bodies and their gender identity" (p. 144). Body modifications reduced the disparity between self-perception and the perception of others, reducing their experience of alienation from their bodies. Engaging in body modifications restores subjectivity and decreases alienation by altering not only the presentation of the body but also the subjective experience of the body and the manner in which other people respond to the embodied person.

While body modification is one avenue of improving body image, another conceivable avenue would be interpersonal relationships that are supportive of gender variation. Nuttbrock, Rosenblum, and Blumenstein (2002) studied the relationship between social and interpersonal support for the feminine identities of 43 transgender women sex workers and symptoms of depression. Using the CES-D scale, the researcher found a negative and statistically significant correlation between depressive symptoms and the index of friend and family support for gender identity. While the researchers did not examine body image variables, it is possible that reduced rates of depression are correlated with improved self-image and increased comfort with body image.

Also suggesting the importance of interpersonal support to body image is an ethnographic study conducted by Mason-Schrock (1996) in which he joined a transgender support group and participated in some social events with its members. From his observations and interviews with group members, he concluded that the support group format was useful for people transitioning genders because group members offered one another affirmations of gender choice, modeling of embodiment of the desired gender, and guidance to new members. While neither study directly addressed body image, the findings suggest that social support is significant to the formation and maintenance of identity as well as general mental health.

Qualitative Study of DMT Group with Six Transgender Adults

This qualitative study of body image of six transgender adults was conducted at a Gay, Lesbian, and Transgender Community Center (GLCC) in a city on the East Coast in the summer of 2009. The study explored the variations and themes of body image as they were experienced and expressed by six transgender people participating in four group dance/movement therapy sessions. Recruitment flyers were posted at a community-based health clinic and the GLCC and distributed to people participating in transgender support groups at the GLCC by the researcher. Eight people expressed interest in participating in the study. After a telephone interview with each of the eight people who responded to the flyer, six were identified as eligible for the study, interested in participating in the study, and available to attend the dance/movement therapy sessions.

The six adult participants identified themselves as transgender and represented a variety of ages ranging from 39 to 63 years old. Five participants were White, and one participant was African American. Four identified as male-to-female transgender, and two participants identified as female-to-male transgender. They were all adult volunteers from the community who identified as transsexual or transgender and who identified as being in a period of transition, meaning that they were actively in the process of expressing gender transformation through dress, hormone therapy, or other medical interventions.[1] To qualify for admission in the study, participants had to agree to participate in four 1-h long dance/movement therapy sessions in a group setting and a 45-min interview after the final dance/movement therapy session.

Data were collected from three sources: field notes that I took of my observations during the four sessions, movement phrases that the participants created, and interviews that I conducted with the participants following the last session.

Drexel University's Institutional Review Board approved all of the procedures utilized in this study.

The Sessions

Dance/movement therapy group sessions met one night per week for 4 weeks in July 2009. Session 1 was 1 ½ h, the first 45 min of which were spent conducting the

consenting process with each participant out of the presence of the group. Sessions 2, 3, and 4 were approximately 1-h long.

In session 1, after the consent procedures and verbal introductions, I led the participants in an abbreviated version of a traditional dance/movement therapy session, which includes a warm-up, theme development, and closure phase designed to maximize participant expression and initiate participant-driven theme development (Chace, 1993). The warm-up included gentle movements performed in a circle designed to prepare participants physically for movement and also to assist them in transitioning into the group dance/movement therapy process. I asked participants to draw their attention to any physical sensations they had and any emotional sensations that arose in order to awaken the connection between physical and psychological experience. Group cohesion was fostered and facilitated by rhythmic music and synchronous movements. In a short discussion that preceded the movement warm-up in sessions 2, 3, and 4, participants were encouraged to greet one another and were given an opportunity to talk about any events, thoughts, or feelings that may have emerged since the last session (Meekums, 2005).

After the warm-up, I moved the group into the theme development phase of the dance/movement therapy session, which lasted approximately 45 min during all sessions except for the abbreviated movement portion of session 1. During theme development, I led the group by encouraging the development of metaphors and themes that emerged naturally from the group movement expression. In session 1, I introduced a simple theme development exercise to invite a deeper exploration of each participant's individual experience of embodiment. The participants took turns saying their names and creating a "signature movement" to accompany their names. The group then repeated back the name and mirrored back the signature movement. The movements made by each participant were later discussed by the group and also discussed during the exit interviews. Participants made highly creative and diverse signature movements, including, for example, a "flower blossoming," a martial arts move, and typing at a computer. The mood was nervous at first but increasingly playful toward the end. Many of the participants seemed visibly pleased to watch others watch their movements and mirror them back to them.

In session 2, I introduced an inquiry into the meaning of gender in movement. I did this because the participants asked to explore gender in movement during the closing discussion of session 1. In order to explore gender in movement, I taught the Laban Movement Analysis concepts of Effort-Shape and invited participants to try moving with different combinations of Efforts, like Strength or Lightness, Bound Flow or Free Flow, Direct or Indirect motion, and Suddenness or Sustained motion. (Laban Movement Analysis is explained further below.) After they had practiced all of the Effort qualities, I invited them to reflect internally on whether any Effort qualities or combinations felt more comfortable for them and also on whether they associated any Effort qualities with masculinity or femininity. The mood was reflective and somewhat solitary during the movement exercises, but the group regained its feeling of cohesiveness during the discussion after the theme development. At the end of the session, the group discussed their experience with the movements and their ideas about gender and movement.

In session 3, I introduced two movement exercises during the theme development phase of the session. I asked participants to think back to someone from their childhood whose movements captivated them, who they enjoyed looking at and perhaps wanted to emulate. I asked them to embody that person for the group and talk about the significance of that person to them. Participants embodied people such as family members, Vivian Leigh, and the George Jefferson character from the Jeffersons and explained what was meaningful about that person's movement. The group joined each participant in attempting to move in the same way. Then I asked participants to try to embody their "ideal self" and move as their ideal selves would move. Again, each participant took turns showing their movement and talking about its meaning, and the group then mirrored the movement and shared their thoughts and feelings as well.

In the final session, I asked the participants to each come up with their own movement phrase that would represent their embodied sense of themselves sequentially in three states of time: the past, the present, and the future. This was essentially asking them to come up with three movements and put them together in a sequence, like a short choreography or dance. One participant was unable to attend this session, but the five attending participants each made a movement phrase to share with the group. Each participant taught the group how to do the movement phrase, and we all did the phrases together. The mood was intimate and reflective, and the participants appeared to cherish one another's shared movement experiences. After the theme development portion of the session, the group sat down for a long discussion about their experiences moving together during the four sessions.

During all of the group movement activities, I moved with the participants, reflecting the quality of their movements back to them. I did this in order to communicate empathy kinesthetically and also to provide them with the cognitive tool of seeing their movements clarified and amplified by me. Moreover, I encouraged the participants to mirror and reflect one another's movements in order to foster group cohesion and empathy.

Outcomes

After analyzing the qualitative data from my field notes from the sessions, the transcripts of the exit interviews, and the participant movement phrases, I developed a summary of common themes that emerged regarding body image. I provided a summary of the themes and the interviews to each participant and invited them to respond via email or telephone with corrections or additions to the summary. After incorporating their feedback, I concluded that there were six dominant themes and four variant themes that emerged from the study. They are discussed below.

The six themes were common to most participants: (a) the importance of expressing one's true and unique self, (b) supporting one another's efforts to express the true self, (c) the body's experience of violence and discrimination, (d) studying and practicing gendered movements, (e) actively working to shape the body as a vehicle

of self-expression, and (f) joy, relief, and celebration in the gender transition. Each theme is discussed first in terms of the data gleaned from the researcher's observations of the group during the sessions. Then, each theme is discussed in terms of how it was experienced or expressed by participants.

Importance of Expressing One's True and Unique Self

A predominant theme throughout the four sessions was the sense that each person has a unique self and that it is important to express the uniqueness of the self. The group expressed this during the movement exercises in a number of ways. In session 1, I asked each member to create a movement to "go with" their name. Although no member of the group had ever participated in dance/movement therapy before, all participants agreed during the discussion that they liked the opportunity to share a movement expression with the group. Moreover, each participant's movement expression was unique in quality and symbolism. The theme of expressing a unique sense of self was manifest by participant 2 who shared a movement with the group that she described as a flower blossoming by spreading her arms wide and stepping forward. She told the group that this symbolized her feeling that she has blossomed into her true identity after transitioning.

Supporting One Another's Efforts to Express the True Self

Group members actively supported one another's individual expression within the sessions. When, several times each session, the participants returned to the circle to share their movements with the group, other group members made eye contact and verbally praised the participant who presented and mirrored the movement with attention to its feeling quality. Participant 1 was particularly vocal during her interview in expressing how other participants in the dance therapy sessions supported her self-expression. She told me that seeing others mirror the movement phrase that she created to go with her name was "kind of a way of seeing other people celebrate me." She further reported that other mirroring exercises during the sessions allowed her to become aware of her movements and "see the image that I'm projecting." She said, "When people pick up your expression and gestures, it's a way of them showing that they respect and enjoy you." Participant 3, one of two transgender men who participated in the study, reflected on moving with the group and the difficulty he had accepting his body in the past. He said, "For some reason I just sort of healed that wound a little to be a part of the group."

The Body's Experience of Violence and Discrimination

The theme of the body's experience of violence and discrimination emerged in relation to body image during the sessions as both fear for future safety and memories

of past discrimination and violence. The participants discussed and expressed in movement past experiences of violence, discrimination, and loss. These painful experiences usually involved losing love, support, and employment when they revealed (intentionally or otherwise) that they are transgender. Many participants said that their parents had punished them for cross-dressing behaviors when they were children. As adults, several had lost spouses because of the decision to transition. They discussed difficulties finding work and finding accepting communities outside of the transgender community. Participant 4 noted that she feels that she has to be on the defensive much of the time, never knowing how others are going to react or whether she is in danger. During session 4, she expressed this experience of being on the defensive by mimicking dodging bullets or darts. Participant 5 demonstrated the effects and memories of violence on her body in sessions 3 and 4. In session 4, she enacted her mother beating her for wearing panty hose. In session 3, she showed us her way of walking, arms and legs held in so that she appeared narrow, carrying her purse clutched against her body, and barely moving her hips. She told us that she calls it her "easy motivational walk" because it is meant to convey self-confidence to anyone who sees her. "I just have to let them know that I'm not an easy target."

The experience of fear of violence or discrimination also manifest in the sessions in discussions and movements designed to explore "passing." In session 2, the group discussed how, if a transgender man or transgender woman does not pass as his or her gender, he or she may be the victim of discriminatory violence or some other form of discrimination. With regard to other forms of gender-based violence, three of four transgender women expressed fear that they would pass but that they would then be the victims of violence against women, a rape or other form of sexual assault. For at least one of the transgender women, participant 5, this dominated her decisions about how to dress and how to carry herself.

Studying and Practicing Gender in Movement

In session 2, participants discussed practicing gendered movements before and after their transitions. They used the session to reflect on gendered movements, explore them, and reflect on them with one another. Some participants shared that they had to practice gendered movements before their transition because the movements associated with their assigned gender felt so foreign to them. Some participants shared that, in contrast, they had to practice the movements associated with their post-transition gender because they had spent most of their lives moving in ways associated with the gender that they were assigned at birth. Participants showed some concern for whether their movements conveyed their experience of their gender and asked one another for feedback, reassuring one another and offering suggestions. They discussed efforts to pass as a man or a woman by studying the movements of others and consciously embodying those movements. Participant 1 shared with the group during session 2 that she has noticed that women carry themselves differently than men and that she has worked to learn the body language of women, in

part by practicing belly dance. During session 3, she showed the group some of her repertoire of movements derived from belly dance videos that she watches at home. For participant 4, memories of teaching ballroom dance while living as a man were prominent. She remembered wanting to dance the woman's part of the dance with full emotion and commitment, but having instead to teach the woman's part to women in a "mechanical way." During sessions 3 and 4, I observed her dancing the woman's part with elegance and emotion, swaying and allowing her arms to gently extend while she floated across the floor.

Actively Working to Shape the Body as a Vehicle of Self-Expression

The idea that the body requires some work in order to accurately express the person's identity was common to group members. While none of the participants expressed dissatisfaction with their bodies as a whole, many mentioned during the sessions and interviews that they are less than satisfied with certain parts of their bodies because those parts inhibit their self-expression. These areas of the body are often the sites of bodywork that includes dieting, electrolysis, hormone therapy, or surgery. During the dance/movement therapy sessions, participants discussed bodywork that they have done or that they plan to do. They talked of time spent in front of the mirror, grooming, dressing, getting bodywork done, and talking to doctors and other professionals. Their agency in working on their bodies included willingness to engage fully in the exploration of movement, within the dance/movement therapy sessions. Participants infused their movements with meaning by symbolizing important aspects of their lives.

Experiences where the body accurately conveyed the internal experience of gender were discussed as well. Participant 6 reflected on the satisfaction and wholeness he felt the first time he passed as a young man: "I remember how I was standing on the side of the road, getting into the car, getting out of the car, doing everything – everything was perfect. Like, there was no inkling in body or mind of femaleness…. It was like for a few minutes I was a 17-year-old boy and that was what I was supposed to be. All layers were congruent, how I was perceived, how I was perceiving myself, what I was doing, how I was doing it."

Joy, Relief, and Celebration in the Gender Transition

At some point during the sessions, all participants except for participant 3 expressed joy and/or relief over having finally decided to live in accordance with their inner experience of themselves. They spoke of the contrast between living a false or inauthentic life and expressing to the outside world their true inner experience. Several reflected on not wanting to see themselves or be seen by others before their transitions. Participant 4 discussed the theme of joy and relief with the group during the sessions. She said that before transition, she did not want to look in the mirror, even to shave, and she did not want anyone to see her dancing. She told me during the

interview, “When I was strictly male in a male role, I had a shadow that used to follow me everywhere I went…. I could never tell what it was…. But I knew, in a sense that it was the female part of me. When I started transitioning, it kind of disappeared, like it came over inside of me.” In sessions 3 and 4, her joy at having made the transition showed in her ballroom dance movements. She floated and glided on the floor, with her arms open wide and a smile on her face. For participant 5, her movements within all of the dance/movement therapy sessions were confident and energetic, such as jumping side-to-side during session 1 and mimicking playing the guitar in session 3. In her final movement phrase in session 4, she did her version of the Charleston, which she described to the group as a “happy dance.”

Variant Themes: Physical Limitations, Deciding to Transition, and Sexuality

Two participants talked about physical limitations caused by medical conditions. Participant 3 explained to me in his interview that, because of a congenital condition, he experiences weakness and pain in his upper body. He experiences pain and weakness in his arms, which interferes with his ability to see himself as physically strong. He can no longer punch a punching bag and has to limit his participation in martial arts to exclude hand-to-hand sparring. He described feeling “small statured and not flexible. Kind of clumsy. Not real strong, but moving forward.” During the interview, he compared being in a chromosomally female body to the congenital neurological condition, likening his birth sex to a medical condition that is limiting, but that can be at least partially overcome. He described the dance/movement therapy sessions as helping him gain insight into his somatic experiences and to feel more comfortable with his body.

Participant 3 was also the only participant who had not decided whether to transition. During session 4, he showed his internal predicament by walking a tightrope, explaining that one side of the rope was his desire to live as a man and the other side of the rope was his husband, family, job, and community. This vividly illustrated the conflict between self-expression and social pressures to conform.

A third variant theme emerged from participant 5: the desire to control the body’s expression of sexuality. In her interview, she told me that she dresses in an effort to de-emphasize her sexual attractiveness. In session 3, she acknowledged that she walks with her torso and hips almost stationary in order to minimize this area of her body. She discussed experiencing sexual violence both with the group and during our interview.

Discussion and Clinical Implications

The data gleaned from the participants in this qualitative study of body image suggest the potential usefulness of the therapeutic group setting in which transgender people can use both verbal and nonverbal techniques to express and explore body

image issues. As the participants in this study reported, the experience of transitioning to living in a sex other than one's birth sex and a gender other than that associated with one's birth sex can be tied intimately to how one experiences and expresses one's sense of embodiment. Sensations in the body change with hormone therapy, different clothing, and other changes. The internal representation of body image changes as well and is partially dependent on feedback from others. Even after transition seems complete, body-memories from childhood and from the client's past experiences living in accordance with his or her birth sex may emerge. Because the transition is tied so intimately to the subjective experience of embodiment, dance/movement therapy may be particularly helpful.

The literature endorses the usefulness of therapy for some transgender people, as well as the usefulness of peer support during the transition (Bockting et al., 2006; Denny & Roberts, 1997; Ettner, 1996; Rachlin, 2002; Raj, 2002). According to Raj (2002), the function of therapy for the transgender person is similar to that of any person undergoing a major life transition. Raj (2002, Sect. 3.1.1, para. 2) found that therapy helps transgender people "consolidate their gender and sexual identities as transgender women and transgender men, and to enhance self-confidence," and "facilitate identity consolidation and social integration." Raj (2002, Sect. 9.4, para. 2) specifically mentioned "the more 'creative' or interactive interventions," such as "expressive therapy," as potentially effective in supporting transgender people. The few case studies of art therapy with transgender people describe the creation of artwork depicting the presentation of gendered self, concern with appearance, and discrimination, echoing the themes that emerged from this study (Barbee, 2002; Picirillo, 1996; Sherebrin, 1996). Barbee (2002) concludes that art can help integrate inner experience with physical manifestations by providing the visual component of the narrative.

Because dance/movement therapy is a body-based therapy that engages the client or participant in creative, self-directed movement, it offers the additional benefit hoped for by Thomas and Cardona (1997) during the dance lessons offered to Thomas by Cardona. That is, by focusing on the subjective experience of the bodily sensations during expressive movement, the transgender client may increase his or her bodily comfort and awareness. Although it was not the objective of this study to explore the effectiveness of dance/movement therapy for transgender clients, the data suggest that the participants in this study found expressive movement in a group setting to be particularly helpful. They discussed increased awareness and comfort in their bodies as a result of expressive movement and interpersonal support.

The power of movement as tool for integrating new experiences and sensations into one's sense of embodiment is presaged in the body image literature and dance/movement therapy literature. Movement helps create a dynamic body image (Goodill & Morningstar, 1993). Through the movement and verbal components of dance/movement therapy, the participants were able to integrate tactile, visual, proprioceptive, and vestibular information into their experiences of embodiment, as well as interpersonal information through interactions with other participants and with me (Kinsbourne, 2002). Movement helps us focus on our subjective

experiences and helps us express emotions stored in the body (Fallon & Ackard, 2002; Rabinor & Bilich, 2002). Dance/movement therapy increases awareness of somatically felt emotions by directing the client's attention to consciously performed movements and any accompanying thoughts and feelings (Dosamantes-Alperson, 1979). Attention to somatosensory signals "anchors our developing sense of self" (Kinsbourne, 2002, p. 27).

Moreover, the manner in which the dance/movement therapy sessions brought individual expression to the forefront suggests that it may be a useful therapy for transgender people contending with a medical and mental health establishment that, as Hines (2007) found, collapses the differences among transgender people's experiences into one dominant narrative about being "trapped in the wrong body." The felt experience of embodiment, as experienced while engaging in expressive movement, yielded more complex and individualistic data than the idea of being in the "wrong body." The importance of individuality extending beyond gender identity emerged from this study. It is possible that individualistic presentations of self emerged in this study because of the unique nature of dance/movement therapy. The body-self may be uniquely activated by expressive movement. Rabinor and Bilich (2002) suggest that experiential techniques such as dance/movement therapy increase awareness of emotions that are stored within the body. Dance/movement therapy increases awareness of somatically felt emotions by directing the mover's attention to consciously performed movements and any accompanying thoughts and feelings (Dosamantes-Alperson, 1979). Sometimes these emotions lead to the discovery of a body-memory, such as participant 4's memory of her experiences driving race cars or participant 5's experience of being beaten for wearing panty hose as a child. These body-memories are particular to the individual and distinguish the individual's experience from others in the group, heightening a sense of the existence of a unique self. It is perhaps because participants' attention was directed toward sensations and inner experiences, and they were encouraged to be creative in their movement expressions, that this study brought the theme of the importance of individual expression to the forefront.[2]

None of the participants felt that their transitions were complete, and most acknowledged that they were actively engaged in studying and practicing gendered movements and working to change the appearance of their bodies. The dance/movement therapy sessions became part of the bodywork and gender practice of the participants. Within the sessions, participants practiced gendered movements and gave one another verbal and nonverbal feedback reflecting on gender presentation. While all of the participants had previously engaged in some bodywork to make their bodies more congruent with their gender identities, even if it was simply changing their clothing, several described movement as providing another dimension to experiencing the embodiment of gender. Using the sessions to practice and reflect on gender in movement heightened participants' awareness of this aspect of their subjective experiences and expressions of body image.

But some of the participants were also in the process of becoming accustomed to physical changes that they had enacted on their bodies. Participant 6, for example, was a transgender man who had just had chest reconstruction surgery. He described

using the movement portion of the sessions to explore how his body felt after this physical transition. This suggests that an important discursive process occurs that works to shape and reshape the subjective experience of embodiment for people in transition. First, the subjective experience of gender motivates the person to change his or her body and movements to better reflect the subjective experience of gender. But then, at least temporarily, the body feels a little foreign because its appearance has changed. Some sort of process is necessary to re-wed the changed body to the internal, subjective experience of self. At the risk of trivializing the process, an analogy may be helpful. If I get cosmetic surgery to change something about my appearance that distresses me, I may initially feel shocked when I look at myself in the mirror, even though I sought the change so that I could feel more like myself. In order to re-wed my subjective sense of myself to my changed body, I may look in the mirror, practice facial expressions and movement, and try on different clothes. I may have a heightened awareness of other people and attempt to gauge their reactions to me as an indicator of how I appear. In short, I have to learn how to inhabit my changed body privately and in the public sphere. I may initially feel inauthentic and false but, over time, will come to inhabit my changed body so that it may feel more authentic to me than it felt before the surgery.

The discursive process between the changes in the body and a sense of authentic subjectivity has been discussed in several other qualitative studies. Schrock et al. (2005) found that the transgender participants in their study used their bodies to take actions to modify their gender presentation in the areas of "retraining," "redecorating," and "remaking" the body (p. 321). The transgender women in their study reported that the changes to their bodies initially felt inauthentic. Through practice and the passage of time, their bodies began to feel authentic again. Schrock et al. suggest that this transition from feeling inauthentic to authentic implies that, as the body is changed and shaped, it must be reconnected to subjectivity. Changes to the body transform one's subjective experience of oneself, just as the subjective experience of self may prompt a person to make changes to the body (Wasserug et al., 2007). Johnson (2007) also touched upon this discursive process when she asked how physical changes affected the subjectivity of the participants in her study. She found that as participants experienced new body sensations, particularly from hormones, and as they practiced gendered movements, they reflected on the ways in which the body refused to change, including vocal and movement patterns that remained inflexible and certain secondary sex characteristics that remained impervious to efforts to eradicate them.

Participants in the dance/movement therapy sessions also discussed and attempted to navigate secondary sex characteristics and movement patterns that they felt did not represent their true gender identities and that they were still working to eradicate. Nonetheless, the participants did not categorically reject their bodies. Rather, they saw their bodies as vehicles of change and self-expression that required a limited number of corrections. In this sense, this study aligned with Hines (2007) study in that the participants did not feel completely "trapped in the wrong body" while transitioning. Participants described feeling trapped in the wrong body as children, but, as adults, they reported wanting to make a limited number of changes to their

bodies in order to better express and manifest their gender identities. These limited numbers of modifications were designed to cure the "expressive failure" that Rubin (2003, p. 181) described as the central problem of transgender embodiment. The bodywork helps to repair the link between outward appearance and gender identity so that the body better expresses a sense of self.

Perhaps most strongly indicated by the data was the way in which the dance/movement therapy process of mirroring the movements of others provided a unique form of interpersonal validation and support. The importance of interpersonal support to the overall well-being of transgender people has been noted by Bockting et al. (2006), Ellis and Eriksen (2002), and Ma (1997). Mason-Schrock (1996) notes the importance of transgender support groups for guidance, encouragement, and modeling. The dance/movement therapy sessions provided a unique kind of interpersonal support and acceptance through the process of mirroring movements (Sandel, 1993b). Participants commented on their positive experiences with empathic reflection, or mirroring, within the group. They seemed to hunger for good nonverbal feedback. In the dance/movement therapy group setting, participants ideally assume the role of mirroring and reciprocating nonverbal cues along with the therapist. They kinesthetically attune with one another and empathize through synchronized and reciprocal movements. This mirroring is a powerful kind of supportive nonverbal feedback that builds on itself as it develops among group members who begin to look to one another, rather than to the therapist, for feedback.

The kinesthetic empathy and empathic reflection that occurred among group members reaffirmed the importance of interpersonal experiences in the formation of body image, particularly in reducing feelings of alienation from the body that derive from negative interpersonal experiences and dissatisfaction with biological sex. The interpersonal context of the participants' experiences can best be understood using Rubin's (2003) conceptual framework of the body-for-self, body-for-other, and alienated body. The subjective experience of embodiment interacted with a sense of the body as an object that others view and judge. If others respond with ridicule, disgust, or even ambivalence, it can result in feelings of alienation from one's own body. Overwhelming social disapproval for a particular type of body can be damaging to body image resulting in pervasive feelings of alienation (Dosamantes, 1992; McKinley, 2002; Rubin, 2003; Striegal-Moore & Franko, 2002). The interpersonal support within the group reduced the alienation that Rubin (2003) described as a pervasive aspect of body image for transgender people.

The lack of interpersonal support and validation in other areas of the participants' lives was expressed and explored by the participants in movement and in words. Participants reported experiencing violence, the threat of violence, ridicule, hostility, judgment, and discrimination because of their transgender identities, confirming earlier documentation that discriminatory actions against transgender people are common (Bornstein, 1994; Dozier, 2005; Meyerowitz, 2002). All participants had the experience of having their gender identities seen as pathological by family members, employers, spouses, or mental health professionals, reflecting a culture-wide view of transgender identities as pathological or bizarre. Many had caregivers who attempted to cure them in childhood by punishments, sometimes employing violence to force gender conformity.

Lack of acceptance of our identities, the flip side of interpersonal support, can negatively impact the development of body image. Because the nonverbal feedback from others is so pivotal to the development of our sense of embodiment, we may begin to see ourselves only as other people see us, ignoring our subjective experiences of our bodies (Dosamantes, 1992, McKinley, 2002). McKinley calls this an "objectified body consciousness," and Rubin (2003) calls it the "alienated body." In Pylvanainen's (2003) framework, alienated body image is akin to experiencing only image properties, how the body appears on the surface, and not experiencing the body-self or body-memories, how the body feels and acts. This is what participants talked about in their childhood and pre-transition lives when, for example, participant 2 described compartmentalizing her feelings of femininity and living a hypermasculine life as a husband and worker in a traditionally male maritime profession and participant 6 described himself as trying harder to be feminine when, as a child and young adult, feelings of masculinity arose. Participants described trying to control the appearance of their bodies while ignoring or attempting to silence their feelings.

Finally, the dance/movement therapy group context created an environment in which happiness, relief, and joy over the decision to transition could be expressed and shared. While some qualitative studies have noted that even preliminary steps toward transition can bring relief and satisfaction, the dance/movement therapy group invites embodied celebration of these changes (Barrett, 1998; Kraemer et al., 2008; Pauley, 1981; Snaith et al., 1993; Wasserug et al., 2007; Wolfradt & Neumann, 2001). Participants were invited to move freely while listening to music. Movement helps us focus on our subjective experience of our bodies (Fallon & Ackard, 2002) and express emotions stored in the body (Rabinor & Bilich, 2002). This context could have allowed for deeper affective responses than those that might have emerged in a format involving only an interview or a questionnaire. These deep affective responses were experienced and expressed somatically and kinesthetically, and thus integrated into the participants' sense of embodiment.

Creative Movement Techniques for Professionals Without DMT Training

Initiating and Supporting Movement Interventions

It is possible for a counselor who is not trained as a dance/movement therapist to incorporate interventions that include the body in the therapeutic process. Indeed, interventions that engage the somatic and kinesthetic aspects of self may be essential to addressing the body image concerns of some clients who are expressing gender variation. And it is for that reason that I included above details about the specific interventions that I used in the study. Before discussing possible interventions that could be employed by a non-dance/movement therapist, I would like to

briefly discuss some aspects of dance/movement therapy practice that are beyond the competence of a counselor who is not a registered dance/movement therapist.

A counselor who has not been trained as a dance/movement therapist should not attempt to analyze a client's movements in an effort to diagnose or clinically assess the client. Dance/movement therapists are trained at the graduate level to use a variety of nonverbal assessment instruments to standardize the observation and the understanding of the qualities of human movement (Dell, 1977). Extensive training in movement observation, assessment, and analysis prepares dance/movement therapists to assess the mental and emotional state of clients through nonverbal channels. Laban Movement Analysis, for example, is a system developed to discern and describe qualitative aspects of movement. Within Laban Movement Analysis, movement is organized into the categories of Body, Effort, Shape, and Space. Individual movement preferences within these categories reflect the way in which the person copes with the environment as well as his or her internal states. The Body category includes organization and connectivity within the body, the activity of body parts, how movement is initiated and sequenced within the body, and the general body "attitude" (Hackney, 2000). The Effort category refers to six qualities that may be present in any movement or action. For example, consider the action of waving goodbye to someone. The wave may appear strong, light, sudden, slow, tense, relaxed, direct, or indirect. Combinations of Effort qualities can be observed and documented in all movements. The Shape category describes how the body shapes or forms itself in a given environment. The Space category describes how a person makes use of the space around him or her. An assessment of Body organization, Effort qualities, modes of Shape change, and use of Space can illuminate how a person interacts with the environment, as well as how he or she manages feelings, impulses, and thoughts (Bartenieff & Lewis, 1980; Fischer & Chaiklin, 1993; Kestenberg-Amighi et al., 1999; Lamb, 1992; North, 1972).

From the above description of Laban Movement Analysis, I hope to make clear that analyzing mental and emotional states from nonverbal communications is anything but simple and requires specific and extensive training. We, however, all make assumptions based on the movements of others on a day-to-day basis and in our practice. I believe that this is fertile ground for inquiry within the therapeutic relationship. So, rather than characterizing a client's movements or presuming to be able to read the client's "body language," a therapist who is not trained in dance/movement therapy might begin by asking the client what his or her movements or posture means to him or her. A meaningful inquiry can be initiated in which the client can pursue questions like, "Why do I seem to retreat into the armchair when I talk about that?" or "What am I really feeling when I roll my eyes and cross my legs?" If you, the therapist, are moving with the client, or inviting the client to move, nonconclusive observations can also generate inquiry. When a participant in my study imitated ballroom dancing, I remarked afterward, "When you were doing the waltz, I imagined an elegant evening where a couple in formal wear twirls gracefully across the floor. The look on your face reminded me of a feeling of peacefulness. Were you imagining anything? What did it feel like for you?" Another technique, borrowed from the discipline of authentic movement, is to acknowledge what watching the movement

(or mirroring the movement) felt like in the therapist's body. Upon seeing a client take a deep, labored breath, I might say, "When I saw you take that deep breath, I was reminded of times when I felt like I just couldn't find the space to breathe comfortably. Is that what it was like for you?" (Adler, 2002).

A second area of dance/movement therapy practice that may be beyond the competence of a mental health professional with a different background is empathic reflection of movement. As a dance/movement therapist, I often move with the client or clients, reflecting back the qualities of their movements, sometimes clarifying, amplifying, or elaborating on the movements to further the development of the nonverbal themes that are emerging in therapy. Sometimes this looks like mirroring the client's movements, and, to a certain extent, it is mirroring. But the distinction between mirroring and mimicking is very important. If I were to simply mimic the movements of a client, it could be offensive or make the client more self-conscious. So it is more a process of attempting to capture the essence of the quality of the movement and reflect it back in a way that is illuminating to the client. If I feel that I cannot do this in a particular instance, I remain still and receptive. I would encourage non-dance/movement therapists to use movement interventions when appropriate with clients but to be careful about moving with a client. A group therapy setting, however, provides a context where group members can discuss moving together and come up with their own guidelines for reflecting each other's movements.

The effectiveness of introducing movement-based techniques with a client may be partially dependent on the therapist's relationship with his or her body. It is not necessary to be comfortable in one's own body – we all experience some degree of self-consciousness about our bodies. But it is helpful to be aware of our bodies and the attendant feelings of comfort or discomfort. As many mental health practitioners have already discovered, mindfulness of breathing patterns and muscle tension can provide useful information about the way in which events and emotions are experienced and expressed by the body. It is also useful for the therapist to explore movement exercises alone or with a trusted colleague before exploring them with a client. The therapist might, for example, explore a life transition that he or she has undergone by creating a three-part movement phrase for the past, present, and future, just as the participants in this study were asked to do. Or a therapist might spend some time attempting to imitate or embody someone significant from his or her past. Attention to emotions and thoughts that arise during this process can generate insight into the difficulties that arise when attempting to move consciously in response to our feelings and experiences and also highlight the dynamic nature of body image.

The Body and Somatic Experience

What did that feel like in your body? Did you notice anything about your breath? Your heart rate, the tension in your muscles? Where do you feel that? These are questions that will be familiar to many counselors, therapists and other health care

workers. As part of an inquiry into the somatic experience, a therapist could invite a client to take a deep breath, stretch, shake out limbs, and so forth. While this is not necessary, it may be helpful if the therapist is considering inviting the client to move in other ways during the session. The questions can be expanded upon to include questions about distinction: Did you feel differently at that moment than you usually do? What did your body feel like the first time you dressed as a man/woman? Did you notice anything about your breath? Your muscles? Questions about the somatic experience of events can be used in combination with other movement interventions as well. You might ask someone to try a movement that is grounding, or to embody their best selves, and then ask questions about what that movement task felt like on a somatic level. This can help the client monitor his or her own somatic responses and also provide an internal gauge that the client can use in the future. Paying attention to somatic experiences and integrating those experiences into our understanding of ourselves form an important part of body image (body-memories and body-self) and give us a sense of being anchored in our bodies.[3]

Exploring Pedestrian Movements

The idea of dance/movement therapy inevitably leads to images of dancing, but many of the movements that I initiated with the participants allowed them to engage in pedestrian movements, such as walking, sitting down, typing, or driving a car. After moving in these ways, the participants were able to reflect with the group on *how* they had done it and what it felt like. The creativity of the movements is in the details. No one's walk is the same as another person's walk. For the participants in the study, enacting common movements sometimes became explorations of how they moved before the decision to transition and after the decision, or as a child and as an adult. Focusing attention to the movements of everyday life is fertile ground for exploring body image issues and concerns as they emerge regarding gender identity.

Exploring Movements That Tell a Story

In Pylvanainen's tripartite theory of body image, the body-self includes narratives that we create to explain who we are. From my research and the literature, it seems that there is a narrative process that often accompanies physical transition for people who identify as transgender. First and second account narratives can be found in books written by transgender and gender variant people, such as Borstein's (1994) autobiographical *Gender Outlaw*, and literature discussing the perspectives of transgender people, such as Cromwell's (1999) book *Transmen and FTMs* and Namaste's (2000) book *Invisible Lives*. Gherovici (2010, p. 230) notes that transgender and gender variant people have written memoirs with great frequency and queries

whether the memoirs can "function as a process of self-invention for the authors." She argues that the presence of so many memoirs suggests that "it is not enough to undergo corporeal reconstruction" (Gherovici, 2010, p. 233). "There is first a change in the flesh, then the artifice of writing is necessary before a full embodiment is accomplished" (Gherovici, 2010, p. 233).

I am not sure whether it is necessary to write a memoir, but movement, like writing, is one of many creative processes that may be useful in constructing the narrative that allows for a feeling of "full embodiment." During the fourth dance/movement therapy session in the study, I asked the participants to construct a movement phrase that represented the past, present, and hoped-for future of their embodied identities. All participants developed movements that were deeply personal and told unique stories. During the exit interviews, the participants remembered all of the details of their movement phrases and attached meaning to each gesture. It is likely that a body-based narrative such as the ones the study participants created would serve the function of self-invention and facilitate full embodiment.

Facilitating a process in which a client creates a narrative in a movement phrase is a natural part of dance/movement therapy but may feel outside of the ken of a mental health professional with a different background. The creative process can be multimodal. A therapist, for example, could encourage a client to talk, draw, move, and then look at the relationship between the spoken word, the art work, and the creative movements. "Through movement and multimodal art mediums (drawing, poetry, journal writing, music making, singing) we are able to bring forward the material of our lives, reveal what has been hidden, and express old stories in new ways" (Halprin, 2003, p. 21). A therapist may be more comfortable with writing, drawing, photography, music, or poetry. Starting the inquiry at that point and then asking the client if he or she would like to create a movement or pose that reflects the word or image can increase both the therapist and the client's comfort with body-based interventions.

Assessing Distress During Movement Exercises

Working with the body and movement in therapy has the potential to elicit somatic memories that are painful. Rothschild (2000, p. 44) has discussed in depth the idea of implicit memories that "are not encoded as words, but as the somatic sensations they are: smells, sights, sounds, touches, tastes, movement, position, behavioral sequences, visceral reactions." These memories can be elicited and even reexperienced when working with the body. While this can be a valuable component in healing, it can also re-traumatize because of its intensity. Moreover, it can be difficult for both the client and the therapist to know exactly what is happening because it often happens without words and without conscious acknowledgment. Certain movements can trigger flashbacks and traumatic dissociation, and, if this happens, painful sensations from the past may be reexperienced (Rothschild, 2000).

You can observe or ask about physical experiences that indicate that the experience of moving in therapy is getting too intense: increased heart rate, sweaty hands or general sweating, tensing of muscles, or other signs of emotional distress or of the engagement of the autonomic nervous system. By attending carefully to the sensations in his or her own body, the therapist may be able to pick up on the client's somatic experiences of distress. For example, as my client's breathing becomes faster and shallower, I may notice a tightness in my chest. The therapist must have a way to stop the action and get the client back to safety. This may mean returning to talking in a seated position, changing the subject and focusing on something that is anchoring and safe for the client, and so forth.

Movements that are grounding are as follows: breathing, feeling feet on the floor or bottom on the chair, and noting the particulars of the surroundings and verbalizing them. You can also ask a client to visualize a time and place where the client felt safe and grounded and ask them to recreate that feeling within the session.

The awareness that your client builds of his or her somatic sensations may enact its own change upon body image, increasing the client's sense of connection to the body and understanding of the body as a usually reliable barometer of emotion and intuition.

If a client experiences difficulty and discomfort with simple breathing exercises or stretching, I would not move ahead to any kind of deeper movement exploration. I would stay within a zone of safety, focusing on verbal therapeutic techniques and helping the client develop an awareness of his or her somatic sensations like his or her breathing, muscular tension, and so forth.

Special Considerations About Gender and Movement

What does it mean to move like a man or to move like a woman? We take it for granted that men and women have distinctive movements and are able to remark when, for example, a man walks like a woman or a woman sits down like a man. Gherovici (2010, p. 236) notes, "Every day, we make multiple gender attributions that are not based on the genitals, but on other makers of gender differences like clothing, manners, behaviors, and style." Yet research on gender differences in movement has yielded mixed and contradictory results (Bente, Donoghy, & Suwelack, 1998). Even at best, the results must be contextualized depending on whether the circumstances surrounding the nonverbal communication are casual, familial, or professional and how well the parties engaged in the nonverbal communication know each other (Bente et al., 1998; Birdwhistle, 1970; Hall, LeBeau, Reinoso, & Thayer, 2001; Koch, 2006; Lamb, 1992). "When context information is taken into account, many gender differences in nonverbal behavior disappear or change" (Bente et al., 1998, p. 36).

On the other hand, the anthropologist Birdwhistle (1970) notes that lay people assume that they can distinguish masculine from feminine movement patterns and also distinguish feminine behavior in men and masculine behavior in women.

He postulates that our weak sex dimorphism causes us to rely heavily on tertiary sex characteristics, such as "position, movement, and expression," to identify sex (Birdwhistle, 1970, p. 42). Birdwhistle (1970, p. 46) defines tertiary sex characteristics as "learned and patterned communicative behavior which in the American body motion communication system acts to identify both the gender of a person and the social expectancies of that gender." Some of the gender differences that have been studied are the frequency and length of eye contact, the frequency and amount of gross and fine motor movement, the length of pauses when speaking, posture, and smiling behaviors (Bente et al., 1998, Hall et al., 2001).

Dosamantes (1992) discusses an unpublished study by Davis and Weitz that was presented to the American Psychological Association in 1978. The study examined sex differences in nonverbal communication by observing conversations between male and female graduate students. The women used peripheral movement, narrow posture, and continuous orientation toward the speaker. Men used more gross movement, assumed wider and larger positions, used stronger movements, and showed more periods of complete stillness. When women talked to other women, their movements were freer, more expansive, and mutual, but when they talked to men, they moved in ways indicating "lower status," including presenting their palms and narrowing their stance (Dosamantes, 1992, p. 261). Men did not display this variation depending on whom they were talking to.

In a survey of the literature reporting studies on gender differences in nonverbal behavior, Hall (2006) concluded that there is evidence that men and women differ in the areas of smiling, nodding, facial expressiveness, gazing, interpersonal distance, touching of others, self-touch, hand gestures, body postures, and nonverbal expressiveness. On the whole, gender differences that appear in one study, however, disappear in another study if the context or setting is different. She states, "The fact that emotions, goals, and motives may vary dramatically from individual to individual, setting to setting, or study to study greatly reduces the prospects of finding consistent results" (p. 387; see also Hall et al., 2001).

Given the infinite variety of possibilities of movement and the contextual nature of gender displays in movement, it seems an impossible task for someone to simply learn to move as a man or move as a woman. Yet, this is part of the bodywork initiated by transgender people in the qualitative studies described by Johnson (2007) and Schrock et al. (2005). Attempting to train their bodies to embody gender is an action and a physical experience that is part of the body-self component of body image. And questions about accurately conveying gender identity were present throughout the dance/movement therapy group that I conducted.

Many transgender people, however, utilize nonbinary ideals of gender as part of their gender identity. In addition to the endorsement of androgynous personality traits, transgender narratives regarding gender identity often diverge from an endorsement of gender as binary. Finn and Dell (1999) conducted a qualitative study, for example, that explored the nuanced and complex facets of gender identity in seven transgender people. Four transgender men and three transgender women were interviewed, and data were gleaned from the transcripts of the interviews using discourse analysis. The interviewees perceived some fluidity in gender identity, yet

they were confronted with medical and psychological establishments that view any departure from "normal" gender to be pathological, requiring surgical transformation. They felt that the idea of embodying a unique or different gender identity should be thought of as a question of personal choice rather than as a question of mental health. Likewise, Gherovici (2010) reviewed publicized cases in which people who identify as transgender explicitly disavow choosing to be men or women but prefer instead to occupy an intermediate space. The process may involve creating pronouns that are gender neutral, such as *hir*, instead of him or her, and *ze* or *s/he*, instead of he or she (p. 23). The goal then is not to transition to living as a man or a woman, but to find a way to present oneself authentically outside of the gender binary. "For these bodies, arriving at a destination is not always granted or a given" (Gherovici, 2010, p. 39).

Given the vast variety of movement styles that can be considered masculine or feminine and given the variety of gender identities that could be constructed outside of the gender binary of male/female, any attempt to work with a client on how to move like a man or a woman must really be more of a joint inquiry. The therapist can facilitate that inquiry with questions like: What does it means to you to move like a man or woman? What are your earliest memories of women and men and how they moved? Would you like to try moving like that now? How would a woman move in a different context if she were a boss or if she were in an emergency situation? Any other approach risks devolving into stereotypes that do not invite either a deeper understanding of the individual client or the individual client's unique path of personal development.

Conclusion

This chapter discussed a qualitative study of the experience and expression of body image for six transgender adults participating in a series of group dance/movement therapy sessions and the clinical implications of the study. The question posed by the study was driven by the paucity of qualitative research on the subjective experience of embodiment of people who are transitioning gender roles and identities, and from the belief that clinicians serving transgender clients would benefit from a more nuanced understanding of issues of body image and embodiment that may emerge during transition. Indeed, as discussed above, the researcher located only four previous qualitative studies that addressed the subjective experience of embodiment for transgender people (Johnson, 2007; Rubin, 2003; Schrock et al., 2005; Wasserug et al., 2007). This study builds on the results of those studies and adds to this emerging body of research the unique context of the dance/movement therapy setting.

What emerged from the study were six group themes and four variant themes that relate to the experience of the embodied self. Some of the themes reflect the findings in other studies of transgender embodiment, such as "studying and practicing gendered movements" and "actively working to shape the body as a vehicle of self-expression," and add to the understanding of the discursive process between

body image and body modification. The emergence of other themes is more unique to this study, specifically the themes of "the importance of expressing a unique self," "supporting one another's expression of the true self," and "joy, relief, and celebration in the transition." The expressions of joy, relief, and celebration within the group sessions may have been enhanced by the dance/movement therapy context. Movement aids in the discovery and expression of emotions and, thus, in the discovery and expression of the unique emotional responses of the individual (Rabinor & Bilich, 2002). As Darwin (1872/1998, p. 234) noted, "Most of our emotions are so closely connected with their expression, that they hardly exist if the body remains passive…." Moreover, the dance/movement therapy context seems to have provided a unique kind of interpersonal support and acceptance through the process of mirroring movements (Sandel, 1993b). The interpersonal support within the group may have reduced the alienation that Rubin (2003) described as a pervasive aspect of body image for transgender people in his study.

This study was designed to yield detailed information about the subjective experiences of a small group of transgender people. As such, the results should not be generalized to transgender people as a whole. Because the study provides some detail about the subjective experience of body image for a select few people who identified as in transition, it may be applicable in clinical settings in which a therapist is attempting to understand the body image experiences of a client in transition. The data suggest that the transgender people who participated in the study saw their bodies as both agents of change and as imperfect reflections of their true selves. The data also highlight the many ways in which some transgender people work on their bodies, acting as resourceful agents capable of making changes to their bodies and their lives (Rubin, 2003).

As mentioned above, the function of therapy for the transgender person is similar to that of any person undergoing a major life transition – "to facilitate identity consolidation and social integration" (Raj, 2002, Sect. 3.1.1, para. 2). Although it was not the objective of this research to study the effectiveness of dance/movement therapy for transgender clients, the data suggest that the participants in this study found expressive movement in a group setting to be particularly helpful. While the dance/movement therapist is qualified through master's degree level training and a rigorous certification process to use movement as both an assessment tool and as a treatment method, the social worker or mental health practitioner who is untrained in dance/movement therapy may find that body-based interventions are helpful in supporting transgender clients. It is helpful for the therapist to develop awareness of his or her own somatosensory cues and address the movements, posture, and body attitude of the client with open, nonjudgmental interest. If both the therapist and client feel comfortable exploring any of the exercises involving creative movement that I have described in this chapter, it would be wise to leave ample time at the end of the session for a discussion of the client's experiences with the movements. And, finally, consultation with a certified dance/movement therapist may be indicated in circumstances where the therapist and the client decide that in-depth movement-based therapeutic interventions would be helpful.

Notes

1. I did not systematically document whether participants in this study received sex reassignment surgery because participants did not highlight surgical intervention as pivotal to the experience and expression of body image, with the exception of participant 6, who discussed enjoying the feeling of his body after chest reconstructive surgery. Some participants specifically mentioned during their interviews that they hoped to have sex reassignment surgery, but did not express this during the sessions.
2. It is important to note that the movement experientials that I suggested to the participants during sessions 3 and 4 encouraged the exploration of individual narratives rather than the emergence of a shared, group narrative. My choices as the leader of the group encouraged the development of this theme of expressing one's true and unique self. At the same time, I suggested movement experientials that focused on individual self-exploration based on cues that I took from the group during sessions 1 and 2. What emerged in discussion at the end of session 2, however, was that individual participants wanted to share their unique experiences with the embodiment of gender. Moreover, I noted movements in the group that suggested enthusiasm for self-presentation to a supportive audience. My choice of movement experientials aimed at deepening this exploration of individual experience was based on these verbal and nonverbal cues from the group.
3. Further techniques to increase clients' ability to monitor their somatic sensations and use their somatic experiences to feel anchored in their bodies have been discussed extensively by Rothschild (2000), and her writing provides a solid blueprint for the therapist untrained in somatic therapy or dance/movement therapy.

References

Adler, J. (2002). *Offering from the conscious body: The discipline of authentic movement*. Rochester, VT: Inner Traditions.

Alexander, R. (2008). *Equal + opposite.* Unpublished film retrieved from filmmaker at Rahnealexander@gmail.com.

Barbee, M. (2002). A visual-narrative approach to understanding transsexual identity. *Art Therapy: Journal of the American Art Therapy Association, 19(2)*, 53–62.

Barrett, J. (1998). Psychological and social function before and after phalloplasty. *International Journal of Transgenderism, 2*(1). Retrieved January 14, 2012, from http://www.iiav.nl/ezines/web/ijt/97-03/numbers/symposion/ijtc0301.htm.

Bartenieff, I., & Lewis, D. (1980). *Body movement: Coping with the environment*. New York: Gordon and Breach Science Publishers.

de Beauvoir, S. (1989). *The second sex* (H. M. Parshley, Trans.). New York: Vintage Books.

Bente, G., Donoghy, W. C., & Suwelack, D. (1998). Sex differences in body movement and visual attention: An integrated analysis of movement and gaze in mixed sex dyads. *Journal of Nonverbal Behavior, 22*(1), 31–58.

Birdwhistle, R. L. (1970). *Kinesics and context: Essays on body motion communication*. Philadelphia: University of Pennsylvania Press.

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *The International Journal of Transgenderism, 9*(3/4), 35–82. doi:10.1300/J485v09n03_03.

Bolin, A. (1992). Coming of age among transsexuals. In T. L. Whitehead & B. V. Reid (Eds.), *Gender constructs and social issues* (pp. 13–39). Chicago: University of Chicago Press.

Bornstein, K. (1994). *Gender outlaw: On men, women and the rest of us*. New York: Vintage Books.

Callender, C., & Kochems, L. M. (1983). The North American berdache. *Current Anthropology, 24*(4), 443–470.

Cash, T. F. (2002). Beyond traits. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 135–141). New York: Guilford Press.

Cash, T. F., & Fleming, E. C. (2002). Body image and social relations. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 277–286). New York: Guilford Press.

Chace, M. (1993). Selected writings: Body image and physiology. In S. L. Sandel, S. Chaiklin, & A. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 345–364). Columbia, MD: The Marian Chace Memorial Fund of the American Dance Therapy Association.

Chaiklin, S., & Schmais, C. (1993). The Chace approach to dance therapy. In S. L. Sandel, S. Chaiklin, & A. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 75–97). Columbia, MD: The Marian Chace Fund of the American Dance Therapy Association.

Cromwell, J. (1999). *Transmen and FTMs: Identities, bodies, genders, and sexualities*. Chicago: University of Illinois Press.

Darwin, C. (1872/1998). *The expression of emotions in man and animals*. New York: Oxford University Press.

Dell, C. (1977). *A primer for movement description using effort-shape and supplementary concepts*. New York: Dance Notation Bureau Press.

Denny, D., & Roberts, J. (1997). Results of a questionnaire on the standards of care of the Harry Benjamin International Gender Dysphoria Association. In B. Bullough, V. Bullough, & J. Elias (Eds.), *Gender blending*. Amherst, NY: Prometheus Books.

Dosamantes, I. (1992). Body image: Repository for cultural idealizations and denigrations of the self. *The Arts in Psychotherapy, 19*, 257–267.

Dosamantes-Alperson, I. (1981). Experiencing movement in psychotherapy. *American Journal of Dance Therapy, 4*, 33–44.

Dosamantes-Alperson, I. (1979). The intrapsychic and the interpersonal in movement psychotherapy. *American Journal of Dance Therapy, 3*, 20–31.

Dozier, R. (2005). Beards, breasts, and bodies: Doing sex in a gendered world. *Gender and Society, 19*(3), 297–316.

Ellis, K. M., & Eriksen, K. (2002). Transsexual and transgenderist experiences and treatment options. *The Family Journal: Counseling and Therapy for Couples and Families, 10*(3), 289–299.

Etkins, R., & King, D. (1997). Blending genders: Contributions to the emerging field of transgender studies. *The International Journal of Transgenderism, 1*(1). Retrieved January 14, 2012, from http://www.iiav.nl/ezines/web/ijt/97-03/numbers/symposion/ijtc0101.htm [cited as http://www.symposion.com/ijt/ijtc0101.htm]

Ettner, R. (1996). *Confessions of a gender defender*. Evanston, IL: Chicago Spectrum Press.

Fallon, P., & Ackard, D. M. (2002). Sexual abuse and body image. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 117–124). New York: Guilford Press.

Finn, M., & Dell, P. (1999). Practices of body management: Transgenderism and embodiment. *Journal of Community and Applied Social Psychology, 9*, 463–476.

Fischer, J., & Chaiklin, S. (1993). Meeting in movement: The work of the therapist and the client. In S. Sandel, S. Chaiklin, & A. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 136–153). Columbia, MD: Marian Chace Fund of the American Dance Therapy Association.

Fisher, S., & Cleveland, S. (1968). *Body image and personality*. New York: Van Nostrand.

Freud, S. (1923). *The ego and the id*. London: Hogarth Press.

Gagne, P., & Tewksbury, R. (1999). Knowledge and power, body and self: An analysis of knowledge systems and the transgender self. *The Sociological Quarterly, 40*(1), 59–83.

Gherovici, P. (2010). *Please select your gender: From the invention of hysteria to the democratizing of transgenderism*. New York: Routledge.

Goodill, S. W., & Morningstar, D. M. (1993). The role of dance/movement therapy with medically involved children. *International Journal of Arts Medicine, 2*(2), 24–27.

Hackney, P. (2000). *Making connections: Total body integration through Bartenieff Fundamentals*. New York: Routledge.

Hall, J. (2006). Nonverbal behavior, status, and gender: How do we understand their relations? *Psychology of Women Quarterly, 30*, 384–391.

Hall, J. A., LeBeau, L. S., Reinoso, J. G., & Thayer, F. (2001). Status, gender, and nonverbal behavior in candid and posed photographs: A study of conversations between university employees. *Sex Roles, 44*(11/12), 677–692.

The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, 6th ed. (2001). Retrieved January 14, 2012, from http://wpath.org/Documents2/socv6.pdf.

Hausman, B. (2001). Recent transgender theory. *Feminist Studies, 27*(2), 465–490.

Halprin, D. (2003). *The expressive body in life, art, and therapy: Working with movement, metaphor, and meaning*. New York: Jessica Kingsley Publishers, Ltd.

Hines, S. (2007). *Transforming gender: Transgender practices of identity, intimacy and care*. Bristol, UK: The Policy Press.

Johnson, K. (2007). Changing sex, changing self: Theorizing transitions in embodied subjectivity. *Men and Masculinities, 10*(1), 54–70.

Kestenberg-Amighi, J., Loman, S., Lewis, P., & Sossin, K. M. (1999). *The meaning of movement: Developmental and clinical perspectives of the Kestenberg Movement Profile*. New York: Brunner-Routledge.

Kinsbourne, M. (2002). The brain and body awareness. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 22–29). New York: Guilford Press.

Koch, S. C. (2006). Gender and leadership at work: Use of rhythms and movement qualities in team communication. In S. C. Koch & I. Brauninger (Eds.), *Advances in dance/movement therapy* (pp. 40–51). Berlin, Germany: Logos Verlag Berlin.

Kraemer, B., Delsignore, A., Schnyder, U., & Hepp, U. (2008). Body image and transsexualism. *Psychopathology, 41*, 96–100.

Krueger, D. W. (2002a). Psychodynamic approaches to changing body image. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 461–468). New York: Guilford Press.

Krueger, D. W. (2002b). Psychodynamic perspectives on body image. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 30–37). New York: Guilford Press.

Lamb, W. (1992). The essence of gender in movement. In S. Loman & R. Brandt (Eds.), *The body-mind connection in human movement analysis* (pp. 135–151). Keene, NH: Antioch New England Graduate School.

Ma, J. L. C. (1997). A systems approach to the social difficulties of transsexuals in Hong Kong. *The Association of Family Therapy, 19*, 71–88.

Mason-Schrock, D. (1996). Transsexuals' narrative construction of the "true self". *Social Psychology Quarterly, 59*(3), 176–192.

McKinley, N. M. (2002). Feminist perspectives and objectified body consciousness. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 55–62). New York: Guilford Press.

Meekums, B. (2005). *Dance movement therapy: A creative psychotherapeutic approach*. London: Sage Publications.

Meyerowitz, J. (2002). *How sex changed: A history of transsexuality in the United States*. Cambridge, MA: Harvard University Press.

Namaste, V. (2000). *Invisible lives: The erasure of transsexual and transgendered people*. Chicago: University of Chicago Press.

Nanda, S. (1985). The hijras of India: Cultural and individual dimensions of an institutionalized third gender role. *Journal of Homosexuality, 11*(3/4), 35–54.

Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research, 15*, 1447–1457.

North, M. (1972). *Personality assessment through movement*. London: MacDonald & Evans.

Nuttbrock, L., Rosenblum, A., & Blumenstein, R. (2002). Transgender identity affirmation and mental health. *The International Journal of Transgenderism, 6*(4). Retrieved January 14, 2012, from http://www.iiav.nl/ezines/web/ijt/97-03/numbers/symposion/ijtvo06no04_03.htm [cited as http://www.symposion.com/ijt/ijtvo06no04_03.htm]

Pallaro, P. (1996). Self and body-self: Dance/movement therapy and the development of object relations. *The Arts in Psychotherapy, 23*(2), 113–119.

Pauley, I. B. (1981). Outcome of sex reassignment surgery for transsexuals. *Australian and New Zealand Journal of Psychiatry, 15*, 45–51.

Poasa, K. (1992). The Samoan fa'afafine: One case study and discussion of transsexualism. *Journal of Psychology and Human Sexuality, 5*(3), 39–51.

Picirillo, E. (1996). In search of an accurate likeness: Art therapy with transgender persons living with AIDS. *Art Therapy: Journal of the American Art Therapy Association, 13*(1), 37–46.

Pylvanainen, P. (2003). Body image: A tripartite model for use in dance/movement therapy. *American Journal of Dance Therapy, 25*(1), 39–55.

Pylvanainen, P. (2006). The tri-partite model of body image and its application to experiences in butoh. In S. C. Koch & I. Brauninger (Eds.), *Advances in dance/movement therapy* (pp. 40–51). Berlin: Logos Verlag Berlin.

Rabinor, J. R., & Bilich, M. A. (2002). Experiential approaches to changing body image. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 469–477). New York: Guilford Press.

Rachlin, K. (2002). Transgender individuals' experiences of psychotherapy. *The International Journal of Transgenderism*, *6*(1). Retrieved January 14, 2012, from http://columbia.academia.edu/KatherineRachlin/Papers/167392/Transgender_Individuals_Experiences_of_Psychotherapy [cited as http://www.symposion.com/ijt/ijtvo06no01_03.htm]

Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgender clients. *The International Journal of Transgenderism*, *6*(2). Retrieved January 14, 2012 from, http://www.iiav.nl/ezines/web/ijt/97-03/numbers/symposion/ijtvo06no02_04.htm [cite as http://www.symposion.com/ijt/ijtvo06no02_04.htm]

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York: W.W. Norton & Company.

Rubin, H. (2003). *Self-made men: Identity and embodiment among transsexual men*. Nashville, TN: Vanderbilt University Press.

Sandel, S. (1993a). Imagery in dance therapy groups: A developmental approach. In S. Sandel, S. Chaiklin, & A. F. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 112–119). Columbia, MD: Marian Chace Fund of the American Dance Therapy Association.

Sandel, S. (1993b). The process of empathic reflection in dance therapy. In S. Sandel, S. Chaiklin, & A. F. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian*

Chace (pp. 98–111). Columbia, MD: Marian Chace Fund of the American Dance Therapy Association.
Schilder, P. (1950). *The image and appearance of the human body*. New York: International Universities Press.
Schmais, C. (1998). Understanding the dance/movement therapy group. *American Journal of Dance Therapy, 20*(1), 23–35.
Schrock, D., Reid, L., & Boyd, E. M. (2005). Transsexuals' embodiment of womanhood. *Gender and Society, 19*(3), 317–335.
Sherebrin, H. (1996). Gender dysphoria: The therapist. *Art Therapy: Journal of the American Art Therapy Association, 13*(1), 47–53.
Snaith, P., Tarsh, M. J., & Reid, R. (1993). Sex reassignment surgery: A study of 141 Dutch transsexuals. *The British Journal of Psychiatry, 162*, 681–685.
Stark, A., & Lohn, A. F. (1993). The use of verbalization in dance/movement therapy. In S. Sandel, S. Chaiklin, & A. F. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 120–135). Columbia, MD: Marian Chace Fund of the American Dance Therapy Association.
Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.
Striegal-Moore, R. H., & Franko, D. L. (2002). Body image issues among girls and women. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 183–191). New York: Guilford Press.
Tantleff-Dunn, S., & Gokee, J. L. (2002). Interpersonal influences on body image development. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 108–116). New York: Guilford Press.
Thompson, J. K., & Gardner, R. M. (2002). Measuring perceptual body image among adolescents and adults. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 135–141). New York: Guilford Press.
Thomas, J., & Cardona, A. (1997). The use of dance/movement in the adjustment to a new gender role. In B. Bullough, V. Bullough, & J. Elias (Eds.), *Gender blending* (pp. 405–412). Amherst, NY: Prometheus Books.
Thompson, J. K., & Van Den Berg, P. (2002). Measuring body image attitudes among adolescents and adults. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 142–154). New York: Guilford Press.
Totman, R. (2008). *The third sex – Kathoey: Thailand's ladyboys*. London: Souvenir Press.
Wasserug, R., Gray, R. E., Barbara, A., Trosztmer, C., Raj, R., & Sindig, C. (2007). Experiences of transwomen with hormone therapy. *Sexualities, 10*(1), 101–122. doi:10.1177/1363460707072957.
Wilson, A. (1996). How we find ourselves: Identity development and two-spirit people. *Harvard Educational Review, 66*(2), 303–317.
Wolfradt, U., & Neumann, K. (2001). Depersonalization, self-esteem and body image in male-to-female transsexuals compared to male and female controls. *Archives of Sexual Behavior, 30*(3), 301–310.

Chapter 2
Engendering Self Through Monologue and Performance: Helping Your Clients Explore Identity and Sexuality

Sana Loue

Introduction

This chapter focuses on the combined use of writing and performance as a means of exploring and validating gender identity and sexual orientation. The chapter is written from my perspective as a licensed social worker, whose training in the use of these modalities derives from conferences, workshops, and extensive reading. My experience suggests that social workers can integrate these modalities into their practices even in the absence of a formal degree in expressive therapies, as long as they have basic training and can secure qualified supervision.

The first portion of the chapter focuses on the use of writing as a means of exploring one's circumstances and discovering the self. The chapter next explores the use of performance to construct and establish identity and the dual use of writing and performance together. A case study of the use of writing and performance with African American young men is presented, including monologues composed by three participants in that project, with their permission. This is followed by a discussion of the various clinical, ethical, and legal issues that arose in the context of that project.

Using Writing and Theater in Therapy

Discovering Self Through Writing

Writing has been found to yield a multitude of beneficial effects on both a short-term and long-term basis. These positive outcomes include improved immune functioning (Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Petrie & Fontanilla, 2004),

S. Loue, J.D., Ph.D., M.P.H., M.S.S.A. (✉)
Department of Epidemiology and Biostatistics, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106-4945, USA
e-mail: Sana.Loue@case.edu

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3_2,

improvements in mood, desired behavioral outcomes (Baikie & Wilhelm, 2005; Pennebaker, 1997), decreases in social dysfunction (Pizarro, 2004) and posttraumatic intrusion and avoidance symptoms (Klein & Boals, 2001), and improvements in sleeping patterns (Harvey & Farrell, 2003). Writing has been found to be particularly beneficial as a means of processing traumatic events (Esterling, L'Abate, Murray, & Pennebaker, 1999). Although not definitive, studies suggest that the effectiveness of writing appears to be equivalent both to vocal expression (Murray & Segal, 1994) and to eye movement desensitization and reprocessing (Largo-Marsh & Spates, 2002).

Various theories have been advanced to explain the underlying mechanism for these effects, although the specific mechanism remains unclear. It has been hypothesized that the nondisclosure of important psychological issues constitutes a form of inhibition, which requires physiological effort. This may manifest as stress, leading to illness. Release of the constrained thoughts and emotions reduces the stress occasioned through inhibition (Pennebaker, 1989). On a psychological level, it is believed

> that translating experiences into language and constructing a coherent narrative of the event enables thoughts and feelings to be integrated, leading to a sense of resolution and less negative feelings associated with the experience. (O'Connor, Nikoletti, Kristjanson, Loh, & Willcock, 2003, p. 196)

Pennebaker and Chung (2006, p. 38) explained how writing can facilitate cognitive and social changes:

> Writing forces people to stop and reevaluate their life circumstance. The mere act of writing also demands a certain degree of structure as well as the basic labeling of acknowledging of their emotions … [which] are translated into words… The cognitive changes … allow the individuals to begin to think about and use their social worlds differently. They talk more, they connect with others differently. They are now better able to take advantage of social support and with these cognitive and social changes, many of their unhealthy behaviors abate.

Accordingly, the process of writing may help the individual make meaning out of his or her circumstances, negotiate change, define boundaries, and/or reinforce self-worth (Sampson, 2007).

Therapeutic writing can be utilized with diverse populations and can assume a variety of forms. The composition of self-obituaries by adolescents has been used as a vehicle to help the youth gain perspective on and assume responsibility for their lives (LaBelle, 1987). Creative writing has been used with women to help them develop a new skill and increase their sense of empowerment (Huss, Tekoa, & Cwikel, 2009). Bereaved individuals' therapeutic use of expressive writing helped to reduce their grief and increase their levels of self-care (O'Connor et al., 2003). Guided letter writing has been used with clients in a therapeutic context to identify salient aspects of their past that may need additional exploration and to promote desensitization to painful conflicts and traumatic experiences (Rasmussen & Tomm, 1992). Creative writing has been used in social work practice with young offenders "to foster a self-reflective reparative state of mind that enhances the

ability to recognize and respond to others" (Froggett, 2007; Froggett, Farrier, & Poursanidou, 2007, p. 105). The use of writing in conjunction with online therapy for the treatment of posttraumatic stress disorder has been growing (Lange, van den Ven, Schrieken, & Emmelkamp, 2001; Murphy & Mitchell, 1998). Known variously as interapy and therap-e-mail, research suggests that participants in this process experience improvements in mood and a decrease in trauma symptomatology (Lange et al.).

The written product itself may assume any number of forms, including poetry (Aadlandsvik, 2007; Bolton, 1999), a blog (Nagel & Anthony, 2009), a journal (Schneider & Stone, 1998), and a narrative, among others. The specific modality of the writing necessarily depends upon the needs and comfort level of the client and the skills and preferences of the therapist.

Self-authored monologues may be particularly beneficial for some clients. The individual is able to develop his *own* story: as the hero or protagonist in his own story, he finds the resources that are needed to address his challenge or crisis as he progresses on his journey, which culminates in success and resolution. Composing one's own story engages the individual's imagination, facilitates the client's discovery of his strengths and resources that he did not know that he had, and promotes transformation. In the telling of the story, however long or short it may be, one can

> create a "story world" in which we represent ourselves against a backdrop of cultural expectations about a typical course of action; our identities as social beings emerge as we construct our own individual experiences as a way to position ourselves in relation to social and cultural expectations. (Schiffrin, 1996, p. 170)

The process of writing the monologue promotes the individual's ability to describe experiences coherently, to reflect upon his internal mental state, and to recognize the complexity of his thoughts and experiences. The client's writing can become a permanent record, if he so wishes, to which he can refer from time to time to review his successes, thereby boosting his self-confidence should he feel the need for reinforcement (Wright, 2005).

Various approaches to the process of therapeutic writing have been utilized. Expressive writing assignments can be given by the clinician on three or four occasions as a homework assignment, or they can be done during, before, or following sessions (Baikie & Wilhelm, 2005). Some writers have suggested that the patient should choose both the focus and the structure of the writing. Although the client may wish the therapist to read his or her writing, the therapist should refrain from providing any feedback (Baikie & Wilhelm, 2005).

In contrast to this approach, it has been suggested that the therapeutic writing process proceeds through three phases. During the first phase, the therapist is directive and makes specific writing assignments. The therapist and the client negotiate the focus of the writing during the second phase. Finally, during the third phase, the client independently determines the focus of the writing (Rasmussen & Tomm, 1992). The writing is intended to bring issues for discussion to the fore for both the client and the therapist.

Constructing and Establishing Identity Through Performance

The creation of a frame through performance permits the creation of a space in which stories can be told. Defined broadly, performance

> suggest[s] not only conventional theatre but any number of cultural occasions and social processes that involve ritual, movement, sound, and/or voice on the one hand, and the various individual and communal roles that socialized subjects embody in the world, on the other. (Román, 1997, p. 151)

Performance permits the creation of new realities, "a world of the possible, a liminal realm where through imagination and playfulness, inventiveness and pretence, we can construct our own reality and make-believe how things might 'really' be" (MacCormack, 1997).

Self-presentation, or self-identity performance, is intended to benefit and achieve recognition for that specific individual. In self-presenting, the individual may concretely represent his or her emotions, while the removal of conflict from inside his or her self permits greater objectivity and an enhanced ability to view, manipulate, and come to terms with the issue at hand. It has been suggested that "the actor or client cannot be real on the stage or in life if he or she does not express emotional truth of the moment" (Fink, 1990, p. 9).

However, individuals can sustain their identities only to the extent that they are able to represent and practice them. Further, to be sustained, the identities must be acknowledged by others (Klein, Spears, & Reicher, 2007; Tajfel & Turner, 1986). Accordingly, individuals may use their self-presentations as a mechanism by which to establish both connections and positive relationships with others (Klein et al.).

In contrast, social identity performance, defined as "the purposeful expression (or suppression) of behaviors relevant to those norms conventionally associated with a salient social identity" (Klein et al., 2007, p. 30), focuses on performances of the actor as a group member. Some performances may be hybrids between the personal and the social, so that individuals may present themselves as group members and claim a social identity to benefit themselves as individuals (Hornsey & Jetten, 2003).

Social identity performance can take any number of forms, including physical action, the manipulation of physical appearance, and the verbal expression of representations and attitudes (Klein et al., 2007). The performance may confirm group identity through the expression of in-group norms and/or may be instrumental, in that it engages group members to preserve or enhance the standing of their group (Scheepers, Spears, Doosje, & Manstead, 2002, 2003, 2006). Individuals may act to secure their social identity as members of a group, and they may act together to secure the recognition of a shared social identity. When the social identity is salient, the benefit to the group may also inure to the individuals (Tajfel, 1978). As Klein and colleagues (2007, p. 32) noted, "By performing their desired identity, they may be accepted as possessing it and, thereby, come to be viewed by others in a manner consistent with their own self-view." Accordingly, members of the social group to which the actor belongs are themselves an audience to the individual actor's identity performance. It should be borne in mind, however, that the affirmation of some identities may incur a cost to the individual and/or to the group.

In both self- and social performance of gender, gender reality is both created and sustained; "because gender is not a fact [but a historical social construction], the various acts of gender creates the idea of gender, and without those acts, there would be no gender at all" (Butler, 1988, p. 522). Indeed,

> gender cannot be understood as a *role* which either expresses or disguises an interior "self," whether that "self" is conceived as sexed or not. As performance which is performative, gender is an "act," broadly construed, which constructs the social fiction of its own psychological interiority. (Butler, 1988, p. 528)

The audience to self- or social identity performance serves as both a witness and a jury to the performers' realities (Yankah, 1985). The performance can reduce the distance between the actor/client and the audience so that the stage and auditorium are abolished as separate entities and direct communication is established between the actor and the audience (Furman, 1988; Sontag, 1976). Identity performance allows the actor to depict his struggles and to identify himself as a hero while permitting the audience member to simultaneously witness the actor-hero and identify himself or herself with a hero (cf. Lothane, 2009). This authority on the part of the performer—the establishment of his identity—may extend beyond the performance setting (Yankah, 1985). The witnessing by the audience also facilitates the establishment or consolidation of the collective identity of those who are performing; the actors are no longer invisible or dismissed (Klein et al., 2007). As Grotowski (1973, p. 124) observed, "We [the actors] are doing something, and there are others who want to meet us; this is not the audience, they are concrete human beings … there is something that will happen between us."

Pairing Writing and Performance

The pairing of writing and performance together may yield greater benefits than the use of either alone (cf. Kranz & Pennebaker, 1996). The use of both engages multiple senses and capacities and permits the writer-actor to engage in self-reflection, to be witnessed, and to witness others. Additionally, writing allows the individual to attain cognitive understanding; speaking of it to others, such as through performance, facilitates social connection and enables the individual to become more integrated within his or her social network (Pennebaker & Graybeal, 2001).

Case Study

The Setting

This writing-performance project was conducted in Cleveland, Ohio, with a group of African American men who have sex with men between the ages of 16 and 24 who were attendees of local drop-in center for sexual minority youth. An understanding of

the context in which they lived is critical to understanding why writing and performance were utilized in this project.

Approximately one-half of Cleveland's population is African American. The remainder of the city's population comprises non-Hispanic Whites (41.5%), Hispanics/Latinos (7.3%), and Asians and Pacific Islanders (1.4%), with small numbers of Native Americans (United States Bureau of the Census, 2000). Cleveland was and continues to be considered by many to be heavily segregated on the basis of race.

Cleveland's 2003 poverty rate was 31.1%, almost three times the national poverty rate of 12.7%. Cleveland is one of the three poorest major cities in the United States and was named the "Nation's Poorest Major City" in 2003 and 2005 (Smith & Davis, 2004; Webster & Bishaw, 2006). The majority of youths living in predominately African American neighborhoods were in homes in poor condition (Salling, 2006). Cleveland's foreclosure rate in 2006 was more than three times the national annual foreclosure rate (Fitch, 2006). A majority of African Americans residing in Cuyahoga County, which includes Cleveland, are in areas known as Health Professional Shortage Areas (HPSA), that is, they lack a threshold number of primary care physicians (Lenahan, 2005). The relative unavailability of treatment services is concerning due to high rates of communicable disease (Cleveland Department of Public Health, 2007).

In addition, there have been and continue to be high levels of stigmatization and ostracism of nonheterosexuals in minority communities and high levels of ostracism of nonwhite sexual minorities in Cleveland's lesbian-gay-bisexual-transgender-queer (LGBTQ) community. Since 2007, there have been multiple murders and drive-by shootings of minority MSM and an apparent increase in numbers of attempted suicides.

At the time that the writing-performance project was initiated in 2011, a number of the young African American MSM who attended the drop-in center had been experiencing a relatively high prevalence of suicidal ideation, suicide attempts, homelessness, and untreated mental illness. The anxiety that prevailed among individuals was exacerbated following several murders of transgender African American males, at least three of whom I personally knew; drive-by shootings of the drop-in center that they frequented and in which I provided services; and an "exposé" in a local newspaper that resulted in the outing and homelessness of several center attendees. Many of the individuals had experienced abuse in their birth families and/or with partners, and many lived in neighborhoods and situations characterized by ubiquitous violence. The shootings of their friends and acquaintances had further traumatized the young men.

Performance offered the young men the possibility of exploring and affirming in a safe space, and completely within their control, their identity as they wish to be defined. The provision of a space that was safe and protected, both physically and psychologically, was of critical importance at the individual, group, and larger community levels. Higher rates of psychiatric disorders have been found in the African American community, with more than one-third of the African American MSM population meeting the criteria for anxiety disorders. African American males are at

exceptionally high risk for adverse mental health outcomes involving self- and other-directed violence, which many of the youth had already experienced. Suicide is the third leading cause of death among African American youth between the ages of 15 and 24 (American Association of Suicidology, 2004), and many of the project participants had attempted suicide themselves, experienced suicidal ideation, and/or had had friends or family members who had committed suicide. Suicide risk is particularly escalated among African Americans living in areas of high occupational and economic inequality between Whites and African Americans (Burr, Hartman, & Mattson, 1999); among those whose families were characterized by incest, physical abuse, sexual abuse, and poor social cohesion (Hernandez, Lodico, & DiClemente, 1993; Summerville, Kaslow, Abbate, & Cronan, 1994); and among nonheterosexually identified youth (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Rotheram-Borus, Hunter, & Rosario, 1994)—all of which characterized the youth who would be participating in the writing-performance project. Also, MSM, including transgender individuals, may be at increased risk of developing a mental illness and frequently experience rejection, discrimination, and isolation. They may also face significant barriers to treatment, including lack of health insurance, provider insensitivity and bias, and stigma associated with both mental illness and MSM identity.

Additional benefits were potentially available through participation in the project. These included the psychological satisfaction of having accomplished the writing and the performance as part of a group effort, a boost in each individual's image from having achieved his intended goal, the individuating nature of performance, and the possibility that the individual might garner enhanced prestige and power in his immediate setting and/or wider social setting because of the courage that was evident in the writing and the performance.

Despite these potential benefits, participation in the performance carries risk. Clearly, the audience might function as a jury, judging both the content and the presentation of the performance. Each individual who self-revealed through his composed monologue and attending performance would be risking both his reputation and credibility and would face the possibility of shame and guilt as a response to the audience's response. Performers had no way of knowing whether their self-revelations through monologue and performance would prompt an empathic response from the audience or would result in the creation of greater, rather than lesser, distance with members of the audience.

The Process

The participants in this writing-performance project initiated the writing process, the focus of that writing, and the organization of the performance during which they would recite their monologues, dressed in a manner they each felt reflected who he was. The participants decided that each individual could invite friends and family members who they believed would be supportive. However, it was possible that one participant might invite guests who looked unfavorably on another participant.

The young men asked me to review their initial drafts of their monologues and offer suggestions. I expressed concern that some of them were too self-revealing in their monologues, particularly those who planned on revealing their HIV-positive status publicly for the first time. They countered by explaining that it was important to them to explore where they had been in their lives and where they were at the time of the writing and performance. Their trust in me to review their initial drafts, which were shown to no one else, and my concern for their well-being if they were to pursue such disclosures serve as a classic example of transference and countertransference, where I stood in for the concerned, caring mother that many of them lacked in their lives and responded as if they were my children needing protection from their heretofore unrecognized dangers. I recognized this dynamic, but because the monologues and identity performances were intended by the participants to be a performance and were not developed as a therapeutic intervention, I did not feel that I had to address these co-transference issues as I might have if it were a therapeutic situation.

The Monologues

Three individuals' monologues are presented below. The names used for each individual are fictitious.

Mitchell spoke about who he had once been, the traits that once characterized him. We follow him on his hero's journey, as he gets stronger, recognizes who he is—a gay man—his challenge as he comes out to his family, and his ultimate triumph. In telling his story, he not only affirms to himself his own identity and his ability to overcome his difficulties but invites the audience to identify with his struggle, his strength, and ultimately his victory.

> I grew up with the title of the quiet child; the one who was somehow depressed about life. As my life went on I became more outspoken and I started to learn and accept who I was. I became this person who grew stronger with every day. When I came out to my family it was like a chain reaction that didn't play into my favor. I became a target of my own mother's rage due to my sexuality. And after dealing with her misconceptions and ignorance about homosexuality, I learned that I am stronger than I thought I was. I eventually learned that I had to get my own mother to respect my decision and get her to understand that I was not going to change just because she didn't understand who I was. From that point on I started to become stronger and more involved in who I was. I started with the gay community at University, trying to help in any way that I could but realized that the community there was so far broken that it was extremely hard to repair. Then I came back to Cleveland and joined the gay community, after a lot of misconceptions that I had about the community. I learned that this community was a little bit more stable but still at the same point that the University's gay community was. So I found myself at [this Center] with a hope that I would be able to help in any way that I could.

Charles also tells the story of a hero's journey, beginning with the date on which he was diagnosed as HIV positive, which he marks as his rebirth. Like Mitchell, he recounts through his writing and performance a traumatic event, but, unlike

Mitchell, we feel that he is more than recounting the fact of the event but is actually processing the traumatic discovery of his HIV status through his writing and his performance. At first a victim in his own story—we see how everything happens to Charles—he emerges a defiant hero, challenging others to put themselves to the HIV test.

> I was born [again in 2008]. On this date I was diagnosed with testing positive for the HIV antibody and my whole life began anew. This was a few weeks after I had been released from the county jail. So now that you have a little background let's get into the story. I was living in [a distant suburb] and dating this guy from Cleveland who shall remain anonymous. We were getting pretty serious and I truly fell in love with him. Unfortunately however, I had a pending case as a juvenile that I had become incarcerated for midway into our relationship. We vowed to make it through this rough patch and stay together. What a joke that was. All the while the only one staying faithful was me. Every day I would call home and hear people in the background or someone else answering our phone. Eventually my mother came to visit me in jail and told me she saw him at the mall hugged up with another man. After that I was done, and I didn't want to remain in a relationship with him any longer. Days later I called my sister and found out that he had stolen everything out of my house and moved out of the state. So now on top of me trying to still deal with the death of my grandmother and finding out he had been cheating on me, I now had to deal with starting over from ground zero. When I was released from jail the only thing I had to my name was just what I went in with, the clothes on my back. When I say he had stolen everything I mean everything from my light bulbs to my food. He even caused me to be evicted from my apartment before he went about his travels to [a nearby state]. So now I had a matter of weeks to find a new place of residence with no money. I refused to let my troubles get me down though. I knew God would find a way. My neighbors began commenting on him moving my belongings out and come to find out many of them helped and even still possessed some of my things in their home. Some neighbors they were huh? To make matters worse they began rumoring to me that he was HIV positive. But then they would turn around and just laugh it off as if it was all a big joke and they didn't mean it. Well clearly they weren't joking. About a week later he called me. I debated on answering at first but eventually decided to. He began by apologizing and then later asking me questions about STDs. Being the person I am I stayed on the phone and answered every question that he posed to me. About a half hour into the conversation he began to become quiet. So just when I was about to disconnect the conversation, he said he had something he needed to tell me. The next words out of his mouth left me speechless. He informed he is in fact HIV positive, but didn't know how to tell me while we were together. Even before I had heard anything about him being positive I had this nagging feeling that something was wrong. More specifically, somehow I "knew" I was HIV positive. I don't know why I had this feeling; I kept thinking back to that one and only time we had sex without a condom, and after that I never had unprotected sex again. But that one time always loomed in the back of my mind. The following week I went to the local health department and took a rapid HIV test. After 20mins of hell my results were finally in. I was called into a small room and asked to have a seat. By then I already knew what was to come next. I had been coming since I was 16 and this time the aura of the room was different. She informed me that my results were POSITIVE. The shock, the stun, the void of emotions, and then the terror, anger, and all the other fun stuff that happens in those 5 s after you're told you are positive… After calming myself down, we went through all the formalities, the partner notification information, the counseling, the how are you feeling now thing, and finally, most importantly, the do you need a hug portion. I desperately remember that hug, one of the best and most needed hugs I have ever received. I calmed myself down, and walked to my car, I thought the worst was over, but when I finally reached my car and was by myself away from everyone else, that's when the real tears came. I remember not just crying or bawling, but wailing, uncontrollably. I got a

> grip and headed home. I didn't know how to react. I felt as if my complete inner being had been torn from within. My body felt numb, inside I felt empty. Testing positive was always something that was in the back of mind. But now here it was right here staring me in the face. I still don't know why I had that "feeling" or where it came from. I was not in any high-risk groups. No drugs, unprotected sex one time, small town boy, what are the chances? Better than everyone thinks apparently.
>
> I refused to let this be the end. I would never say that my life went downhill from that point or even that my life changed for the worse. But rather that my life changed for the better and I took it as a spiritual awakening, a sign from God. I will definitely say that that period in my life was one of the greatest struggles that I have ever had to overcome. So here I am A Sexy dude with H.I.V. Judge me by getting to know me, not by my status…Yes I am HIV positive! If that's an issue for you then I really don't know what to tell you. I know my status… do you?

Like Mitchell, Frank situates himself in the social context in which he functioned, sharing the expectations that were placed upon him, his violation of those imposed norms, and the consequences that befell him as a result. Like both Mitchell and Charles, he emerges from his struggles as a victor, affirming his identity and ownership of a space in this life.

> Who am I? Where do I run to? I can't talk to my mother about this; she will condemn me to hell. What will my grandmother think? My dad will hate me cuz I won't pass the family name on. But this is who I am. This is what makes me happy. HIS hand in mine. HIS arms around me. HIS lips on mine. But the journey is never over and I need help.
>
> As a young man growing up I was taught that a man was supposed to be with a woman and those who violated this was going to hell. With me being adopted and now wanting to be with boys I really felt alienated and lost. I had no one to talk to and felt like there was no one else to help me. So I fled to my group of friends and the theater. These were my refuge. Places where I could be myself without persecution. But as I grew in social status within these havens my family took notice and sought to sever my connection with them. I, once again, was on the run in search of the place to get away.
>
> [Here is] a place where anybody, no matter race, gender identity, orientation, expression, or etc., could come and be yourself as long as you're comfortable. That was something I had never heard of. I was told what I was comfortable with. I wasn't used to be able to decide my own future. [This place] allowed me to be more comfortable with my feminine side. It allowed me to meet other young people who were struggling and dealing with things I was going through … [and] also provided services to me that my family could have never provided.

Assessing the Project's Impact

The project formulated by the young men appeared to be successful on a number of dimensions. First, it provided an opportunity for the participants to solidify their own identities, to recount their stories, and to emerge as heroes in their journeys. By engaging in the performance of their monologues together, the participants were able to validate for each other each individual's identity and their own identity as a community.

However, the success of the project demands, at a minimum, at least a lack of opposition from both co-participants and those in the audience (Klein et al., 2007).

Because the youths invited only individuals to participate in or to attend the performance who they believed would be supportive, the possibility that either co-participants or audience members would react negatively was minimized. Nevertheless, in one instance, the participant's self-disclosure of his HIV status was later used by a co-participant to mock him; the co-participant loaded a song with HIV-related lyrics onto his own cell phone and played it whenever the HIV-infected individual entered the room, signaling the individual's HIV status to everyone else there.

The disclosure of participants' sexual or gender identity and HIV status through the performance to unsympathetic individuals had been one of the risks that I had discussed with each prospective participant individually and with the group as a whole. I stressed the need for containing the disclosures within the context of the performance and the limited public nature of the performance. I explained that because neither I nor any participant could guarantee that these parameters would be respected by every individual who participated or attended, each participant needed to consider how much he wanted to disclose since there was always the risk of an unwanted disclosure to others. This was a particular issue in view of the likelihood that invited audience members might want to take photographs or videos of the performance, which would likely include images not only of the individual who invited them but also of co-participants in the performance. Accordingly, I suggested to each individual that he assess whether the potential benefits associated with participation in the activity and/or his intended level of disclosure would outweigh the potential harms.

Discussions with participants also focused on ownership of the monologues and the videos produced from the performance. It was agreed that each participant owned his own monologue and could determine whether and to what extent it could be used in other contexts by other individuals. Because videos and photographs of the performance had been taken by members of the audience who had been invited by the participants, it was agreed by the participants that those photos and videos were the property of the taker.

Additional Observations

The performance-writing project which was developed and implemented by the clients themselves provided a mechanism through which participants could ask and respond to the following questions: Who was I? Who am I? How do I want others to see me? By facilitating this consolidation and validation of their identity, the monologue and performance together provided participants with an opportunity to assume greater power and control over the construction of their own identities, providing an alternative construction to that fashioned by others in their family and social contexts. The monologues and accompanying performances also served as a restorative process for some individuals in helping them to identify their strengths and victory following a traumatic event, whether it was rejection from their families after their disclosure of their homosexuality or diagnosis with HIV infection.

Additionally, the use of monologue and witnessed performance together provided a mechanism through which the participating individuals could establish and solidify their identity as members in a particular group—African American same-sex loving men—and build a bridge with the audience to garner support for their individual and group identities. The discussions that preceded the performance facilitated individuals' exploration of comfort with varying levels of disclosure. Finally, the monologues and performances may have prompted audience members to reconsider any preexisting stereotypes about gender and sexuality, thereby broadening their perspectives and creating or facilitating an empathic understanding of the performers.

Despite the apparent success of this project and the appeal of working creatively with writing and performance, it is critically important that we, as social workers, recognize the complexity and depth of these modalities and their potential for both benefit and risk. The potential benefits and risks inure not only to the individual client but to the participating group as a whole and even to members of the audience. It is not sufficient to believe that because audience members are not themselves our clients that we bear no responsibility in this regard, if for no other reason than their response to the performance may have a direct impact on our individual clients and the group-as-client. I was fortunate to have, during the ongoing development of this project, supervision from a clinical social worker who, although not trained in either writing or performance therapy, had tremendous insight into both the group dynamics and the group-audience interaction, as well as my own issues that I brought to the dynamics. In addition, I was able to confer with colleagues who had utilized drama therapy and psychodrama both personally and professionally. I strongly encourage any social worker who wishes to integrate these modalities into their practice to do so only with supervision from an experienced, insightful supervising social worker and/or to seek supervision from experienced professionals who are specifically trained in these modalities.

References

Aadlandsvik, R. (2007). Education, poetry, and the process of growing old. *Educational Gerontology, 33*, 665–678.

American Association of Suicidology. (2004). *African American suicide fact sheet*. Washington, DC: Author. Retrieved May 25, 2009, from http://www.suicidology.org.

Baikie, K. A., & Wilhelm, K. (2005). Emotional and physical health benefits of expressive writing. *Advances in Psychiatric Treatment, 11*, 338–346.

Bolton, G. (1999). "Every poem breaks a silence that had to be overcome": The therapeutic power of poetry writing. *Feminist Review, 62*, 118–133.

Burr, J. A., Hartman, J. T., & Mattson, D. W. (1999). Black suicide in U.S. metropolitan areas: An examination of the racial inequality and social integration-regulation hypotheses. *Social Forces, 77*, 1049–1081.

Butler, J. (1988). Performative acts and gender constitution: An essay in phenomenology and feminist theory. *Theatre Journal, 40*(4), 519–531.

Cleveland Department of Public Health (CDPH) (2007). Cleveland (Only) HIV/AIDS prevalence report: Reported persons living with HIV/AIDS as of December 31, 2006 by selected

characteristics, Cleveland resident cases, and prevalence per 100,000. Retrieved May 29, 2007 from Health Division, HIV/AIDS at http://www.clevelandhealth.org/.
Esterling, B., L'Abate, L., Murray, E., & Pennebaker, J. (1999). Empirical foundations for writing in prevention and psychotherapy: Mental and physical health outcomes. *Clinical Psychology Review, 19*, 79–96.
Fink, S. O. (1990). Approaches to emotion in psychotherapy and theater: Implications for drama therapy. *The Arts in Psychotherapy, 17*, 5–18.
Fitch, S. (2006). Home foreclosure hot spots. *Forbes Magazine Online*. Retrieved May 29, 2007, from http://www.msnbc.msn.com/id/13086712/.
Froggett, L. (2007). Arts based learning in restorative youth justice: Embodied, moral and aesthetic. *Journal of Social Work Practice, 21*(3), 347–359.
Froggett, L., Farrier, A., & Poursanidou, D. (2007). Making sense of Tom: Seeing the reparative in restorative justice. *Journal of Social Work Practice, 21*(1), 103–117.
Furman, L. (1988). Theatre as therapy: The distancing effect applied to audience. *The Arts in Psychotherapy, 15*, 245–249.
Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., & Goodman, E. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatrics and Adolescent Medicine, 153*(5), 487–493.
Grotowski, J. (1973). Holiday. *The Drama Review, 17*, 113–135.
Harvey, A. G., & Farrell, C. (2003). The efficacy of a Pennebaker-like writing intervention for poor sleepers. *Behavioral Sleep Medicine, 1*(2), 115–124.
Hernandez, J. T., Lodico, M., & DiClemente, R. J. (1993). The effects of child abuse and race on risk-taking in male adolescents. *Journal of the National Medical Association, 85*, 593–597.
Hornsey, M. J., & Jetten, J. (2003). Not being what you claim to be: Impostors as sources of group threat. *European Journal of Social Psychology, 33*, 639–657.
Huss, E., Tekoa, S. D., & Cwikel, J. G. (2009). "Hidden treasures" from Israeli women's writing groups: Exploring an integrative feminist therapy. *Women & Therapy, 32*, 22–39.
Klein, K., & Boals, A. (2001). Expressive writing can increase working memory capacity. *Journal of Experimental Psychology. General, 130*, 520–533.
Klein, O., Spears, R., & Reicher, S. (2007). Social identity performance: Extending the strategic side of SIDE. *Personality and Social Psychology Review, 11*, 28–45.
Kranz, A., & Pennebaker, J. W. (1996). Bodily versus written expression of traumatic experience. Cited in J.W. Pennebaker. (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science, 8*(3), 162–166.
LaBelle, I. R. (1987). Obituaries by adolescents: A therapeutic technique. *Social Work, 32*(6), 538–539.
Lange, A., van den Ven, J.-P., Schrieken, B., & Emmelkamp, B. M. G. (2001). Interapy. Treatment of posttraumatic stress through the internet: A controlled trial. *Journal of Behavior Therapy and Experimental Psychiatry, 32*, 73–90.
Largo-Marsh, L., & Spates, C. R. (2002). The effects of writing therapy in comparison to EMD/R on traumatic stress: The relationship between hypnotizability and client expectancy to outcome. *Professional Psychology: Research and Practice, 33*(6), 581–586.
Lenahan, T. (2005) Shortage areas of primary medical professionals. *Public Health GIS and Information, 63,* 19–21. Retrieved May 29, 2007, from http://www.cdc.gov/nchs/data/gis/cdcgis63.pdf.
Lothane, Z. (2009). Dramatology in life, disorder, and psychoanalytic therapy: A further contribution to interpersonal psychoanalysis. *International Forum of Psychoanalysis, 18*, 135–148.
MacCormack, T. (1997). Believing in make-believe: Looking at theater as a metaphor for psychotherapy. *Family Process, 36*, 151–169.
Murphy, L. J., & Mitchell, D. L. (1998). When writing helps to heal: E-mail as therapy. *British Journal of Guidance and Counselling, 26*(1), 21–32.
Murray, E. J., & Segal, D. L. (1994). Emotional processing in vocal and written expression of feelings about traumatic experiences. *Journal of Traumatic Stress, 7*(3), 391–405.

Nagel, D. M., & Anthony, K. (2009). Writing therapy using new technologies—The art of blogging. *Journal of Poetry Therapy, 22*(1), 41–45.
O'Connor, M., Nikoletti, S., Kristjanson, L. J., Loh, R., & Willcock, B. (2003). Writing therapy for the bereaved: Evaluation of an intervention. *Journal of Palliative Medicine, 6*(2), 195–204.
Pennebaker, J. W. (1989). Confession, inhibition, and disease. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 22, pp. 211–144). New York: Academic Press.
Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science, 8*(3), 162–166.
Pennebaker, J. W., & Chung, C. K. (2006). Expressive writing, emotional upheavals, and health. In H. Friedman & R. Silver (Eds.), *Handbook of health psychology* (pp. 263–285). New York: Oxford University Press.
Pennebaker, J. W., & Graybeal, A. (2001). Patterns of natural language use: Disclosure, personality, and social integration. *Current Directions in Psychological Science, 10*(3), 90–93.
Pennebaker, J. W., Kiecolt-Glaser, J. K., & Glaser, R. (1988). Disclosure of traumas and immune function: Health implications for psychotherapy. *Journal of Consulting and Clinical Psychology, 56*(2), 239–245.
Petrie, K. J., & Fontanilla, J. (2004). Effect of written emotional expression on immune function in patients with human immunodeficiency virus infection: A randomized trial. *Psychosomatic Medicine, 66*(2), 272–275.
Pizarro, J. (2004). The efficacy of art and writing therapy: Increasing positive mental health outcomes and participant retention after exposure to traumatic experience. *Art Therapy: Journal of the American Art Therapy Association, 21*(1), 5–12.
Rasmussen, P. T., & Tomm, K. (1992). GUIDED letter writing: A long brief therapy method whereby clients carry out their own treatment. *Journal of Strategic and Systemic Therapies, 11*(4), 1–18.
Román, D. (1997). Latino performance and identity. *Aztlán, 22*(2), 151–168.
Rotheram-Borus, M. J., Hunter, J., & Rosario, M. (1994). Suicidal behavior and gay-related stress among gay and bisexual male adolescents. *Journal of Adolescent Research, 9*(4), 498–508.
Salling, M. (2006). Children living in severely distressed neighborhoods and poor housing. *Public Health GIS and Information,* 68, 19–22. Retrieved May 29, 2007, from http://www.cdc.gov/nchs/data/gis/cdcgis68.pdf
Sampson, F. (2007). Writing as 'therapy'. In S. Earnshaw (Ed.), *The handbook of creative writing* (pp. 312–319). Edinburgh: Edinburgh University Press Ltd.
Scheepers, D., Spears, R., Doosje, B., & Manstead, A. S. R. (2006). Diversity in in-group bias: Structural factors, situational features, and social functions. *Journal of Personality and Social Psychology, 90*(6), 944–960.
Scheepers, D., Spears, R., Doosje, B., & Manstead, A. S. R. (2002). Integrating identity and instrumental approaches to intergroup differentiation: Different contexts, different motives. *Personality and Social Psychology Bulletin, 28*, 1455–1467.
Scheepers, D., Spears, R., Doosje, B., & Manstead, A. S. R. (2003). Two functions of verbal intergroup discrimination: Identity and instrumental motives as a result of group identification and threat. *Personality and Social Psychology Bulletin, 29*, 568–577.
Schiffrin, D. (1996). Narrative as self-portrait: Sociolinguistic construction of identity. *Language in Society, 25*(2), 167–203.
Schneider, M. F., & Stone, M. C. (1998). Processes and techniques of journal writing in Adlerian therapy. *Journal of Individual Psychology, 54*(4), 511–534.
Smith, R. L., & Davis, D. (2004). Cleveland No.1 in big-city poverty/Nearly half of children among the poor. *Cleveland Plain Dealer.* Retrieved May 29, 2007, from http://www.cleveland.com (archived) and UrbanOhio.com archives, http://www.urbanohio.com/forum2/index.php?topic=978.0.
Sontag, S. (Ed.).(1976). *Antonin Artaud: Selected writings* (H. Weaver, Trans.). New York: Farrar Strauss & Giroux.

Summerville, M. B., Kaslow, N. J., Abbate, M. F., & Cronan, S. (1994). Psychopathology, family functioning, cognitive style in urban adolescents with suicide attempts. *Journal of Abnormal Child Psychology, 22*, 221–235.

Tajfel, H. (1978). *Differentiation between social groups*. London: Academic Press.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. G. Austin (Eds.), *The psychology of intergroup relations* (pp. 7–24). Chicago: Nelson-Hall.

United States Bureau of the Census. 2000 census of population, general population characteristics, Cleveland, Ohio, Summary File (SF1). Available at http://factfinder.census.gov

Wright, J. K. (2005). Writing therapy in brief workplace counseling. *Counselling and Psychotherapy Research, 5*(2), 111–119.

Webster, B.H., Jr., & Bishaw, A. (2006). American community survey reports. ACS-02, income, earnings, and poverty data from the 2005 American Community Survey. Washington, D.C: United States Bureau of the Census. Retrieved May 27, 2007 from http://www.census.gov/prod/2006pubs/acs-02.pdf.

Yankah, K. (1985). Risks in verbal art performance. *Journal of Folklore Research, 22*(2/3), 133–153.

Chapter 3
The Use of Poetry Therapy for the Treatment of Sexual Abuse Trauma

Cynthia Blomquist Gustavson

Introduction

Both sound and meaning of incanted words have been used for centuries for physical, emotional, and spiritual healing. Before poetry was used in formal therapy, people understood that it spoke a language of the heart. As a professional poet, I have been a judge at many poetry contests for teens, where common themes were unrequited love, physical and sexual bullying, and suicidal ideation. When emotions are raw, writing about them is a safe way of venting. Poetry condenses feelings into words that can easily contain the ambiguity often present in traumatic situations. When an individual writes a poem in a time of desperation, he or she learns something new, something hidden away, but revealed by the poem. Poetry therapy is the harnessing of this ancient way of retrieving and experiencing our own hidden feelings and information.

The terms "poetry therapy" and "bibliotherapy" are used synonymously to describe the intentional use of poetry, or other literature, for therapeutic purposes. Bibliotherapy is the more general term for any form of literature used for this purpose. It may include the reading and discussion of literature, creative writing, storytelling, life review, or journaling. Although poetry therapists concentrate on poetry, they may also use other types of literature for therapeutic healing.

This chapter will give a brief history of the use of poetry for healing. It will then trace the theories of why poetry is a successful and powerful therapeutic agent. A new metaphoric model for practicing poetry therapy will be introduced and explained, step-by-step. And finally, a model for treating sexual abuse trauma survivors will be outlined. These two practice models (for poetry therapy and sexual trauma treatment) will be synthesized and explained, with extensive examples.

C.B. Gustavson, MSW, ACSW, LCSW (✉)
2817 E, 34th Street, Tulsa, OK 74105, USA
e-mail: gustavson@gmail.com

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3_3,

Throughout this chapter, poetry written by my clients will be used. (References to clients all use fictitious names.) Their insights not only helped them heal but they were a constant reminder to me of the power of poetry, the power of our own words to teach, to illuminate, to uncover, to soothe, to explain, and to heal.

Historical Marriage of Poetry and Healing

In prehistoric times, many cultures associated language with the power of healing. Shamans chanted words as part of rituals to heal tribe members and bring about changes in their lives and community. These magical words contained both rhyme and rhythm and could be thought of as the first poetry. Hynes and Hynes-Berry (1992) report that in the fourth millennium BCE, ancient Egyptians wrote words on papyrus, dissolved it in a solution, and requested patients to drink it for healing purposes. The words were clearly understood as important to the patient's well-being.

In ancient Greece, the god Apollo stood as the god of both medicine and poetry (general knowledge). It is no wonder that Greek libraries were considered to be "healing places of the soul" (Chavis & Weisberger, 2003, p. 1). In *Poetics*, Aristotle discussed the concepts of using poetry for both insight and catharsis, still universal principles in therapy today.

In the first century AD, Soranus, a Roman physician, prescribed tragedy for his manic patients and comedy for those who were depressed (Hynes & Hynes-Berry, 1992). This passive use of literature, where it was put into the hands of the patient but not discussed with a physician or therapist, continued for many centuries.

In the United States, the use of literature for therapy began at its first hospital, Pennsylvania Hospital, founded in 1751. One treatment used with mental patients in the early 1800s, prescribed by Dr. Benjamin Rush, "the father of American psychiatry," was a prescription of reading, writing, and publishing of their writings in their own newspaper called *The Illuminator* (Rubin, 1978). At that time, the activity was self-directed and mostly recreational.

Poetry and other literature were recognized for their curative value not only by psychiatrists but also by librarians. In 1916, the term "bibliotherapy" was coined by Samuel Crothers. Librarians adopted the term as they suggested literature for psychiatric patients. Hospital librarians at the Menninger Psychiatric Clinic in Topeka, Kansas, worked closely with doctors and patients. According to Hynes and Hynes-Berry's research (1992), this too was a passive form of bibliotherapy, and its proponents had no interaction with therapists.

During the twentieth century, poetry therapy developed direction and structure. According to Nicholas Mazza (1999), two articles written by an English professor, Frederick Clark Prescott, and published in the *Journal of Abnormal Psychology* (1912, 1919), focused on the language of poetry and dreams and ultimately linked poetry and the psyche. Prescott later published the book *The Poetic Mind* (1922), referring to poetry as a kind of safety valve for individuals with problems.

Also in that decade, *The Poetry Cure: A Pocket Medicine Chest of Verse* (1925) was written by Robert Haven Schauffler, who later wrote a similar book for children, *The Junior Poetry Cure: A First-Aid Kit of Verse for the Young of All Ages* (1931). In his books, Schauffler, considered a pioneer in the field, listed poems that could be used to heal 14 common complaints, allowing the poetry to be targeted to specific problems. He understood its curative powers, not only for those who read it but also for those who wrote personal poetry, which he encouraged his patients to do. However, he cautioned that poetry could be very powerful, and therefore, the poems needed to be chosen carefully. This is still a precaution poetry therapists take seriously. In the 1960s, poetry therapy was given its formal name by Eli Griefer, a poet, lawyer, and pharmacist, who in the early 1950s developed a "poemtherapy" group at Creedmoor State Hospital in New York (Hynes & Hynes-Berry, 1992). In 1959, together with the psychiatrist Jack Leedy, Griefer started a "poemtherapy" group at Cumberland Hospital. Griefer published *Principles of Poetry Therapy* in 1963, using the new term "poetry therapy." Leedy edited books about the subject in 1969, 1973, and 1985. In 1969, with the help of Leedy, the Association for Poetry Therapy (APT) was established. The association held annual conferences in New York beginning in 1971. In 1981, that association became formally known as the National Association for Poetry Therapy (NAPT). The NAPT is also an affiliate of the National Coalition for the Creative Arts Therapies Association (NCCATA).

An offshoot of the NAPT is the National Federation for Biblio/Poetry Therapy, a nonprofit organization in charge of the credentialing of poetry therapists, with designations of certified applied poetry facilitator (CAPT), certified poetry therapist (CPT), and registered poetry therapist (RPT). Another positive outcome of the NAPT was the 1987 founding of *The Journal of Poetry Therapy: The Interdisciplinary Journal of Practice, Theory, Research and Education.* Its editor since its inception has been Nicholas Mazza.

Advancing from imbibing dissolved poetry to being treated by a trained poetry therapist, backed by research, education, and a working knowledge of both literature and psychology, the field of poetry therapy has come of age. Classes in poetry therapy are now taught in graduate schools, and articles from *The Journal of Poetry Therapy* are valued in social science settings.

Underlying Theories and Practice Models

Freud wrote, "Not I, but the poet discovered the unconscious" (Hynes & Hynes-Berry, p. 2).

Poetry therapy's original theoretical foundation was in psychoanalytic thought. Freud emphasized the unconscious and preconscious self and its exploration through dreams and language, specifically, with the use of symbols. Pattison (1973, p. 212) wrote, "Because symbolization is the communicational vehicle for organizing, synthesizing, and representing the self, the poem as a symbolic vehicle is a potent mode of psychotherapeutic communication." Poetry was regarded as a pathway into the unconscious.

Rothenberg (1972) states that "poets and psychotherapists are blood brothers" in their mutual interest of coaxing the "dispossessed consciousness into self-awareness." Stainbrook elaborates on that idea by saying that poetry therapy does more than merely enable the unconscious to become conscious. It helps in "not only emphasizing how to be less unconscious, but of learning to be more conscious" (Stainbrook, 1978, p. 9). Poetry engages us in our own lives and educates us as well.

Another concept with Freudian origins is the idea of "condensation." Poetic symbol and metaphor are perfect vehicles to condense life's complexities into a single whole. In psychoanalysis, this symbol is understood to be a symptom. In other schools of thought, this distilled experience is used for greater understanding of self or circumstance. John Fox explains "condensation" in non-Freudian terms in his book, *Poetic Medicine: The Healing Art of Poem-Making* (1997, p. 3):

> Poems distill experience into the essentials… The exciting part of this process is that poetry used in this healing way helps people integrate the disparate, even fragmented parts of their life. Poetic essences of sound, metaphor, image, feeling and rhythm act as remedies that can elegantly strengthen our whole system – physical, mental and spiritual.

Reading literature is a time-honored way to visit different experiences in life without living the risks. It can also be a way of reviewing parts of our own lives through other characters and places. A wonderful quality of poetry is that it enables that to happen in a few condensed thoughts on the page rather than in hundreds of pages of literature.

The concept of "image" is central to poetic meaning and also central to psychology. Jerome Bruner (1966) studied the role of imagery in cognition. Stainbrook (1978, p. 10) elaborated on Bruner's thoughts and stated:

> To evoke the imagery of experience by linguistic symbolization and metaphor is an essential characteristic of poetic communication. Therefore, the general psychology of cognition is highly relevant, particularly the functions of imagery as a mode of processing information and of representing, storing, transforming, and communicating experience.

Stainbrook (1978, p. 1) summarizes the importance of the poem's image by saying that it is "an esthetic organization which makes it possible for a person to feel his thoughts and imagery, and to image and think his feeling."

There is another newer reason for the use of poetic images in therapy. In the last decades, science has learned that a large number of people with Asperger syndrome are visual thinkers, or as researchers, such as Grandin (2001) advise us, they think in pictures rather than words. For the rest of us, language often covers up our visual thinking. But poetry demands visual thinking, and because metaphor compares one image to another image, its therapeutic value may come from that property. I avoid using long poems, or complex, wordy poetry with Asperger clients, or those with Asperger-like symptoms, but I have found that using metaphors with them has worked well. The story of Arthur illustrates the point:

> Arthur was a 48 year old male engineer, whose wife was threatening divorce because he chronically ignored her. He stated he loved her, but gave no indication of it. During marital therapy we discussed on three separate occasions the fact that he had forgotten her birthday. She said it would be okay if he thought of something nice to do in the future to celebrate it. Unfortunately, he kept saying he would do something, but never followed through. Finally,

he said the sessions were not helping him because he never remembered what we had discussed.

As one last try I asked him to visualize his truck. "What do you have to do to keep it going?" I asked.

He replied, "Fill it with gas."

"What else?" I continued.

He said he needed to change the oil periodically, and rotate the tires.

"Good," I said. "Now imagine that your truck is your marriage. What is the gas that keeps your marriage going?"

"I guess the common ordinary stuff," he said, "like taking out the garbage and mowing the lawn."

"And talking to each other?"

"Yup. That too."

"Okay," I said. "What would changing the oil mean in marriage?"

"Well, going to movies sometimes maybe?"

"Yes, that needs to be done periodically. How about rotating the tires. What would that mean?"

"Oh, I guess that would be how I cook dinner every once in a while, just to change up things, and get out of the same ol' routine."

"Okay. Here's an important one. What if you back over a nail, and the tire goes flat. What would that be in a marriage?"

He sat silently for a while and replied, "That's forgetting her birthday. I get it. And if that nail doesn't get pulled out, and the truck sits there and gets rusty, it'll get towed to the junkyard. Kaput! Dead! Yah, I get it."

That week he stopped at a restaurant, brought home a nice dinner, and topped it off with a bouquet of yellow roses. His wife was thrilled.

When Arthur could think of marriage (an abstract term for him) in terms of his very concrete truck, it all made sense. The use of concrete images is central to poetry therapy within all of the psychological theories.

Nicholas Mazza (1999) writes a comprehensive review of the ideas of Freud (1908/1959), Jung (1922/1972), Adler (1954), the Gestalt theorists (Perls, Hefferline, & Goodman, 1951), and narrative therapy (White & Epston, 1990), as they relate to the concepts of poetry therapy. Later, in a chapter in *The Healing Fountain* (Chavis & Weisberger, 2003), Mazza uses the concept of "choice" to show how it would be treated differently in various psychotherapeutic settings. It "could be classified as learned helplessness, a cognitive distortion, a developmental problem, a defense mechanism, or a storied experience." But regardless of classification, he states that all schools agree therapy includes "choice, action, and empowerment." He also sums up how three different schools of psychotherapy would characterize the use of poetry in therapy:

> The differential use of poetry and poetry therapy methods vary with respect to purpose defined in each theoretical model (e.g., reframe a problem in cognitive therapy, promote catharsis in ego psychology, re-story an experience in narrative therapy) (Mazza, 2003, p. 59).

The physical sciences too have been looking at the process of meaningful writing (including both poetry and journaling) and have found a positive effect on heart rate, blood pressure, immune system, and mood. Writing reduces days in the hospital and also reduces depressive symptoms before exams. It lowers stress levels and helps restore feelings to normal (Baikie & Wilhelm, 2005; Davidson et al. 2002; Lepore & Smyth, 2002; Norman, Lumley, Dooley, & Diamond, 2004; Pennebaker & Beall,

1986). This research is essential in understanding that the use of poetry and other writing can translate into living healthier lives. Sherri Reiter, in her book *Writing Away the Demons* (2009, p. 3), states:

> Modern researchers support the premise of a self-righting mechanism that is similar to a body's innate ability to heal wounds. Just as a plant will naturally turn toward light, given the opportunity and resources to "right" (balance) oneself, human beings possess an amazing capacity for self-healing.

Reiter uses the term "transformative writing" (2009, p. 1) and lists ten principles she believes are therapeutic. The first is "mastery," (2009, p. 5) explaining that language empowers us. The second principle is "ritual" (2009, p. 6). The daily habit of writing enables a person to chart his or her transitions, traumas, and even the small things in life, then acknowledge their existence, and move on.

Her third principle, "safety," (2009, p. 7) implies that writing is a safe place to express emotions without imposed judgment. In therapy, the written word is meant for the writer (and therapist) and no one else. As John Fox (1995, p. 3), Director of the Institute for Poetic Medicine, states, "The paper on which you inscribe your poetry is a safe haven. It will not strike back at you; rather it will give your imagination and feelings the space they need to breathe and wander, laugh and wail."

Writing also externalizes what is felt within. Reiter calls this fourth principle "witnessing" (2009, p. 7). This is the ability to look at your own writing and gain new knowledge. This is especially true, because the writer alone decides what, when, where, about whom, and why to write. "Freedom/poetic license" is Reiter's fifth therapeutic principle (2009, p. 8). Kathleen Adams (2011, p. 2), Director of the Center for Journal Therapy, states:

> Your own truth is not your enemy. Don't try to talk yourself out of knowing what you know or feeling what you feel. If there is one inviolate rule … it is that there simply are no rules! Do what works. Don't worry about what you're doing. Give yourself permission. Let yourself enjoy the process.

Reiter's sixth principle "venting and containment" (2009, p. 9) is referred to in psychology as catharsis. Not only are thoughts and emotions vented but they are also contained on the written page, where the words are safely stored and can be examined. Sometimes, this examination requires a "transformation of time, space, and matter," Reiter's seventh principle (2009, p. 10). The writer can freely return to a time of difficulty or joy and determine what length of time he/she wants to spend there.

The eighth principle is "the magic of the poetic" (2009, p. 11). This allows the writer to tap into the mysterious, the spiritual, and the unconscious. Fox (1997, p. 4) writes, "You make a poem with words – but you also build an interior place when you write, a place where your intuitive voice may awaken and thrive." That "intuitive voice" depends on "creativity," which Reiter lists as the ninth principle of healing (2009, p. 13). It kindles the imagination and renews the spirit. Perie Longo (2011, p. 2) talks about the healing power of creativity:

> In the years that I have been writing poetry with many different individuals and groups, I have come to respect more and more the indefinable place from which the poem comes, and the ability of each individual to travel to that source of creativity easily and naturally.

Lastly, "integrating parts into a whole" is Reiter's tenth principle (2009, p. 14). Writing unites intelligence, feeling, spirituality, the unconscious, the magical, and the real. It is holistic medicine at its finest.

Many of Reiter's principles of healing are tacitly included in the NAPT's (2011) goals of poetry therapy:

- To develop accuracy and understanding in perceiving self and others
- To develop creativity, self-expression, and greater self-esteem
- To strengthen interpersonal skills and communication skills
- To ventilate overpowering emotions and release tension
- To find new meaning through new ideas, insights, and information
- To promote change and increase coping skills and adaptive functions

Clearly, there are many healing properties of writing, but to harness that energy and to direct it to a specific problem require a framework for treatment. In Nicholas Mazza's (1999, p. 17) poetry therapy model, three components are listed to address the "cognitive, affective, and behavioral domains of human existence" that he states "can be adapted to most psychological practice models":

- The receptive/prescriptive component involving the introduction of literature into therapy
- The expressive/creative component involving the use of client writing in therapy
- The symbolic/ceremonial component involving the use of metaphors, rituals, and storytelling

These three modes of poetry therapy (the reading of introduced poetry, the writing of client poetry, and the use of metaphor and storytelling) all require a disciplined discussion process led by a therapist. That discussion process used in poetry therapy is called the four general stages of the interactive process (Hynes & Wedl, 1990):

1. Recognition: Client identifies with the poetry selection.
2. Examination: Client explores details of poem with therapist.
3. Juxtaposition: Client looks for contrasts and comparisons to further explore poem's meaning with therapist.
4. Application to self: Client makes connection between own circumstances and the poem and applies it to his/her own life in terms of feeling and cognition.

The SAFE Model: A Practice Model Using Metaphor

Poets and therapists depend on metaphor for explaining the unexplainable. We teach clients to think in terms of metaphor and symbol, and we encourage them to dig deeply into their creativity. Psychiatrist Iain McGilcrist (2011), in a lecture about

the latest research on lobes of the brain, explains that scientific language is formed in the left lobe. That lobe looks for clarity and homes in on "the static, the lifeless, and the perfectly known." The right lobe of the brain also has language, but it is the language of metaphor, the language that "is constantly changing, evolving, and never perfectly known." That is the language the poetry therapist draws upon. And that is the language of this model.

I have distilled the various theories and fragments of theories into a working metaphor, which emphasizes the process of growth and change. I call it the *seed, sprout, flower, fruit (SAFE) model*. As a gardener, I am aware of the growth cycle. I plant a bean *seed* underground. It struggles to dig away dirt on its way to breaking through the surface. The *sprout* emerges, still bent over and clinging to the seed. As it grows silently toward the light, it gets stronger and larger. Next, it forms a *flower,* purple and passionate, that draws bugs and bees to its center. Those crawling, bothersome insects pollinate it, so that it produces *fruit* (or vegetable.) The cycle ends with the fruit ripening, forming, and dropping its own seed, so that the cycle begins again.

Stage 1: Seed

In this extended metaphor, the *seed* is the carefully chosen poem that is read and discussed between therapist and client. Discussion will center around the four stages of the interactive process (recognition, examination, juxtaposition, and application to self). At the beginning of this stage, the client feels as though he/she is in the dark. The chosen poem and its discussion bring movement in terms of thought or feeling. Those thoughts, feelings, and remembrances are often painful, and the client feels as though he/she is digging in the dirt.

Stage 2: Sprout

The *seed* (poem) has engendered enough movement to break through the ground and feel the light. This stage, the *sprout* (inner growth), is still unfolding, gathering new information or rethinking old information, getting stronger from the sunlight and occasional rain. This is a mostly silent stage that happens in the client's own heart and mind. The therapeutic soil is rich and supportive.

Stage 3: Flower

The *sprout* (inner growth) gets strong enough to put forth a *flower* (client-written poem). This can happen spontaneously or through poetry prompts from the therapist. Again the interactive process (recognition, examination, juxtaposition, and application

to self) will be applied here to further understand the client-written poem. The flower is open to pollinators, which might be bothersome or even painful. Again, the therapeutic soil is rich and supportive.

Stage 4: Fruit

The final stage is the *fruit,* in which the client now has information, strength, tools, and new understandings. These, too, will ripen and lead to new ways of viewing the world and personal circumstances. The seeds that form from this fruit will lead to new therapist-found poems and/or new client-written poems.

There will also be variations within these stages. A client may come into a first session with a poem that is already written. Let his/her poem be the *seed*. Another client may never want to write a poem of his/her own. Let the *flower* be his/her response to more therapist-chosen poems. The *flower* could also be a journal entry, an artistic representation, a song, a dance, or a poem of his/her own choosing. The time spent on each stage will be different for each individual.

In summary, the theories of why poetry therapy works are different depending on psychotherapeutic school. I have put forth a practice model for clinicians (*SAFE model*) that works within various theoretical frameworks. It is easy to use because it avoids scientific jargon and embraces the use of metaphor, the common language of both therapist and client.

Conducting a Poetry Therapy Session

According to Gladding (1998), three elements are needed for a poetry therapy session: literature (the primary tool), facilitators, and participants, which foster a triadic connection. We will begin by examining what type of literature is used in poetry therapy.

Choosing Literature

Leedy (1969) suggests that the therapist should choose a poem with emotional content close to what the client is feeling, but the poem must have a positive ending. Therapists now feel that a positive ending is not always needed, but an accepted general principle is to avoid violence, self-destructive poetry, and poems that offer no hope. Rossiter, Brown, and Gladding (1990) found that the discussion of the poem and the questions asked of the client are often more important than the poem itself.

In general, poems should be chosen for their content, not their literary value. They should be easily understood after one oral reading and therefore need to be

gauged to the literary level of the client. Poems should also be open-ended, with a wide variety of possible responses. Care should be taken to find poetry relevant to the client in terms of ethnicity, gender, age, and cultural circumstance.

The most important aspect of the poem is that it does not retraumatize the client. You might find relevant poems about sexual abuse trauma, but they may be too intimate for your client. Sometimes, those poems can be used later in therapy, but not at first, when the trauma is raw. Skill is needed in determining the type of poem used at each level.

There are excellent books and workbooks that suggest poetry to use in many different circumstances (Chavis & Weisberger, 2003; Fox, 1995, 1997; Gustavson, 2006a, d, e, f). The poetry books of Shel Silverstein (1974, 1981, 1996) and Koch (1970) and the child and teen poetry therapy workbooks of Gustavson (2006b, 2006c) and Gustavson and Gustavson (2011) are excellent sources to use with children. You can also create a poetry file from your own library of poetry books and anthologies. To create your files, choose favorite poems and subdivide them into headings such as fear, anxiety, depression, loss, transition, joy, aging, bullies, teen problems, etc. I have found that *The Writer's Almanac* with Garrison Keillor, broadcast daily on PBS radio stations, is a great resource to find easily understood emotional poetry. You can arrange to have the broadcast poem sent to your computer every day by contacting newsletter@americanpublicmedia.org.

If you can find no applicable poetry for your client, you may choose to write your own. For children's poetry, I suggest the following:

- Keep it short and to the point with simple words.
- The therapist does not want to recreate "school" for the child, so make it fun or funny.
- Choose a situation that will evoke emotions in the child.
- Create distance by using an animal or object as the subject of the poem. Children will often talk about their worries through the voice of an animal or other character.

In poetry for adults, you may still want to use the concept of distance by writing about an animal or object, especially for trauma survivors. Again, keep the poem fairly simple for a once over reading (depending on literary level of client), and write for emotional content, not literary value.

The Facilitator

The second part of the triad is the facilitator. Poetry therapy is practiced mostly in individual counseling and group work by licensed therapists but also by librarians, volunteers, and poetry lovers with various groups of individuals. It can be used for more simple, developmental purposes or for complex mental health counseling. There exist three levels of certification in the field, two for those with advanced degrees (CPT and RPT) and one for those with a bachelor's degree (CAPT).

The therapist's role is important because it is the therapist who determines what poem is read, when it is used, and what questions will be asked of the client concerning the poem. The therapist also suggests poetry prompts to encourage client writing.

The Clients

Clients are the third part of this triad. Poetry is not something to which everyone relates. The therapist needs to understand the client's response to poetry before it is used in session. Some clients have terrible memories of being embarrassed in school, because they could not interpret the complexity of a poem. Others simply do not like it. I have found that the three populations most open to poetry are children, female teens, and female adults. However, I have had men who specifically came to me as a therapist because I used poetry.

Poetry therapists often refer to the writings of clients as "process poetry," because what matters is what happens to the client in the process of writing the poetry, not in the end product itself. The purpose of writing is for personal growth, not publication. According to Lerner (1987, p. 54), "the focus is on the person, not the poem." These intimate poems need to be treated delicately and confidentially.

After the client's history is taken, diagnosis determined, and initial rapport established, the therapist determines the client's response to poetry reading and/or writing. This can be done with a simple conversation about whether the client has ever enjoyed reading or writing poetry. If the client is not sure, the therapist may read a simple poem, such as a few verses of "This Woman's Path" (Gustavson, 2006d, p. 118), and determine if it helps to bring out thoughts or feelings.

> Always the route around;
> like a wild-flowered country road
> meandering beside swamp,
> sometimes becoming the swamp
> when cattails can't hold it all –
>
> Travelers meet here eye to eye,
> nod and wave, brake for anything.
> This woman's life path
> is soft and slow-geared.
> Less road kill.

Applying the SAFE Model

Stage One Using the SAFE Model

If the client responds well to poetry, the therapist begins the first stage of the *SAFE model,* the *seed,* and chooses an appropriate poem to begin the poetry therapy process. For example, I will use the poem "Kirin" (Gustavson, 2006d, p. 32) because it has to do with self-concept.

High cheek-boned and proud,
poet yourself in imagining life
as bearable, fought alcohol,
fought drugs, fought abusers,
fought men and IUD companies.

You, the winner still fight you,
the loser, all the while you,
the referee, keep track of
left hooks and knockouts,
ready to raise the hand of victory.

Both the therapist and client have a copy of the poem, as one of them reads the poem aloud. Discussion follows, using the four stages of the interactive process.

In stage one of the interactive process, "recognition," the client works on understanding the poem and identifying with it. Questions the therapist might ask are: "What do you think about the woman in the poem?" "Do you like her, or not?" "Have you ever felt that way?"

In stage two, the therapist and client do an "examination" of the poem. In this example, the therapist might say, "Sounds like she is a fighter. Do you know anything about professional fighting?" "In this poem, who is she fighting?"

The third stage of the interactive process is "juxtaposition." The contrasts and comparisons are already in this poem, as the poet calls her a winner, a loser, and a referee. The therapist may ask, "How can the person in this poem be all three of those characters?"

In the fourth stage of the interactive process, "application to self," the therapist might ask, "Which one of those three characters are you?" "Have you ever been any of the other characters?"

Stage Two Using the SAFE Model

The second stage of the *SAFE model*, the *sprout* stage, concentrates on the inner growth of the client. In this stage, discussion continues by looking at the issues that were brought up in the last stage. If the client had said, "I'm still the loser and I can't get past it," the therapeutic intervention would be to work on self-esteem issues. If the client had said, "I don't feel like the person in this poem, I feel more like the fist," the therapist would elaborate on the client metaphor: "Why do you feel like a fist?" "That fist must be really sore and tired, how do you care for it?" Inner growth continues silently as the client wrestles with the issues.

Stage Three Using the SAFE Model

In the third stage of the *SAFE model*, the *flower* stage, the client will be asked to write his/her own poem. There will be clients who are already writing poetry. Use whatever they bring. For others, however, the therapist will need to suggest a poetry

prompt to get them started. A poetry prompt may be as simple as suggesting a title, giving a sentence stem to finish, or suggesting a metaphor. For the client in our example, the therapist might suggest he/she write a poem entitled "Fight or Flight." A sentence stem might be "Left hooks and knockouts are …." And a poetry prompt might be to finish the metaphor "I used to be a punching bag, but now I am …." This prompt (finishing the sentence *I used to be … but now I am …)* was written by Kenneth Koch in 1970 and is a widely used poetry therapy technique.

Make sure the client understands that this is not an English class. No one will judge his/her writing. Also suggest to the client that he/she turn off the inner censor and write what flows onto the page without editing it. The poem may be given as an assignment to be written at home and brought to the next session, or written in session, if it is short.

After the poem is written, the client reads it aloud. Before discussion begins, the therapist needs to remember three things. First, never judge the quality of writing. Even if it is professional quality, do not discuss it, because the client may feel that all of his/her poems need to be of that quality. Second, always find some aspect of the poem to praise. And third, emphasize the feelings behind the words.

Let's say the client writes, "I used to be a punching bag, but now I am a brick wall, and no one dares touch me."

The therapist will use the four stages of the interactive process to discuss this client-written poem, beginning with "recognition." The therapist might say, "Wow. That's a strong image. Tell me how that image represents you." The discussion will concentrate on this central theme of self-image and how the client relates to others.

In the "examination" phase, the therapist will look closely at the metaphor and ask if it says what the client wants it to say. "Is it true that no one touches you?" "Does that mean physically, emotionally, or both?"

This short poem uses "juxtaposition" as its main theme. It puts "punching bag" and "brick wall" side by side and asks the reader to choose which describes him/her best. The therapist might ask the client what used to happen when the terms were in a different order. "Could they be changed around again?" "Would you want that?" "What might happen?"

In the "application to self" phase, the discussion continues with the therapist's support. The therapist might ask the client, "Do you want to be a brick wall?" "What does the brick wall do for you?" "Is there a place between the brick wall and a punching bag?" "How do you get there?"

Stage Four Using the SAFE Model

The fourth stage of the *SAFE model* is the *fruit* stage. At this point, the client and therapist review what has been learned both cognitively and emotionally. They also review what behavior has changed or has been identified for change. At this point, the therapy might be terminated. If a new issue, or an old issue that is not thoroughly resolved, needs further work, then the therapist cycles back to the *seed* stage and chooses another poem to begin the entire cycle again.

Using Poetry Therapy: Issues for the Therapist

This chapter specifically addresses using poetry therapy for sexual abuse trauma. Any therapist who works with clients who have suffered abuse needs to understand his/her own vulnerable areas and feelings about all aspects of sexuality. The best way to do that is to confront poetry written by sexual abuse survivors. The poetry examples listed below are meant to raise personal questions in the mind of the therapist. When addressing this poetry, use the four stages of the interactive process: recognition, examination, juxtaposition, and application to self.

Sharon Olds is one of America's best contemporary poets. In her book, *The Dead and the Living* (1988), she writes about many aspects of abuse. In the poem "The Takers," Olds writes how her older sister, who endured the same abuse as she, urinated on Sharon to show her power. "Hitler entered Paris the way my sister entered my room at night…" (Olds, 1988, p. 44). The issue of powerlessness for a therapist is important to understand in terms of trauma but also because a client needs to feel empowered by a therapist, not feel as though he or she is under the therapist's power.

Olds' poem "The Victims" raises the question of revenge toward her father, the abuser. (The "she" in this poem refers to her mother.) "She had taught us to take it, to hate you and take it until we pricked with her for your annihilation" (Olds, 1988, p. 34). Even the language chosen by the poet suggests sexual abuse. The therapist needs to understand his/her own response to revenge, whether thought about or acted out.

Abuse is often multigenerational. Olds deals with that issue in the poem "Of All the Dead That Have Come to Me, This Once." She writes about the relationship between her grandfather and father and states, "in that cabin where he taught my father how to do what he did to me, and I said, No" (Olds, 1988, p. 21). This poem brings up the questions: How do you blame an abuser who has been abused? How does a therapist keep from judging? Should a therapist ever judge?

This intergenerational poem leads to the next, "The Pact" (Olds, 1988, p. 45), in which Olds blames her sister for not protecting her own child. How does abuse enter into the next generation? How is it stopped? Does the therapist have a role to play in that story?

One last theme in Olds' book is highlighted in the poem, "The Departure." She ends the poem by asking, "Did you love us, then?" (Olds, 1988, p. 36). The sexually abused person is often confused about what love is and if there was any love present in the sexual abuse. The therapist must question himself or herself about all aspects of love and how it relates or does not relate to abuse.

Joan Larkin, in her book, *A Long Sound* (1986), writes a poem called "Origins," in which she tells her mother that a man has touched her, and is told that it is not true. "She explained the facts to me quickly. *No*, she said. *The man is a nice old man*" (Larkin, 1986, p. 43). This experience has happened to many clients. They either were not believed, or their actions were minimized. Many therapists can relate to that general kind of treatment in their own lives.

Tap Dancing for Big Mom, written by Roseann Lloyd (1985), contains several strong poems about sexual abuse. In the poem, "Insect Is An Anagram for Incest," Lloyd uses the metaphor of insects to describe her feelings. "My father's fingers

skip spider feet across my skin… my mother was eaten alive" (Lloyd, 1985, p. 46). This poem gives an emotional description of what it feels like to be sexually abused by one's father.

Lloyd's poem, "This Child," describes the life of a child who hides her body, who feels betrayed by her family, and is called "seductive/beautiful/slut." She feels "deprived of childhood" (Lloyd, 1985, p. 61). Therapists may relate to this in the sense that they, too, somehow lost their childhood.

Often sexual abuse gets repressed. But there is also a time (usually inopportune) when it is remembered. Lloyd's poem, "How the Mind Releases What Memory Refuses to Know – The Lunchroom, Sunshine School, Sixth Grade" (Lloyd, 1985, p. 59), tells of a time when she recalled the sexual abuse by her father. Memory comes at unexpected, uncontrolled times and takes over as if it were happening at the moment.

Alice Anderson has written an entire poetry book about her experience of sexual abuse by her father and the neglect she felt from her mother. She dedicates the book, *Human Nature* (1994), to poet Sharon Olds, with whom she shares the trauma of sexual abuse. She wrote the poem, "The Split" (p. 3), about trying to deal with her adult sexual partner without thinking of her father and his behavior. Her poems, "What the Night Is Like" (p. 15) and "Playing Dead" (p. 45), describe lying in bed in terror. "Grief" (p. 58) tells the story of a child who hates her father for his behavior and hates her mother just as much for not rescuing her. Anderson writes how upset she was as a child in the poem "Defense" (p. 47), describing how she put together a stinky potion that included her own urine and rubbed it all over her body, to keep her father away.

A chilling poem, "Human Nature" (Anderson, 1994, p. 85), explains how sexual violence perpetrated on a child leads to unquestioned obedience and eventually to violence perpetrated on others. These horrendous themes in Anderson's poems are universal experiences of sexual abuse trauma survivors.

Here are poetry prompts to help you as a therapist write about these issues:

- I feel vulnerable sexually when …
- Write an acrostic poem using the words "My Sexuality" (a poem where you write the letters vertically and then start each line of the poem with that letter).
- Write a multiple metaphor poem starting each line with the words: My home is like …
- The first time I remember …
- It's not easy …
- Write a poem with the title "No One Would Listen."
- Write a poem titled "Memory Hit Me Like A Bullet."
- Write a poem in the voice of a child.

Using Poetry Therapy with Sexual Abuse Survivors

Mary Bratton, in *Surviving to Thriving: A Therapist's Guide to Stage II Recovery for Survivors of Childhood Abuse* (1999), has formulated a treatment model for abuse survivors. Although the book is written for childhood survivors of all types of

abuse, the model works well with sexual abuse survivors of any age. The treatment is based on trauma research and was developed to help the survivors move toward "transformation in self-image and life patterns" (Bratton, 1999, p. XV).

Bratton lists eight stages in her treatment model: defining assault, challenging the distorted reality, using the PTSD diagnosis as a therapeutic intervention, understanding the brilliance of childhood defenses, recounting the abuse, reparenting, repairing developmental damage, and integration and transformation. For my work with sexual abuse survivors, I have condensed the eight stages into four.

Stage 1: Redefining Coping Behavior as a Normal Response to Abnormal Circumstances

In this stage, the client recognizes the reality that sexual assault is about power. The client's response to that assault required the use of many defense mechanisms that may no longer be helpful and may in fact be contributing to the trauma.

Stage 2: Recounting the Story

Some clients may be able to talk about their trauma from the beginning, but many need extra time before they can recount it. The therapist reads the client's emotional state and determines the best time to begin the recounting process. A client may remember information in bits and pieces.

Stage 3: Reparenting and Repairing Developmental Damage

In this stage, the client learns to trust in his/her own judgment and behavior. Damage done by the trauma is assessed, and various areas of developmental damage (loss of trust, uncontrolled anger, lack of intimacy, etc.) are treated.

Stage 4: Integration and Transformation

In the final stage, clients review all that has been learned, integrating it into their cognitive and emotional processes. This different way of looking at his or her own life leads to a transformation of attitude and behavior and a redefining of self-worth.

Using the SAFE Model of Poetry Therapy for Sexual Abuse Survivors

Case Vignette, Child (Lily)

A 10-year-old girl Lily (not her real name) was brought to my office for counseling because her mother could not get her out of bed in the morning, which caused her to be late to school every day. The teacher reported that Lily was not concentrating in class. Mother was also concerned because she had noticed Lily had stopped talking to her friends, and when her daughter came home from school, she went straight to her room, closing the door behind her.

Lily sat with her head down in my office and mumbled "Yes, Ma'am" and "No, Ma'am" in answer to my questions. She volunteered no information and continued to stare at her toes.

> "Do you like poetry?" I asked her.
> "It's okay."
> "May I read you part of a poem I wrote when I was feeling really sad?"
> "Okay," she replied.
> "It's called, 'I Won't Get Up'" (Gustavson, 2006b, p. 44).

She raised her head and looked at me.

> You can turn on lights, jump on the bed –
> I won't get up – I'm covering my head.
> It's cold out there – unfriendly too –
> besides I'm tired and there's nothin' to do.
>
> Don't even try to change my mood –
> GO AWAY, and don't bring food.
> Her blank eyes held a stare,
> I'm staying here. It's cold out there.

Lily took a deep breath, nodded her head, and whispered, "Yah."

The *seed,* therapist-chosen poem, addressed the first stage in therapy, redefining coping behavior as a normal response to abnormal circumstances. The abnormal circumstances had not yet been defined, but the coping behavior had been. In this instance, her excessive sleeping had gotten her into trouble. The discussion still had nothing to do with her trauma, only the coping mechanisms she was using that were working against her.

In this *seed* stage, I initiated a discussion about the poem with Lily, using the interactive process.

> "Is that how you feel in the morning?" (recognition)
>
> "Does it help to stay in bed? What happens when you're late to school?" (examination)
>
> "Tell me, which is worse: Having your Mom scream at you for not getting ready, and then being mad at you all day and night, or having the teacher and principal angry at you and ruining your whole school day?" (juxtaposition)
>
> "Is there a different way to handle your sadness?" (application to self)

At the conclusion of this initial discussion, Lily understood that it was okay to feel sad at times. In the *sprout* stage, we discussed other feelings that were troubling her as well, such as anger and frustration. She was taught helpful coping mechanisms, such as cuddling with her kitten.

In the next stage of poetry therapy, the *flower* stage, I suggested that Lily write something about her kitten. She wrote a poem called, "Why Does God Make Cats and Kittens?"

> God made them for you and me.
> Why are they awake at night?
> So someone's there when you can't sleep,
> then you don't have to wake anyone up.
> Why don't they talk?
> So you can say anything, and they won't laugh.
> They can't hurt your feelings.
> They cannot scold you for being mad,
> or for saying something you will be sorry for.
> The best thing is they forgive ME, no matter what.

This poem was diagnostic. In it, I learned that Lily did not sleep well at night, her mother was not happy being awakened, and someone in this child's life did not listen to her, often laughed at her, shamed her, and hurt her feelings. The interactive process discussion followed with these questions:

> "You really love your kitten don't you? Animals love us, no matter what, don't they?" (recognition)
>
> "Tell me about not sleeping at night. What happens when you ask for help?" (examination)
>
> "What do you think the differences are between cats and people?" (juxtaposition)
>
> "Would it be okay if you and I talk about some of those scary things?" (application to self)

In the *fruit* stage, I supported the child as together we continued to talk about feelings and coping mechanisms. I asked Lily, "May I read you another poem?"

She nodded yes, and I read, "Everything Is Down Today" (Gustavson, 2006b, p. 38):

> Red and yellow are turning brown as leaves are falling all over town.
> Rain won't stop – it's dark and gray. I'm sitting inside on this gloomy day.
> The leaves fall down – rain falls down –even my socks fall down in a mound.
> Mama says I need to erase that down-in-the-mouth frown on my face,
> But it won't go away when leaves fall down
> And the rain and my socks agree with my frown.

Lily nodded and said, "I have lots of days like that." This comment led to further discussion about her depression and how to cope with it. At the end of this stage, Lily trusted me enough to go on to the second stage of treatment, recounting the story of the trauma.

Often a child is threatened with harm if he or she tells anyone what happened, and the child is reluctant to tell the story, sometimes even admit it to him- or herself because of the perceived danger. The *seed* poem, "Black Bird" (Gustavson, 2006b, p. 106),

gives a safe distance to the child, because it is about a bird, not the child, that watches and sees everything that goes on.

Black bird with a shiny blue head
Shiny blue head on a black, black bird
Black bird with a shiny blue head
Fly down in front of me
Fly down in front of me

Black bird with a tiny piece of bread
Tiny piece of bread in a black bird's beak
Black bird with a tiny piece of bread
Tell me all that you see
Tell me all that you see

Tell me, oh tell me, black, black bird
What is it that you heard? What is it that you heard?
Tell me, oh tell me, black, black bird
From your perch in the box elder tree
What is it that only you see?

Questions used in discussion of this poem were:

"Do you ever watch the blackbirds? How are you like them?" (recognition)

"What do you think the birds see? What do they hear?" (examination)

"Do you think it would be safe for a blackbird to tell what it saw? Do you think it might get hurt? Is it different for children, or the same?" (juxtaposition)

"What does the blackbird know about you? Can you talk in a blackbird voice and tell me?" (application to self)

Lily began talking about the sexual abuse perpetrated by her mother's boyfriend. She could not sleep at night because she had to remain vigilant. She had tried to tell her mother who would not listen.

In the *sprout* stage, I remained supportive, always reminding Lily that it was not her fault. I called in Lily's mother and together we reported the abuse. She cut off the relationship with the perpetrator and began listening to her daughter.

I then asked Lily to write her own poem (*flower* stage) about the trauma. She was given the poetry prompt (Koch, 1970) I used to be … but now I am ….

She wrote, "I used to be a furry bunny, but now I'm a rabbit nobody wants. I have to hide in the bushes and can't even come out at night."

"Sounds like you grew up too fast, huh?" (recognition)

"How does that rabbit feel different than the bunny?" (examination)

"Let's think about the rabbit. Do people only love little, furry bunnies, and hate grown-up rabbits?" (juxtaposition)

"Tell me why this rabbit in you is still hiding." (application to self)

In the *fruit* stage, I continued to address the feelings that came pouring out as Lily told her story, and confronted her pain. She finally said she did not think her mother loved her, because she let this happen to her. This led to the third stage of treatment: *repair developmental damage.*

I began this phase of treatment with the *seed* poem, "You Know What I Wish?" (Gustavson & Gustavson, 2011, p. 104):

> You tell me you love me, but what does that mean?
> Will you love me if I fail to keep my room clean?
> Will you love me if I'm ugly, or if we never agree?
> How am I supposed to know if you really love me?

In this verse of the poem, the child wants to know if he/she is loved because of good or bad behavior. Or, is there another standard for love? The poem goes on to say, if you "smile when I'm happy, soar when I'm free, and if you cry when I'm sad, then I'll know you love me."

Discussion questions following this poem were:

"Do you feel that way sometimes?" (recognition)

"What do you think it means to love someone? Is that different from loving something like pizza?" (examination)

"Do you have to be good to be loved? Are any of us perfect? How good do we have to be?" (juxtaposition)

"Who loves you? Who do you love?" (application to self)

In this stage, I delineated the developmental processes that were damaged by the trauma. Lily not only questioned if her mother loved her, she wondered if it was possible for anyone to love her. She did not trust authority figures, especially her teacher and principal, who had disciplined her without caring what the problem had been. She was afraid of the night and did not trust men. The world looked like a dangerous place to her, and she felt overwhelmed.

In the *sprout* stage, I continued to offer support to her while working on the developmental issue of feeling loved. At one point, Lily said, "You know, I still feel like a rabbit, but at least I'm poking my head out a little bit."

In the *flower* stage, the therapist suggested that Lily write a metaphor poem using the word "love." She wrote:

> Love is like a cold breeze in my face.
> Love is like a daisy in an onion patch, so lonely and unloved.
> Love is like a snowflake on my nose, so cold and lonesome.

It was obvious that Lily still questioned if she was loved, still felt lonely, but there was something positive that showed up in this poem. Did she see herself as a daisy, a bright, white, shiny, open-faced flower? Did she think of herself as a beautiful, unique snowflake, even though she was lonesome?

"Love still doesn't feel warm and cozy, does it?" (recognition)

"Snowflakes melt. Is that what love does, disappear?" (examination)

"Where'd that daisy come from? Everything else in the poem is cold and lonesome?" (juxtaposition)

"Do you feel that maybe you could be a bright daisy, even if you're stuck in an onion patch, or a beautiful, one-of-a-kind snowflake?" (application to self)

In the *fruit* stage, I reviewed the progress on this developmental issue and decided to go over several more issues before moving on. But after a while, Lily was able to talk about and understand several developmental issues, and she was ready to move on to stage four of treatment, *integration and transformation*.

The *seed* poem in this stage was "Resilience" (Gustavson, 2006b, p. 60), a poem that talks about using coping skills to recover from whatever life brings:

> When I fall I get back up. I don't like mud.
> If you call me a *fathead* – I'll call you a *thud*!
> If I'm sick in my bed, I'll enjoy the soup,
> Watch TV and relax. That's how I'll recoup.
> Push my head beneath the water and bubbles I'll blow.
> Call me names – I'll just laugh. They won't hurt me – No!
> Like a cat with nine lives, I refuse to give in.
> I'm a very special person – and I intend to win!

I brought up the following questions:

"Do you act that way sometimes?" (recognition)

"What does that mean, 'That's how I'll recoup'?" (examination)

"Are you always this way, never this way, or learning to be this way?" (juxtaposition)

"Can you give an example of when you were hurt, and got right back up?" (application to self)

In the *sprout* stage, I continued reviewing the changes Lily had been making, always being supportive, and looking for new areas that still needed work.

I asked her to write a poem (*flower* stage) about how she had changed. She wrote, "I used to be just a weed, but now I am a rose in Grandma's garden, but I've got thorns."

"You feel beautiful, like a flower?" (recognition)

"When you were a weed you felt as though you didn't have a home?" (examination)

"You're tamer now, but you have thorns? What does that mean?" (juxtaposition)

"How does that make you feel, to think of your self as a rose?" (application to self)

In the *fruit* stage of this final phase of treatment, we reviewed progress in terms of integration and transformation. The therapist determined that the therapy was complete, and set up a timetable for termination.

Case Vignette: Teen (Laura)

Laura (fictitious name), a 16-year-old girl, came to me for counseling because she was exhibiting sexual acting-out behavior and occasional drug use, as well as causing trouble at school and with her family. She had been a straight A student, but little by little she had lost interest in everything and let her grades drop to failing. In order to change Laura's behavior, her mother had taken away everything Laura liked, but

up to the time she came for counseling, nothing had worked. When Laura spoke, it was mostly profanity. She came dressed inappropriately and refused to engage in any real conversation.

Her mother mentioned that Laura enjoyed writing poetry, so I asked her if I could read a poem. She agreed, and I chose the *seed* poem, "Sixteen Rebel" (Gustavson, unpublished).

> You entered my office, the fourth therapist in three years.
> "You're sixteen and worse than a rebel – more like a devil," says her mom.
> They've taken away your car, your phone, your freedom, nothing worked –
> now they've taken your dresser, mirror, bed, and door.
> Your mattress lies on the floor stripped of crisp sheets and pillows.
> No privacy until you behave.
> You know exactly what you want,
> and with every taking you become more the rebel.
> I say STOP! Where are you in this taking away of things, this taking away of you?
> You are in the poem. You have been given paper. You have been given
> back the pen. You have recovered your voice, your spirit.
> You are flowing into the words, flowing into recovery.

Laura opened her eyes wide and asked, "Who'd you write that for? Probably one of my friends." She obviously recognized some of herself in the poem (recognition). I asked her:

> "Which of those things has happened to you?" (examination)
>
> "Did it work for her? Is it working for you? What do you think might work?" (juxtaposition)
>
> "Do you feel as though you have had your 'self' taken away?" "How can you get it back?" (application to self)

In that first stage of sexual trauma treatment, redefining coping behavior as a normal response to abnormal circumstances, we talked about the coping skills she had been using and what worked for her and what did not. In this stage, the client had not yet told her trauma story, and in Laura's case, she had repressed the sexual abuse and did not know why she harbored so much anger and negativism. But she knew she was in trouble, and we could talk about that.

In the *sprout* stage, we began to build trust as we continued to discuss her aberrant coping mechanisms. Because she loved to write, from time to time Laura wrote short poems. Her writing brought her closer to her feelings and would later lead to remembering painful sexual abuse.

In the *flower* stage, when Laura still had little understanding of her behavior, she wrote:

> I used to be a beautiful flower,
> but now I am a stem,
> because I am broken.

Interactive process questions were as follows:

> "That's a beautiful way of saying how hurt you feel." (recognition)
>
> "Tell me about that flower." (examination)

"Do we always throw away broken things? What else can be done?" (juxtaposition)

"Can a broken stem bloom again?" (application to self)

Laura related that she was having frightening dreams, all of which took place in her backyard. In the *fruit* stage, I supported her, and her memory of the abuse gradually returned.

As Laura entered the second phase of treatment, recounting the story of abuse, I wrote her a *seed* poem:

Whoever said it was easy to remember
was never abused.
Confused dreams become more real
than the feelings
held in by drugs
held in by secrets
melted into a steel bullet aimed inward.

Interactive process questions were:

"Do you recognize the person in the poem?" (recognition)

"What do drugs do for people?" (examination)

"Do secrets protect or harm people?" (juxtaposition)

"What does it mean that the bullet was aimed inward?" (application to self)

In the *sprout* stage, Laura continued to remember secrets she had been forced to forget. She recalled a playhouse in her backyard, where her uncle, cousin, and older brother had repeatedly sexually molested her. At the time of therapy, all three of the men had been incarcerated for other offenses.

In the **Flower** phase, Laura wrote:
Tell me your sorrow. Tell me your pain.
Watch me cry, I'm going insane.
Watch me cringe, I'm fading away.
Don't underestimate me or walk away.

Discussion centered on her pain and abandonment issues.

"There's a lot of pain in that poem." (recognition)

"What does that mean, 'I'm fading away'?" (examination)

"Would the pain go away if you faded away?" (juxtaposition)

"Everyone else in your life has let you down. Are you afraid I will also abandon you?" (application to self)

Trust issues were examined and dealt with in the *fruit* stage. Now that she had recounted her story of trauma, she moved on to the next stage of treatment, repair developmental damage.

The damage done to Laura included trust issues, abandonment, questioning what love is, self-esteem, and shame issues. For the *seed* stage, I chose to use one of Laura's poems she wrote when her boyfriend broke up with her:

I didn't think someone like you could love a girl like me
so I changed myself into someone I thought you wanted me to be.
I realize now it was silly to put on an act that way
but now it's too late, you see, for you have run away.

Questions for discussion were:

"Wow! That's a lot of growth in four lines of poetry." (recognition)

"You feel you changed your identity for him. In what way?" (examination)

"You feel good that you learned something, but it doesn't make the pain go away, does it?" (juxtaposition)

"Where do you go from here?" (application to self)

In the *sprout* stage, she continued working on developmental issues. This was a slow process that led to the *flower* stage in which Laura wrote:

The moon shining above is my only secure love.
The stars everlasting glow gives me the warmth I know.
The beauty of the sky calms my mind. I don't know why.
If I had only one wish, do you know what that would be?
For me to fly into the sky for all eternity.

This poem starts out sounding serene and ends sounding like a veiled suicide wish. Discussion followed:

"This is all really difficult, isn't it?" (recognition)

"Tell me about that last line, about 'eternity.'" (examination)

"Sounds pretty calm in this poem. Would ending your life really be calm for you or your family?" (juxtaposition)

"Let's talk about other ways to calm down your thoughts and feelings." (application to self)

As she found out, sometimes writing about her sad feelings or destructive wishes actually disarmed them. In the *fruit* stage, she continued to grapple with hard developmental issues until she was ready to move on to the final stage of sexual abuse trauma treatment, *integration and transformation*.

In the *seed* stage, I again used one of Laura's poems.

Hope is a changing attitude
which to others we should warn
one moment our hopes are flying high,
the next our dreams are torn.
Hope is a solid foundation
of dreams, joy and sorrow.
It is the force which encourages me
to carry on 'til tomorrow.

I asked these questions:

"I see you really want to understand what is going on, and hope keeps you on the right track, right?" (recognition)

"What do you mean by 'hope is a solid foundation'?" (examination)

"So you're still feeling both hope and despair, but it seems as though hope is winning. " (juxtaposition)

"How is this feeling different from what you have experienced in the past?" (application to self)

In the *sprout* stage, we continued to look at the changes in Laura's thoughts, feelings, and behaviors. Finally, she wrote a beautiful poem (*flower*) to summarize how she had transformed and rediscovered herself.

I looked in the mirror and what did I see
but the face of myself that was nothing like me.
The face of a stranger covering my own
had entered my body. Was I its new home?
I studied this stranger for many days
until at last I realized it was going to stay.
I soon grew to know it, and like it as well.
What would others think? Only time would tell.
I started to change in other ways too.
People said I looked different. I said, "I just grew."
I was now a new person. I took on new trends
and my stranger and I are now best of friends.

In the *fruit* stage, the therapist started the process of termination of counseling.

Case Vignettes: Adult (Barbara and Gloria)

Barbara and Gloria were both college-educated women who had been neglected and physically, as well as sexually, abused during childhood. Barbara was 35 years old, married, and the mother of one child. Gloria had never married and was 68 years old. In this section, I will list poems the women wrote in session, as well as poems I used with them, without going into the discussion questions.

In the first stage of treatment, redefining coping behavior as a normal response to abnormal circumstances, each woman had to confront her own ways of coping that had eventually made life more difficult. I chose to read the *seed* poem, "Step Around" (Gustavson, 2006a, p. 30):

"Life ain't been no crystal stair" Langston Hughes
They try to make it into a stair, crystal or no,
Tell us we're moving up, a step ahead, up another rung,
Until we reach a plateau and where do we go from there?
I say we don't need to climb a ladder, or get high enough to fall.
All we need to do is walk together on this flat-on-the-ground circle,
stepping around stones, entering doorways.

In response to this poem, Barbara, a mother, wrote about how difficult it is to be responsible for everyone else, when it is so hard to just live her daily life.

Does the Statue of Liberty ever let down her torch,
drop it in the harbor, her robes accidently scorch?
Does she ever get tired of being so tall,
of being the strong one who welcomes all?

What's it like to be like everyone else?
She's the great lady of the harbor with a different story to tell.

Gloria, an artist, had a different response to the *seed* poem. She told about the complexities of life through art, in this poem called "Impressionism."

Absinthe and spice,
tawdry ways and broad strokes,
A no-pass zone to the new
a mile into the future,
A devotion of the 21st century:
Every master must study to Manet
(what isn't there) and look back.

In the second stage of treatment, recounting the story of trauma, I read the *seed* poem, "Trail to an Inner Lake" (Gustavson, 2006d, p. 6). It tells the story of a person walking on a trail that is full of stinging insects that are trying to tell her she is not wanted there. The last verse states:

Still I continue exploring, ignoring the "I am not wanted here" signs
(poison ivy, nettles) to glimpse the untamed, the unnamed,
the unsettled, the domain of the stinging insect,
that I have entered with no repellant.

Remembering trauma is painful. The therapist must offer complete support, or the client might choose to stop looking. The relationship between therapist and client needs to feel safe. I wrote the poem, "The Secret of Finding Joy" (Gustavson, 2010, p. 27), for Barbara after she had revealed her trauma.

I offer Kleenex to a woman who describes her hidey-hole,
where Dad couldn't find her in the night.
She slept there, curled into a ball, and I say,
Tell me about its walls. Feel its warmth.
The brain doesn't know you're not there.
If you tell it so, it believes you. Go there.
Feel safe again from the demons of the night.

In the third stage of treatment, repair developmental damage, I chose to read, "No Geysers Lifted" (Gustavson, 2006d, p. 44). This poem describes how life has a way of numbing our feelings. One verse states:

I wanted to scream,
but I had long ago forgotten
how to bellow like a lion
with a haunting belly growl,
its neck raised, arched,
its claws carved into dried clay.

Gloria responded with a poem (*flower*) about how she had never been able to get close to anyone. She called it, "The Result":

Nearness of desired touch,
a vapor of hope
observed but sieved through

vague memories of fear.
Wispy secrets
remove all hope and
dilute the senses.

Barbara's response to the *seed* poem was also about the damage caused by not knowing how to love.

The demons of childhood simmer just below the surface.
When I yell at my son, or watch my husband turn away,
a little girl inside cries and cringes in a corner.
Will someone please take the girl out of the corner,
dry her eyes, and show her the way to love?
The Bible says that a child shall lead them,
but first, someone needs to lead the child.

And finally, in the fourth stage of treatment, integration and transformation, I read the *seed* poem, "Frozen Ground" (Gustavson, 2006d, p. 110), that tells about a child who was too cold to skate with the others long ago but now, as an adult, has equipped herself with warm clothing. The second verse of the poem states:

Now grown, that child, no longer with protruding bones,
pulls on *thinsulate* gloves, a parka of down,
laces insulated skates over polypropylene socks
and enters as a stranger. She traces figure eights
cut by a fanciful child, then races forward, stiff-ankled,
catching up with frozen ground.

Sexual abuse trauma survivors all come from that land where they were not prepared for the chill of frozen ice. Barbara responded to this *seed* poem with these words: "I used to skate in tennis shoes with holes, but now I've bought myself a pair of insulated skates, and I'm ready to go."

Barbara terminated counseling, increased her family by one more child, and is living a rich and meaningful life. Gloria continues in therapy but has better self-understanding and improved self-esteem. She wrote this poem about her experience of poetry in therapy:

It tickles the mind, poetry,
a windstream of thought,
a draught of mystery,
a portion of implementation,
a soft ride within the mind
to listen, as every word
hums the chord of spirit.

That is what poetry brings to therapy, "a soft ride within the mind." Therapy is a bumpy road, and clients often need that softer ride to go the distance. Poetry brings out "the windstream of thought," the "draught of mystery," and "the chord of spirit," all elements that may be hidden and difficult to access. And finally, poetry enables "a portion of implementation," a way to move forward on the path to transformation.

Conclusion

Transformation is a goal in all areas of social work practice, and poetry therapy is a creative, useful tool that can be used to achieve it. Start your next therapy or support group with a poem, and see where the discussion leads, or ask each participant to add a line to a group poem. Use a Shel Silverstein poem (1974, 1981, 1996) to break the ice with a child who will not talk to you. Read a poem about being overwhelmed with life's stresses to an overwhelmed woman, and watch her slowly open up to you. Poetry entertains, enriches, digs deep into unexposed areas of hurt, and allows clients to understand that they are not alone. Someone else has written this poem and knows their pain. Social work has always been about relating to our clients in the most human and humane way, and social workers have done that with their carefully chosen words. Poetry adds another set of carefully chosen words to our toolkit and in the process also adds the gift of beauty to our client's lives.

Acknowledgments My clients (not their real names) are thanked for their words.

References

Adams, K. (2011). *Eight suggestions for journal writers*. Retrieved September 3, 2011, from http://www.JournalTherapy.com

Adler, A. (1954). *Understanding human nature*. New York: Fawcett.

Anderson, A. (1994). *Human nature*. New York: New York University Press.

Baikie, K., & Wilhelm, K. (2005). Emotional and physical health benefits of expressive writing. *Advances in Psychiatric Treatment, 11*, 338–346.

Bratton, M. (1999). *From surviving to thriving: A therapist's guide to stage II recovery for survivors of childhood abuse*. Binghamton, NY: The Haworth Maltreatment and Trauma.

Bruner, J., Olver, R., & Greenfield, P. (1966). *Studies in cognitive growth*. New York: Wiley.

Chavis, G. G., & Weisberger, L. L. (Eds.). (2003). *The healing fountain: Poetry therapy for life's journey*. St. Cloud, MN: North Star Press.

Davidson, K., Schwartz, A. R., Sheffield, D., McCord, R. S., Lepore, S. J., & Gerin, W. (2002). Expressive writing and blood pressure. In S. J. Lepore & J. M. Smyth (Eds.), *The writing cure: How expressive writing promotes health and emotional well-being* (pp. 17–30). Washington, DC: American Psychological Association.

Fox, J. (1995). *Finding what you didn't lose: Expressing your truth and creativity through poem-making*. New York: Tarcher/Putnam.

Fox, J. (1997). *Poetic medicine: The healing art of poem-making*. New York: Tarcher/Putnam.

Gladding, S. T. (1998). *The creative arts in counseling* (2nd ed.). Alexandria, VA: American Counseling Association.

Grandin, T. (2001, October 20). *Thinking in pictures*. TED Talk. February 2010, from http://www.facebook.com/TED

Griefer, E. (1963). *Principles of poetry therapy*. New York: Poetry Therapy Center.

Gustavson, C. (2006a). *Con-versing with god: Poetry for pastoral counseling and spiritual direction*. New York: Blooming Twig Books.

Gustavson, C. (2006b). *Fe-vers: Feeling verses for children*. New York: Blooming Twig Books.

Gustavson, C. (2006c). *Fe-vers: Feeling verses for teens*. New York: Blooming Twig Books.

Gustavson, C. (2006d). *In-versing your life: A poetry workbook for self-discovery and healing*. New York: Blooming Twig Books.
Gustavson, C. (2006e). *Re-versing the numbers: A poetry workbook for eating disorders*. New York: Blooming Twig Books.
Gustavson, C. (2006f). *Re-versing your pain: A poetry workbook for those living with chronic pain*. New York: Blooming Twig Books.
Gustavson, C. B. (2010). *Please use this for children and not for war and guns*. New York: Blooming Twig Books.
Gustavson, C., & Gustavson, K. (2011). *Bully: The big book for bullies and the bullied* (2nd ed.). New York: Blooming Twig Books.
Hynes, A., & Hynes-Berry, M. (1992). from *Biblio/poetry therapy: A resource bibliography*. St. Joseph, MN: The Bibliotherapy Roundtable. Retrieved November 2, 2005, from http://www.NAPT.org. (hyperlink no longer valid; page numbers are from the website material).
Hynes, A., & Wedl, L. (1990). Bibliotherapy: An interactive process in counseling older persons. *Journal of Mental Health Counseling, 12*, 288–302.
Koch, K. (1970). *Wishes, lies and dreams: Teaching children to write poetry*. New York: Harper and Row.
Larkin, J. (1986). *A long sound*. Penobscot, ME: Granite Press.
Leedy, J. J. (Ed.). (1969). *Poetry therapy: The use of poetry in the treatment of emotional disorders*. Philadelphia: Lippincott.
Leedy, J. J. (Ed.). (1973). *Poetry the healer*. Philadelphia: Lippincott.
Leedy, J. J. (Ed.). (1985). *Poetry as healer: Mending the troubled mind*. New York: Vanguard.
Lepore, S. J., & Smyth, J. M. (Eds.). (2002). *The writing cure: How expressive writing promotes health and emotional well-being*. Washington, DC: American Psychological Association.
Lerner, A. (1987). Poetry therapy corner. *Journal of Poetry Therapy, 7*, 54–56.
Lerner, A. (Ed.). (1994). *Poetry in the therapeutic experience* (2nd ed.). St. Louis, MO: MMB Music.
Lloyd, R. (1985). *Tap dancing for big mom*. St. Paul, MN: New Rivers Press.
Longo, P. (2011). *Poetry therapy*. Retrieved September 10, 2011, from http://www.perielongo.com
Mazza, N. (1999). *Poetry therapy: Interface of the arts and psychology*. Boca Raton, FL: CRC Press.
Mazza, N. (2003). Encountering dilemmas and life's choices. In G. Chavis & L. Weisberger (Eds.), *The healing fountain: Poetry for life's journey* (pp. 59–74). St. Cloud, MN: North Star Press.
McGilcrist, I. (October 2011). *Brain research*. TED Talks. Retrieved October 23, 2011, http:/www.facebook.com/TED
National Association of Poetry Therapy (NAPT). (2011). Poetry therapy. Retrieved July 2, 2012 from http://www.nccata.org/poetry_therapy.htm.
National Association of Poetry Therapy (n.d.). Retrieved October 10, 2011, from http://www.poetrytherapy.org
Norman, S. A., Lumley, M. A., Dooley, J. A., & Diamond, M. P. (2004). For whom does it work? Moderators of the effects of written emotional disclosure in a randomized trial among women with chronic pelvic pain. *Psychosomatic Medicine, 66*, 174–183.
Olds, S. (1988). *The dead and the living*. New York: Knopf.
Pattison, E. M. (1973). The psychodynamics of poetry by patients. In J. J. Leedy (Ed.), *Poetry the healer* (pp. 197–214). Philadelphia: Lippincott.
Pennebaker, J. W., & Beall, S. K. (1986). Confronting a traumatic event. *Toward an understanding of inhibition and disease. Journal of Abnormal Psychology, 95*, 274–281.
Perls, F. S., Hefferline, R., & Goodman, P. (1951). *Gestalt therapy: Excitement & growth in the human personality*. Gouldsboro, ME: Gestalt Journal Press, Inc.
Prescott, F. C. (1922). *The poetic mind*. New York: McMillan.
Reiter, S. (Ed.). (2009). *Writing away the demons*. St. Cloud, MN: North Star Press.

Rossiter, C., Brown, R., & Gladding, S. T. (1990). A new criterion for selecting poems for use in poetry therapy. *Journal of Poetry Therapy, 4*, 5–11.
Rothenberg, A. (1972). Poetic process and psychotherapy. *Psychiatry, 35*, 228–254.
Rubin, R. J. (1978). *Using bibliotherapy: A guide to theory and practice*. Phoenix, AZ: Oryx Press.
Schauffler, R. H. (1925). *The poetry cure: A pocket medicine chest of verse*. New York: Dodd, Mead and Co.
Schauffler, R. H. (1931). *The junior poetry cure: A first aid kit of verse for the young of all ages*. New York: Dodd, Mead and Co.
Silverstein, S. (1981). *A light in the attic*. New York: Harper and Row.
Silverstein, S. (1996). *Falling up*. New York: HarperCollins.
Silverstein, S. (1974). *Where the sidewalk ends*. New York: Harper and Row.
Stainbrook, E. (1978). Poetry and behavior in the psychotherapeutic experience. In A. Lerner (Ed.), *Poetry in the therapeutic experience* (pp. 1–11). St. Louis, MO: MMB Music.
White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton & Company.

Chapter 4
Masks, Wounds, and Bridges: Expressive Arts Therapy with Sexual Abusers

Haley Fox

In writing this chapter, I have been challenged to bring forward in clear and understandable language two fields of study whose paths to date have scarcely crossed. I have had the rare opportunity myself to walk freely among both landscapes, and as such I can easily lose touch with how poorly the "left hand knows the right hand" outside of my own experience.

In truth, I feel as though I am standing in a sandbox engaging two toddlers. Both fields of study, expressive arts therapy and treatment of sexual abusers, remain in their infancy. Both remain somewhat poorly understood by the world at large. Each seeks to be noticed and accepted, though often from different camps and in starkly different ways. I appreciate the vigor and willfulness they each bring to me, contagious excitement about new discoveries and possibilities. So distracted are these two by their respective, dynamically forming worlds, I feel I have to begin by formally introducing them to each other.

It is not easy to get toddlers to sit down for a moment and to regard each other, never mind to pause long enough to peek into the world of the other, never mind to try to see that other world from the lens of the other. The notion of these two toddlers actually *embracing* each other seems a bit elusive at this juncture in time.

Nevertheless, I imagine great riches waiting at the end of this endeavor, good things that can bring both parties inestimable profit and enjoyment. Turning back now, refraining from stepping into the sandbox, would erase those delicious possibilities, and it would not only result in my personal sadness; it would be, I believe, a tremendous loss to the world. So here goes.

I begin by introducing each of these fields separately, doing my best not only to describe but also to illustrate the nature of each with examples and, where I can,

H. Fox, Ph.D., REAT (✉)□
Clinical Director, Minnesota Sex Offender Program,
17355 River Birch Lane, Prior Lake, MN 55372, USA

100 Freeman Drive, St. Peter, MN 56082, USA
e-mail: drhaleyfox@gmail.com

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3_4, © Springer Science+Business Media New York 2013

with provocative images, as is the way of my own artistic tradition. (Fortunately, art at least speaks in terms all humans can usually understand.) I spend some time challenging long-held views—inviting the reader "out of the box," so to speak. And finally, I explore a number of practical concerns and creative opportunities that face practitioners who seek to bring expressive arts therapy into this most important clinical work with sexual abusers.

I believe these two young and growing fields can and will be good friends, and I invite you all to join me in my enlarged sandbox.

What Is Expressive Arts Therapy?

Expressive arts therapy refers to a specific treatment approach that incorporates an array of arts modalities in psychotherapy. A registered expressive arts therapist (REAT) is a master's degree level therapist with a clinical skill set comparable to other master's degree level mental health professionals[1]; indeed, many expressive arts therapists (though not all) elect to also become independently licensed as professional clinical counselors, marriage and family therapists, or social workers.

Unlike the separate disciplines of art, dance, music, drama, and poetry therapy, expressive arts therapy draws upon *all* the arts. Clinicians in this discipline find grounding not in the particular *tool* applied but rather in a particular theoretical orientation (Fox, Knill, & Fuchs, 2005). Expressive arts therapists build on the qualities all the arts have in common and value the ways in which moving among different art forms can deepen imagery and advance the therapeutic process. Although a given art-making process may look the same from an observer's point of view, what really distinguishes expressive arts therapy from art education or leisure activity is the lens the particular clinician brings to the work.

Expressive arts therapy is not merely "nonverbal" therapy. Language plays a role in this treatment approach too. Parallels can be found in talk therapy; for example, the modality of storytelling offers a comfortable starting point for many clients. Having a client tell his or her story helps a therapist to discern salient treatment issues. The expressive arts therapist pays particular attention not only to narrative content but also to prominent images and metaphors that may emerge. These can then be explored and deepened through the application of art-making, music-making, poetry-writing, enactment, sand play—anything with roots in the imaginal realm.

[1] For information on becoming a registered expressive arts therapist (REAT) or a registered expressive arts consultant/educator (REACE), contact the International Expressive Arts Therapy Association (IEATA), www.ieata.org.

In expressive arts therapy, work with images and with the imaginal realm is paramount. While Ego[2] generally imagines "reality" as being limited to a consensual, "actual" realm, expressive arts therapists see the imaginal realm as every bit as "real." Seeing the world through an artist's lens, we understand that images rule the imaginal realm with autonomy and intent and have enormous influence with Psyche. Indeed, the way we *imagine* our worlds generally has far more influence on our thoughts, feelings, and behaviors than do "actual" realities.

Sexuality, Treatment, and the Arts

It may be no accident that clinical training programs as a rule frequently overlook the particular treatment needs of sexual abusers. These individuals, mostly men,[3] are a feared and maligned group whose disastrous interpersonal relationships and terrible deeds are more often attributed to moral failure than to psychological brokenness. Historically, not many have believed that sexual abusers can "get better" or be rehabilitated. Debate continues even among clinicians and researchers.

Many clinical training programs fall short on the most basic human sexuality coursework, failing to acknowledge the key role sexuality plays in *all* relationships—including therapeutic relationships—owing in no small measure to the highly intimate nature of these relationships. Sexuality is part of the human condition, and as such it has a profound impact on inner drives and behavior—on *both* sides of the consulting room. Let us not forget (as if we could) that sexuality also saturates our external world, now more explicitly than ever through media and the Internet.

For human beings, at first blush, the solution to the many forms of wounding that arise from misguided or inappropriately emphasized sexual behavior might be abstinence. But we cannot erase sexuality from humanity. Instead, it behooves us as individuals and as a culture to revisit our *relationship(s)* with sexuality—to find healthy, life-affirming, and open-eyed ways to incorporate sensuality and touch into daily life. Without it, any one of us fails to thrive. From the perspective of expressive arts therapy, the arts provide particularly effective avenues for this healing work.

---

[2] I capitalize "Ego" to emphasize the archetypal nature of my understanding of Ego. Archetypes, per Carl Jung (1959 trans in Hull, 1980), are complex psychic forms. They sometimes reveal themselves in the images that appear in artwork and in dreams. By capitalizing terms associated with strong images and archetypes, we in effect personify them, and in doing so we acknowledge their complexity and become able to engage them more dynamically, in the spirit of James Hillman (1977). Ego, for example, is a distinctive archetype in that he typically imagines himself as "the only one"—though many, many other images and archetypes populate the imaginal realm and influence Psyche.

[3] I will refer to sexual abusers in this chapter using predominantly male pronouns because of the fact that the vast majority of clients in prisons and treatment programs are men, not in any way to minimize the existence of female sexual abusers nor the terrible hurts they cause.

The story of Eros and Psyche offers some insight here. This ancient myth artfully illustrates the indomitable efforts of the erotic (Eros) and human consciousness (Psyche) to unite. In my unpublished book *Sexual Healing* (2009), I reflect upon this myth:

> The strivings of these two lovers, fraught with challenges superbly designed to cultivate maturity, culminate in ultimate pleasure. Eros and Psyche love and desire each other. On one hand, Eros offers sensuality to the mix, with his innate ability to stir and enliven all the senses—touch, taste, smell, sound, vision—the very same senses that enrich the human experience of music, art, poetry, dance and all the arts. In a beautiful encounter, Psyche takes Eros into herself…enriching experience and lending thought, intuition and heart-wisdom to her partner in the creation of a joyful, soulful climax that would not be possible without the active involvement of both parties.
>
> Simply put, Eros represents sensuality. Psyche, a lantern shining light upon Eros. Soul-making, the act of unifying the two. The child called "Pleasure" or "Joy" in the myth is the ultimate product of the union.

The myth of Eros and Psyche calls us to recognize that although people may live full and enriching lives without *sexual* eroticism (some choose celibacy as a way of life), none of us can truly thrive—or glean any pleasure from life—without Eros.

Fortunately for us, Eros comes in many forms. Dancing wild dervishes, eating chocolate, drinking in the scent of a rose, plunging hands in wet clay, and even guiding a delicate paintbrush in a careful calligraphy curve—all these are erotic, sensual activities. Those who have had the pleasure of witnessing Sister Wendy Beckett's many talks about art (2009) can attest that Eros is alive and well even among the sexually celibate.

By the same token, the desire for Eros can be regarded as a legitimate need. We all have a human need for sensual experiences in our lives. What we do *not* have, of course, is the right to rob others without their consent in a misplaced effort to meet this need, nor do we have a right to cause hurt or pain to others in our pursuit of Eros. Those who have sought to meet the legitimate need for Eros in ways that are harmful to others quickly find themselves facing an array of consequences for their behavior. Those whose sexual behavior has gone most horribly wrong frequently end up incarcerated or civilly committed to state—and now federal—treatment programs.

Prisons and treatment programs for sexual abusers are a growth industry. The expense of running these institutions has been skyrocketing in the face of near panic over state and federal budget deficits. On the other hand, it seems that no one wants to release untreated sexual abusers onto the streets, and understandably so. No one wants to endanger public safety. The only reasonable answer to this public health problem appears to be *high quality treatment that fosters meaningful change.*

Change is not easy. But change is possible. And expressive arts therapy is an approach uniquely suited to fostering change in human beings. I will elaborate upon this unique facility after a brief review of the history of treatment approaches with sexual abusers.

A Brief History of Treatment Approaches with Sexual Abusers

Although sexually abusive behavior has always existed in the repertoire of human experience, prior to the twentieth century, not much attention was paid to the diagnosis and treatment of sexual abusers. Krafft-Ebing (1886) was one of the first to clinically examine the problem of sexual abuse; he coined the term "pedophilia." His contemporary, Freud (1905/2000), wrote extensively on the subject of sexual abuse. Those early writings appear to have been strongly influenced by Krafft-Ebing; however, Freud retracted his initial theories after a hostile response from his professional peers.

It was not until the 1960s that practitioners began to initiate modern approaches to treating problematic sexual behaviors (Marshall & Laws, 2003). In those days the behavior of sexual abusers was understood to be essentially a product of sexually deviant arousal patterns, and initial treatment approaches focused on attempts to measure and influence sexual interest. Marshall (1971) was among the first to point out that reshaping arousal patterns may not be enough; he noted the importance of helping clients build prosocial skills and attitudes essential to establishing healthy adult relationships.

Subsequent research, most notably by Andrews, Bonta and Hoge (1990), identified an array of deficits in functioning that could be predictive of sexual offending, referring to these as *criminogenic needs* or *dynamic* risk factors. This research was nicely complemented by the development of risk prediction instruments that examined actuarial data and *static* risk factors, that is, factors *not prone to change* (such as number of victims, number of offenses, age, and so on). While static risk factors offer good information regarding treatment need and optimal treatment intensity, dynamic risk factors, being changeable, identify important targets to guide treatment programming.

Also in the 1990s, before much of the research into static and dynamic risk factors had rolled out to the treatment community, the relapse prevention (RP) model, a cognitive behavioral approach originally developed for the treatment of addictions, found widespread popularity as a method for treating sexual abusers. Essentially, RP involves a thorough examination of an individual's precursors to sexually abusive behavior and specific interventions (including escape and avoidance) thought to be effective in interrupting a sexual offense pattern and thereby in preventing relapse. The RP model relies upon clients to recount a laundry list of risk factors and strategies for intervening on each, without regard for whether any given factor is a likely predictor of reoffense, since the model was not grounded in research. Because the approach seems so logical, treatment programs all over the world began to implement immediately, especially in the United States, some say prematurely. To date, RP's efficacy has not been supported in the research, although the model remains in place as at least a partial approach to the treatment for sexual abusers in most programs around the globe.

Despite the controversy surrounding relapse prevention, cognitive behavioral therapy (CBT) itself, designed to address distorted and criminal thinking, has been

widely accepted as standard for treatment with individuals who sexually abuse others. This is also true of the practice of group therapy, which engages peer support and confrontation and is considered vital to treatment progress.

Newer treatment approaches have focused more attention on dynamic risk factors and strength-based treatment. Risk-needs-responsivity (RNR) principles, elucidated after extensive meta-analyses by Andrews, Bonta and Wormith (2006), have been highly influential in the treatment of sexual abusers in recent years. According to these principles, those at the highest risk of reoffense ("risk") require the most intensive treatment, and criminogenic needs drive treatment targets ("needs"). The "responsivity" principle emphasizes the importance of "packaging" treatment in a way that clients can understand and use, based on learning styles and language. For example, Ward and Hudson's self-regulation model (2000) targets a particularly important dynamic risk factor, the ability to effectively monitor and regulate one's own emotional responses and behaviors.

Tony Ward has also promoted his Good Lives Model (GLM, 2002) in recent years, which for the first time departs from a problem-focused approach and emphasizes how the "goods" that give life meaning and purpose ought to play a key role in driving treatment. Having a better life, according to Ward, will itself inhibit criminogenic features.

Following that strength-based lead, the already well-published Marshall, Marshall, Serran, & O'Brien (2011), have begun to apply Seligman's positive psychology principles, placing particular emphasis on the importance of therapeutic relationships characterized by warmth, empathy, and support. The intent, of course, is not to condone sexually abusive behavior but rather to ameliorate it. The Marshalls' positive approach marks a clear departure from previous confrontational approaches to the treatment of sexual abusers; in their view, confrontational approaches can exacerbate shame in a manner that interferes with positive and prosocial therapeutic movement.

There appears to be a general trend in thinking among practitioners currently that the optimal treatment programming may consist of a balanced blend of traditional RNR approaches with more positive, strength-based treatment approaches.

So How Does Expressive Arts Therapy Fit in?

Expressive arts therapy still lies on a pioneering edge when it comes to the treatment of sexual abusers. A few practitioners exist in treatment programs around the country, and various arts modalities have surely found a way into the private lives of clients seeking outlets for expressing pain and exploring treatment issues. However, to date, there has been a paucity of published research.

A review of existing research concerning the treatment of sexual abusers, however, suggests that expressive arts therapy makes a compelling fit for the unique treatment needs of this population. As already noted, cognitive behavioral therapy (CBT) has been the standard of treatment for sexual abusers since people began offering treatment to this population. But changing thinking is simply not sufficient to effectuate

long-lasting change. Experiential exercises that also engage feeling serve as much more powerful change agents (Marshall, Marshall, Serran, & O'Brien, 2011). Associating images and experiential touchstones to thoughts make the thoughts more memorable and compelling.

Images dominate the rubric of expressive arts therapy and set it apart from other theoretical orientations. It is important to remember that images are not only visual, they are multimodal. Even a simple "O" shape has not only a visual roundness we can imagine in our mind's eye but a particular sound too. For the synesthetes[4] among us, it may even possess a taste. "O" is a vessel, an opening, an exclamation or a sigh, hands held in a circle, an image of unbroken connection. Most images are far more complex than "O"; all of them carry that same multimodal aspect.

How does an expressive arts therapist work with images? The simplest answer is, expressive arts therapists work with images in essentially the same way that an artist does. We first assume and acknowledge the reality and power of the imaginal realm (vs. the "actual" realm). We respect the autonomy of the image, which may have wisdom and intentions far different from what lies within Ego's immediate grasp. Expressive arts therapists also refrain from allegorical, limiting interpretations—we simply "stay with the image" and allow it to continue to reveal itself. We let the art tell *us* what it needs—perhaps some yellow over here, a cymbal crash there, a more tentative entrance onto the stage. We nurture this same aesthetic judgment and sensibility in the clients with whom we work. Instead of "Are you finished with this painting" we might ask, "Is the painting done?" and let the painting tell us that.

A single image may mean many things; the minute we attach a single defining label to an image, the creative/therapeutic process stops dead. And this reality lies at the heart of the work. The creative process itself is therapeutic on its own terms, and it will remain so even if—or especially if—we never take our thoughts out of the artistic realm to "interpret" it with psychological jargon.

Finally, in the spirit of James Hillman (1977), we "befriend" images, especially those most insistent ones, that recur within our dreams and artwork. We take the time to examine them, share them with others, dialog with them, learn from them.

Why the arts? What good does this intimate involvement with the arts do for sexual abusers? Part of the answer must look at what the arts do for *all* human beings.

Research has shown that *just having art and music around* exerts a notable impact on mood, depression, anxiety, and even pain (Bhangu, 2011; Nanda, 2011). This finding speaks directly to an important criminogenic need among sexual abusers: emotional regulation. The arts offer many opportunities for stress reduction and for emotional expression *in safe containers*—that is, within the confines of a stage, within the structure of a dance, within the bars of a musical score, even within the confines of a canvas.

[4] Synesthesia is a condition in which one type of stimulation evokes the sensation of another, as when the hearing of a sound produces the visualization of a color.

The arts can directly impact other criminogenic needs as well. Engaging with arts modalities offers countless opportunities to exercise imagination—a particularly useful tool when it comes to problem-solving. The arts introduce surprise and outside-the-box thinking, encourage creativity, and allow for experimentation with different ways of seeing and being in the world. *Prosocial problem-solving* is an important and well-researched criminogenic need among sexual abusers. So is the *ability to follow rules*, a skill that comes into play with many art forms and also with play, a closely related sister discipline.

Play therapists, like expressive arts therapists, work within the imaginal realm and optimize the benefits of engaging the arts through play. And play can offer not only "fun" but also serious benefits. Many theorists including Piaget (1962) have suggested that repeated exposure to playful games "… [fosters] skills such as rule following, fairness, turn taking, gracious winning and losing, and cooperative and competitive behavior." Serok and Blum (1983) describe games as "mini-life situations in which the basic elements of socialization (rule conformity, acceptance of the norms of the group, and control of aggression) are integral components of the process of play" (p. 320). Physician, psychiatrist, and researcher Stuart Brown (2010), who authored a delightful book on play, found entrée into his study when he decided to research what had "gone wrong" with mass murderers and found that they all shared an absence of play in childhood.

The act of engaging the arts creatively can encourage risk taking, so important in treatment, and also give the creator/client a sense of mastery—an important component of the Good Lives Model (Ward et al., 2006). The emphasis in expressive arts therapy is always "high sensitivity/low skill" (Fox et al., 2005), and as such, sophisticated artistic talents are not required. The effort always emphasizes not technical rendering but rather an opening to the imaginal and seeking the "just-right" artistic expression from the art's point of view. Crude renderings still inform, as do "mistakes" that Ego finds difficult to receive. Sexual abusers, child molesters in particular, often tend toward perfectionism—selecting fine-point pens over finger paint when given a choice, at least in the initial stages of treatment. Most feel far more comfortable with achromatic renderings, as well—that is, one color only, as color tends to bring more emotional content into a piece, and this can be difficult bear. Clients who can move out of their comfort zones to try new things artistically are able to improve their risk-taking skills in an atmosphere of very low risk.

I have already noted how the arts can give Eros a nonsexual outlet and allow us to give expression to human experience. Not only that, the arts help us to *document* human experience in a manner that permits us to go back again and again to the work, to examine how a series unfolds and illustrates change, to continue to learn new things from images, to further inform and enlarge our understanding by rendering anew those images and the myths and stories they populate when we bring different artistic modalities to bear. Through reflection upon the images that emerge in expressive arts processes, we can find meaning and insight, and this can provide a catalyst to lasting change.

In other words, arts modalities are much more than vehicles for cathartic self-expression. They offer natural and safe "containers" for therapeutic material and

opportunities to reflect upon existing pieces, perhaps when things have moved in a new or different direction. Valuable metaphors generally emerge, marking visible pathways and touchstones through treatment.

The following discussion, which explores the important niche expressive arts therapy can fill in the treatment of sexual abusers, is built around three primary images that are a mainstay of work with sexual abusers: the mask, the wound, and the bridge.

Fig. 4.1 *Masks* - These masks were created by clients at the Minnesota Sex Offender Program during a group process facilitated by art therapist Connie Gretsch, under the supervision of Haley Fox, in March 2010

> Man is least himself when he talks in his own person. Give him a mask, and he will tell you the truth. ~Oscar Wilde (1969, p. 114)

Masks

It goes without saying that a "bottom-line" goal in any treatment program for people who have committed sexually abusive acts emphasizes *behavior change*, and there is strong evidence in the psychological literature that both shame (Tangney & Dearing, 2002) and low self-esteem (Baumeister, 1993) inhibit people from engaging

in behavior change. Marshall and others have shown that upon their arrival at a treatment facility, sexual abusers consistently score high on measures of shame (Sparks, Bailey, Marshall, & Marshall, 2003; Marshall, Marshall, Serran, & O'Brien, 2011) and low on measures of self-esteem (Marshall, Anderson, & Champagne, 1997).

The image of the mask informs discussions of shame and self-esteem better than any other image I have encountered. Likewise, working with this image in treatment offers multiple layers of possibilities both for overcoming shame and for building self-esteem.

The mask is that second, superficial face that covers the face we want to hide. It offers a barrier between the person we do not wish to reveal to the world, at least in particular settings, and the person we do want others to see.

We all wear masks. It would not be safe to walk bare into the world at all times. Masks are socially adaptive. We plant a smile to appease or to avoid conflict, we darken our eyes to ward off threats, we look away to feign disinterest. Many treatment programs actually encourage mask-wearing among clients—"good behavior," a respectful presentation. Clients who are able to master an appealing presentation can, and sometimes do, slide under the radar and out of treatment programs without ever really addressing their core issues, like shame.

Masks may be our best defense against shame. People who have engaged in acts that hurt other people experience both the shame imposed by the society at large and most often, too, a very personal experience of shame.

Shame is an awful, unbearable feeling. Different from the healthier experience of guilt, by definition shame speaks not only to the things we have done but to the core of who we are. For many, a primal shame came first, perhaps long before the sexual offending began. It may have been a by-product of being the subject of demeaning verbal assaults, physical abuse, and, not infrequently, sexual victimization. So begins what for many can be a multigenerational cycle.

Shame is by nature a thing we all want to protect against and hide. When we feel shame, we cover our faces, or we don an entirely *different* face that we hope the world will find less offensive.

Using a treatment tool he designed called "Hermes' Web," psychologist Jerry Fjerkenstad (2010) illustrates a process in which the "perpetrator self" may lie deeply hidden beneath the surface for most of the waking hours in the life of a sexual abuser. On the surface, this gentleman may present as a remarkably personable fellow. In fairness, his mask portrays a genuine representation of some aspects of the personality, the kind of person he *wants* the world to see and appreciate. But during a period of stress, the web can "flip," and for a brief moment perhaps, the perpetrator rises, storms the area, and commits his crime before shrinking back into the oblivion of that deeply hidden underworld. In many cases, no one is more horrified by the sudden appearance of cruelty, selfishness, and oftentimes rage than the individual himself. This is human shadow material, in the language of Carl Jung (1983, p. 87, Ed. A. Storr); by definition, it remains suppressed *because* we cannot bear to look at it.

The arts provide useful entrée into shame that is generally not so threatening as a direct inquiry. Attending to art materials permits a safe psychological distance from another person who may intentionally or not intentionally bring shaming moral judgments into the engagement. And yet, the encounter with therapeutic material is utterly direct. By sculpting masks of paper molds, paint, clay, papier-mâché, and/or collage materials, we engage a creative process that brings forth those images most present and most operative with respect to Psyche. The longer we work, generally, the deeper we go. Surface layers tend to come forward first, then deeper layers as we get more comfortable.

These masks may be surprising to the maker at first; that is the way of shadow material. Processing the material through dialog and feedback from others helps us to acquaint ourselves with the images and to better understand their pain, motives, needs, and even aspirations. Interesting to look at and reflect upon, masks are also conducive to dramatic enactment. If we *stay with the image*—that core principle in expressive arts therapy (Fox, Knill, & Fuchs, 2005)—and refrain from jumping to psychological interpretations not grounded in the art itself, this can be an incredibly rich and therapeutic process.

Jim Haaven's Old Me/New Me curriculum (1990), intended and designed for individuals with intellectual disabilities in residential treatment for sexual abusive behavior, seems well suited to activities involving work with masks. Giving more life and dimension to an imagined "Old Me" (the way I used to be, when I was committing sexual offenses) and "New Me" (the person I want to be, the person I am becoming, the person I am today) lends a richer understanding of where a person has been, why he does not want to offend anymore, and what he has to look forward to in a crime-free life.

But caution is advised here. The emphasis on Old *Me* (as opposed to "old ways," for example) may activate a shame response and lead the person to further suppress past behaviors, when in fact remaining cognizant of that past is critical to eluding reoffense. A more useful goal may involve becoming better acquainted with every mask and working toward acceptance and integration of all of them. We carry all our masks with us, and each is a part of who we are. Pushing those distasteful aspects of ourselves into the background, or in some cases projecting them onto other people, as we know ultimately ends up with those shadows rearing their ugly heads when we least expect it and in some cases wholly outside our awareness. These aspects become much more difficult to "rein in" when they are not within our open-eyed purview.

For most of us "normal neurotics," there may be little risk involved in keeping shadow suppressed. Perhaps on our "bad day" we offend someone or even lose a friend. When shadow blindsides a sexual abuser, people can be terribly hurt. It is vital that shadow work be an integral part of the treatment of sexual abusers.

To get a bit more specific about working with masks, shame, and shadow, let us consider a man I will call Max, who has a long history of raping women. Most of the time, he seems like a likeable fellow, and when things are going well for him, he maintains an agreeable disposition, does a good job at work, and is kind to his

neighbors. The rapes he has committed occurred when things were *not* going well for him—when he lost a job and/or a relationship and started drinking heavily. (Alcoholism is a frequent comorbid occurrence with sexual abusers, owing in part to the disinhibitory effects of intoxication.) Max has a very difficult time even understanding, or admitting to, the "monster" that emerges to aggressively "take what he wants" without concern for the innocent woman he picks up in a bar. By engaging in an art process and constructing a mask, he *externalizes* this monster so that he can get to know it better and, ultimately, reach a place of acceptance and the ability to manage that monster.

Moreover, it is okay to call this archetype a "monster," and it is even okay to feel resentment or horror toward it, for it is not the whole of Max. Shame becomes more manageable, as it becomes apparent that this monster, though it can have a strong presence and take hold when Max is not vigilant to it, is nevertheless only a piece of the whole. Max is larger than his monster and can bring many skills to bear in the management of the fiend. With the monster outside of him, he can do battle with him, as opposed to identifying so strongly with the monster that he essentially becomes it—in which case a battle would be impossible; to destroy the monster would be to destroy himself; it would essentially be suicide.

Once externalized, the possibility arises to engage in a dialog or dramatic enactment that can lead to further understanding. A word of caution: This sort of deep work ought to be overseen by well-trained clinicians who know their way around the arts. It is not for the faint of heart, nor for well-meaning counselors without the benefit of intensive study in arts-based therapies.

Where shame is high, self-esteem generally lies pretty low. Addressing shame can therefore improve self-esteem, but there may be more to it than that. Once a body has been emptied of shame, there sometimes becomes apparent a "hole in the soul," so to speak, a void, longing to be filled.

Self-esteem begins with self-knowledge, and the arts can be a useful vehicle to this end, offering myriad opportunities for self-exploration and self-expression, mining for "gold" and integrating aspects of the Self heretofore suppressed. Think of how much more effective a poem or an original song can be in describing a person's experience, for example, as compared with a rote list of criminal charges. Think of the palatable difference between enacting a "good-bye" scene between a child and a soon-to-be-absent father versus simply stating the fact, "He left me when I was six, and I never saw him again." Think of how much more engaging, for the protagonist as well as for a witnessing therapist and peers, to see a real-life drama played out in gestures or dance movements, or a simple paper collage of images and words, to express an experience of grief.

Think of how difficult it would be for any one of us to stand up and describe the worst act we had ever committed in stark black and white, without context, perhaps filled with the shame of feeling defined by that act. This is too much to expect of any human being, certainly too harsh a process to enable any meaningful therapeutic change, not without commensurate psychological injury or reinjury.

The material that emerges through the process of self-discovery with the aid of the arts helps to fill that hole in the soul, and this is the surest path not to conceit, but to improved, genuine self-esteem and to a good life.

Digging for Gold

Sometimes masks serve as distractions from or barriers to seeing what lies beneath them. People who carry long criminal histories behind them often identify with their "badness." They may be accustomed to being seen as "bad guys," perhaps even comfortable with the moniker. On the other hand, they may be quite *un*comfortable about an underlying sensitivity and sweetness, or a hidden talent, even though these qualities may also be a true part of their personal makeup. The rest of us may be more inclined to suppress thoughts and behaviors that we consider socially unacceptable, whereas we do not hesitate to showcase our best traits.

Human shadow can be defined as those qualities and traits that lurk in the shadows because we cannot bear to look at them. Our knee-jerk response with human shadow is to project it onto others and/or to suppress it as deeply beyond our awareness as we can. Whereas many think of human shadow as the "dark side" of humanity, gold nuggets reside there too.

I had a gentleman I will call Gus in a small prison-based therapy group one day, and he illustrated this dynamic in a beautiful way. He was a tough, abrasive, well-tattooed biker, proud of his "war wounds" from countless barroom brawls. I knew he had a secret life as well. He was a romantic poet—his muse, the love of his life whose death a few years earlier had left him heartbroken.

I introduced a scribble drawing process, a popular art therapy technique. The instructions are simply to (1) make a scribble on the paper and (2) allow imagination to take hold and make something out of it. Gus started out by lightly scribbling a simple curve onto the top left hand corner of the paper. He then leaned in and added wisps of grass on either side of it, red eyes, and a forked tongue. "It's a snake," he sneered, "a snake in the grass!" He finished quickly, while the other group members continued to work on their pieces. Then spontaneously, he was drawn back to his own paper. (Time is a vital tool in expressive arts therapy—the arts often need more of it than we allow.) Gus made another scribble, identical to the first, but on the right hand side of the paper. This time, though, as he entered that all-encompassing, almost hypnotic art zone, his large hands crafted slender stalks and pastel blooms from the core scribble, ending with a lovely bouquet of flowers. First the mask, the persona—then the shadow, the sweet, feminine, hidden parts of himself.

I had a powerful encounter with shadow myself at about this time. I was writing my dissertation (Fox, 2004), and I had assembled an arts-based research group to explore and inform emerging images.

Fig. 4.2 *Clay Piece and Bread Bowl* - These two images of "The Well" were created within the context of an arts-based research group by the author, Haley Fox, in Spring 2002

I chose to explore the image of the Well [in clay], which was at that point more a feeling-sense than a visual idea… [The image had first emerged in a song.] …everyone seemed to have a strong reaction to [the snakes crawling out of my vessel] ….One question emerged: Were the snakes coming out of the well, through the cross-hatched opening at the top, or going into it?

A month or two later [when this group met again], I had the idea to make a bread bowl …Directly across from me…a potter worked with her dough. She was weaving her dough in a crisscrossing, lattice design ….

[When the pieces had baked], I made the observation that once again, snakes had appeared on my creation …Without speaking, [the potter in the group] reached over and placed her piece over mine—a perfect fit! … In this latest rendering, the crisscross opening of the Well had spread, and it was now clear that the snakes had in fact traveled out from within the vessel, rather than the other way around…

Once again I thought about the snakes, my shadow, and I began to wonder about the repulsion towards the snakes that two of my arts-based research companions … had brought to the table … It was not difficult to understand why people would find shadow material unpleasant to encounter—especially their own, but also perhaps the shadows of people close to them that could also touch their own shadow. After all, that phenomenon of finding shadow repulsive and virtually impossible to bear is precisely why people repress it! … Why, then, did I seem to approach the task with such zeal? It did not make sense.

In time, I discovered the answer to my question. I found that shadow material exists in layers, and the first layers I reached in my heuristic study, … as unpleasant as they might have been to look at, were really distractions from the even more difficult shadow material that awaited me—my golden shadow.

Indeed, I had buried my own greatest gifts and talents…more deeply than any other personal shadow material I encountered. Further, I was terrified to dig the golden shadow up, terrified too of the responsibility of fully owning that shadow material. But the art and song images lured me ever nearer to … with what I would discover to be the relatively benign snakes at the surface. Carefully tucked into the furthest depths of the moist, dark Well, I would discover [my gold] (Fox, 2004, pp. 135–140).

Fig. 4.3 *Grey and pink crack in pavement photograph* - The artwork "Earth Wound" is an installation made in Pietermartizburg, Kwa-Zulu Natal, created by South African Environmental Artist Simon MAX Bannister. Used with permission

> You have to crawl into your wounds to discover where your fears are. Once the bleeding starts, the cleansing can begin. ~Tori Amos (2011)

Wounds

Where there is shame, underlying wounds can surely be found. Whether fresh or scarred over, wounds mark places of injury.

The wound is another important image in the treatment of sexual abusers. Creating and describing wounds allow us to externalize, see, and manipulate therapeutic material, to have some understanding of and mastery over it that is impossible when it remains internalized.

Wounds are the remnants of trauma. Indeed, the word "trauma" derives from the Greek word for "wound" and has been defined as "emotional, psychological and physical injuries that cause pain and suffering" (Boyd, p. 40, in Carey, 2006). Serious trauma and even less dramatic but persistent traumatic experiences (Doherty, 2011), which many sexual abusers have encountered, can damage the nervous system and result in insecure attachments, acute stress disorder, and/or

post-traumatic stress disorder (PTSD), a lifelong condition characterized by hypervigilance, avoidance, flashbacks, episodes of reexperiencing the original trauma, and in some cases dissociation.

Cathy Malchiodi (2010) has worked with and written extensively about trauma-informed art therapy (a term she coined), showing how well suited the arts are to navigating this difficult terrain. It is notable that although expressive arts work with sexual abusers is still a field in its infancy, expressive arts therapists have for years worked with victims of sexual abuse. These technologies are absolutely transferable to work with sexual abusers, as many have also experienced their own victimization, and these early experiences can often be linked to a wound that remains operative within the sexual offense pattern.

Especially for wounds that link with preverbal memories, people typically have difficulty using words to describe traumatic experiences. Traumatic events can be too overwhelming for Ego to assimilate, literally, too "unspeakable" for words—unless they are of a poetic nature. So those who have experienced trauma tend to shut away the experience until a safe place allows feelings to flow again. The arts provide opportunities to shape the raw material of trauma, to get closer to it, find meaning in it, and through this process learn to better regulate emotional responses.

Better understanding traumatic events also enlarges our sense of self. Witnessing the material that surfaces, we can finally become "unstuck" and begin to recognize that our identity is not and need not be built solely around that early victimization. We are all much more than our victimizations. When people are able through therapy to put early trauma into perspective, they can begin to rebuild their lives. The wound can serve as an opening to empathy for other victims of sexual abuse—including the persons harmed by the client doing the work.

In an article I wrote several years ago about my work in community-based treatment for sexual abusers (Fox, 2003 p. 5–6), I described an exercise that illustrates how the arts can be used to address deep psychological wounds—in this case, wounds that have resulted from personal victimization. I quote:

> [The] personal victimization exercise [was] expected to last several weeks and aimed at guiding group members to an opening to empathy. The first stage in the exercise, before exploring past experiences of victimization, is to create or review a "Life Vision," an image of what kind of man each wants to be and what kind of life he wants to have. Each man holds his image before him as a beacon of hope when he descends to the hard places. The Life Vision is explored in words and images and sometimes in song.
>
> Next, each man chooses a past event in which he has felt victimized. Those who have been in the program for some time may dare to explore very difficult material, such as a memory of being raped as a child. Newer group members may choose less threatening events, perhaps a hurtful memory of being picked on in school. The event is plumbed and expressed in words and art, with an emphasis on grieving the loss of the fantasy of how their life might have been, while honoring the reality of the event.

A man I'll call "Bo" began one session with a clay sculpture he had made of being forced to perform fellatio on his stepfather in his mother's bed. Bo described the difficult time he'd had forming the sculpture the day before, stating that he'd fought temptations to destroy it throughout the process but felt compelled to keep it intact until he'd had a chance to share it with the group. Examining the [unfired] piece of clay before him, Bo pointed out that the stepfather's head had fallen off. He picked up the small ball of clay, and as he talked he began gouging its eyes with a gouging tool. When only dust remained, he picked up an arm, talking in low tones about the myriad abuses he'd suffered from this man, as he broke the arm into tiny bits.

Bo proceeded to dismantle and crush the stepfather's body bit-by-bit, sharing stories as he went. When nothing remained of the stepfather, he picked up pieces that represented his *own* body on the bed, stating, "I'm broken, too." He shared stories of his brokenness to an attentive group until a plate of rubble sat before him. As he finished, he observed, "Even the bed is gone now."

Bo breathed long, and his mood lightened some. He said he was glad to have waited to destroy his piece, but glad to have destroyed it. During his dismantling process, he had spoken about a desire to track his stepfather down and kill him. Now, he said he had no desire to do so. He had his own life to live.

Other group members offered feedback by sharing from their experiences, and we all took turns responding to the artwork—before and after—and talked about what we'd seen in it. In a final cathartic ritual, Bo dumped his rubble into the trash.

Incarceration itself can be traumatic, a source of wounding, for many sexual abusers. Regardless of the justness of an incarceration, the emotional impact cannot be avoided. While banging on walls or shouting at security staff can bring on additional hurts, the arts can provide safe containers for the grief and rage that a sometimes abrupt removal of liberties can cause. Drumming, singing, and spoken word poetry can be particular engaging of the whole body, but visual art creations can also give voice to feelings, sometimes even more fully than words can.

Wounds are viewed differently through an artist's lens that through the traditional lens of practitioners who are raised, for example, within the tradition of a medical model. The latter might view that rotting knot in a tree trunk as something needing to be cut out, removed, perhaps replaced with unmarred wood matched up with the rest. An artist brings an aesthetic sensibility, viewing a knot in the wood as a focal point of beauty, to be honored. There's no point trying to cover up or hide the knot. Rather, the knot may indeed become the center of a sculpture. The artist endeavors to *make something out of* that knot. The expressive arts therapist, too, accepts and honors wounds, makes them a focal point of treatment, remains aware that this is part of the person, and yet remains open to the possibility that greatness can come of those wounds. Artists avoid shame-based moral judgments, not because they are "wrong," but simply because a more aesthetic approach *works*—both artistically and therapeutically.

Fig. 4.4 *Bridge photograph* - "Bridge to Peace" is a photograph by Morrie Farbman, Farbman Photography, at farbmanphotography.com. Used with permission

Let every man praise the bridge that carries him over. ~English proverb

Bridges

A bridge provides a way over calm or turbulent waters or rough terrain to move us from point A to point B—from where we are to where we want to be. People who have been charged with sexual offenses sometimes find themselves incarcerated or civilly committed. Point B for them is freedom. But there is a difference between being released and being free. Real freedom comes from breaking lifelong patterns that keep us imprisoned behind walls of our own making. Those personal prisons travel with us beyond the razor wire if we have not done the therapeutic work that would truly set us free.

Bridges appear naturally in many art forms, most obviously perhaps in music, where the notion of the "bridge" denotes a clear transition from one place to another. Something magical often happens within the creative process. When we surrender to the art and let it come through us, without trying to control it, the art itself can be transformative, can usher in profound change. While exploring the nature of a thing in its complexity, we are drawn to see the other sides of it, the hope and possibilities as well as the pain of it.

Such a transformation happened to me during a songwriting process. The song came to me unbidden out of a terrible anxiety I was feeling, and to my surprise, by the time it ended, it carried an entirely different mood and feel. The change was embodied in the music as well as the lyrics. The beginning of song had a driving, relentless beat, but when the bridge entered, the song took on a suddenly lyrical, flowing, and contemplative mood. The lyrics illustrate this movement, though perhaps not as completely as the full musical piece:

I Don't Like It Here
I don't like it here, this relentless anxiety.
I don't like it here, with my jaw clenched tight.
I don't like it here, most familiar of agonies.
I don't like it, I don't like it here.

Sleep eludes me, taunts me, dances just beyond my reach now.
Thoughts race through my head as the dawn draws near.
Weariness and woe are my constant companions.
I don't like it, I don't like it here.

I freeze and brace myself for the blow that is sure to hit.
I hang on for dear life, lest I fall in the pit.
I know deep in my gut, there's no way of avoiding it, still
I don't like it, I don't like it here.

Bridge:
Yet here in this place, there's a seedling that stirs in my breast.
If I can get through this place, there's a promise of rest,
There's a promise of life,
Something newly created from this turmoil and strife
And the dank, ugly stuff of this place.

I don't like it here. I thank God for the poetry.
I don't like it here. I see my soul in the art.
I don't like it here. But the music's redeeming me.
It's a miracle and a blessing to be here.

Now, as I noted, this song emerged from a highly personal place. Such is the case with most of the songs that come through me. Nevertheless, it emerged at a time when I was working with a young man in a prison setting, and no sooner had I put my guitar down than I realized that this song might speak to him as well. That is the nature of all art, I believe: Once created, it doesn't belong to me. It takes on a life of its own, and it belongs to the world.

I took the risk to share the song with the young man who was seeing me for depression and anxiety related to his incarceration, and I will never forget the deep sigh that punctuated the end of the piece. The song sparked a meaningful conversation. We were able to connect as human beings. I remembered the phrase, "The universal lives in the particular," and I thought about how our most personal artistic work always seems to engender the strongest interpersonal connections because they touch that place of humanity where we are all the same.

Cautions for Expressive Arts Therapists and Others Working with Sexual Abusers

Getting Hired

Because the field of expressive arts therapy is a relatively new approach in correctional and forensic settings and because sex offender specific training is so difficult to find, getting hired in this field can be a challenge.

The first step is to notice that the treatment of sexual abusers *exists* as a field, and it offers rich clinical possibilities for practitioners. The second step is to know that treatment programs always need skilled clinicians. The best opportunities exist for those already in a position to straddle both fields, that is, for those trained as primary therapists, knowledgeable about diagnosis and assessment, treatment planning, and group therapy—and in some cases individual and family therapy, though that is not as common. Expressive arts therapists skilled as primary clinicians may find some resistance because the field remains relatively new and misunderstood in these settings, but if it is any consolation, the same is really true for any psychotherapists wielding a psychodynamic approach. With new emphases within the field of sex offender treatment drawing increasingly from the general psychological literature—particularly areas like positive psychology—I believe the way is beginning to open for expressive arts therapy.

Of course, the best job security for expressive arts therapists will likely come from people recognizing how effective it can be as a treatment approach. A little published research also would not hurt.

Constraints of Working in Secure Settings

Many constraints exist for those working in correctional settings, such as restrictions on allowable materials. Prisons and treatment programs both may forbid certain "contraband" items that could compromise security in such settings. Many "tools of the trade" for expressive therapists fall among these contraband items. Clay, for example, can be used to plug keyholes or make impressions of keys. Sharp knives and scissors and even long-handled paintbrushes may be considered potentially dangerous. Stickers may not be allowed, as they can be used to alter or obstruct signage. Masks may not be allowed because they can be used to conceal one's identity. Long scarves, wire, and ropes could be brought to bear in suicidal or escape efforts. Musical instruments will likely fall under scrutiny for potential risks, as well various audiovisual media. Clients or inmates themselves (the language changes depending on the setting) may have to operate under strict property limits.

However, from an artist's point of view, *every limitation is a creative opportunity*. I have seen some pretty amazing artwork within prison walls made of toilet paper,

candy wrappers, and ramen noodles and, less often, compelling music utilizing only human voices and percussive rhythms from human hands and feet. Of course, there has never been a shortage of drama, either. Where humanity goes, there too goes art. When any of these things are unleashed without the safe containment that art modalities naturally provide, fear abounds, especially among staff. Expressive arts therapists can be crucial helpmates when it comes to offering fresh containers for inevitable expressions of human emotions and creative ideas.

Working with adjudicated youth and adults brings particular ethical concerns. A detailed discussion of these ethical issues could easily fill another chapter, if not a book, but I will try to note some important highlights here.

Clinical documentation among this population is typically "discoverable," meaning records can be subpoenaed by courts and used for civil commitment reviews, for assigning risk levels, and for a variety of legal processes and hearings. Document carefully and know your particular state's laws and statutes; these can vary widely. Be prepared to testify in court to your own documentation, and when you are documenting clinical work, apply the Evening News "best test" for what is fit to print.

Familiarize yourself with privacy laws. Helping professionals must be aware of how the Health Insurance Portability and Accountability Act (HIPAA) and related regulations apply to this population. Chemical dependency histories and records tend to be particularly well-guarded.

Facilities that incarcerate individuals may be allowed by statute to limit some client liberties and privacy. Do not be tempted to treat confidential and private data in a more cavalier manner just because a client resides in a prison or civil commitment program. If you observe that an investigatory body monitors phone calls, for example, recognize that phone monitoring is generally permitted for security purposes only, and as much as you might like to listen in to get some clinical insight on a client, such an act would be inappropriate. Apply the "need to know" standard, and honor client privacy as you would your own.

Remember, too, that even people with whom you work may fall short of understanding and appreciating complex clinical diagnoses and treatment processes, so it is best to refrain from excessive detail that could cause people to draw inappropriate conclusions from what you write. Recognize that you as a practitioner may be mandated under some state laws to report when clients give identifying information about particular types of prior offenses. Be sure to advise all your clients of the limits of confidentiality before disclosures like this come up, or it can wreak havoc with your therapeutic relationship.

Relationships with Other Disciplines

Much of the treatment for sexual abusers happens in secure treatment settings. Building positive working relationships with staff designated to maintain the security of these environments is critical to effective treatment programming. A working

partnership is essential. That means we must appreciate—and be able to convey our appreciation for—the important role security staff play and not allow divisive relationships to form with them. Residents in a correctional setting or treatment program will take advantage of any opportunity we give them to "split" staff. This is where the rubber meets the road, and where the quality of interaction among those playmates in the sandbox can make or break what has the potential to be a powerful therapeutic partnership.

Another important consideration pertinent to good communication among staff is language and documentation. A common phrase heard in programs where not only treatment but also legal concerns abound is: "If it is not written down, it did not happen." Expressive arts therapists need to take special care in documenting their work in a way that is clear and understandable to both clients and to other members of the treatment team, a way that accurately conveys and guides treatment progress, always providing context, without simply aligning to other schools of thought but in fact honoring the unique discipline of expressive arts therapy. This is no easy task and perhaps a topic for another book. Suffice it to say here that it behooves us to become a bit "multilingual" and able to translate therapeutic material while also remaining cognizant that most treatment documentation is legally "discoverable" in this field, meaning we could at any time be asked to defend our written reports in a court of law.

Many expressive arts therapists find report-writing challenging. We generally come into the field because of creative talents and interpersonal skills, not always with strong writing skills. Even those uncomfortable with formal report-writing can make tangible contributions to the treatment of sexual abusers, however—perhaps not always as primary therapists but as adjunctive therapists or consultants presenting workshops designed to offer opportunities for clients to explore therapeutic material through other modalities, to crack open new places, perhaps cofacilitating with others who possess complementary strengths. As noted above, every limitation is a creative opportunity.

The Therapeutic Alliance

There is no denying the importance of a therapeutic alliance; that is, a positive therapeutic relationship in psychotherapy. Scott Miller's meta-analyses (2005) left little room for doubt that the therapeutic alliance is the primary determinant of successful outcomes in therapy. However, it is no surprise that practitioners have shied away from therapeutic alliances in their work with sexual abusers and indeed with others who have a history of engaging in criminal behavior. How does one form a therapeutic alliance with someone whose very pathology supports deception and antisocial tendencies? Is it our challenge to believe everything we are told?—to accept and validate their wishes and ambitions, even when they seem counter to social mores?

Blanchard devotes an entire book, *The Difficult Connection*, to this subject (1995). It has been my experience that our particular challenge with this population is to discern each individual's psychopathology from his humanity—that deeper part of himself genuinely concerned with his best interest, the part interested in getting

better, in doing no more harm, in ending his own suffering. In Jung's framing, it has to do with distinguishing the small "s" self (Ego) from the large "S" Self (where the collective unconscious and perhaps what we might call a "higher power" reside) (C. G. Jung in Campbell, 1976, pp. 23–46). I have yet to meet a sexual abuser who did not have some genuine desire toward improved functioning, social acceptance, and psychic wholeness. These are human needs common to all. As hidden as a person's humanity may seem to us, it is by definition a universally shared quality.

Beyond aligning with the humanity in people, perhaps the best way to develop a therapeutic alliance is through consistency. Be reliable. Keep your word. Show up when you say you will show up, and model how to manage imperfection when you slip up. Be transparent about your observations and intentions, and collaborate on creating treatment goals. Clients will appreciate that consistency.

I Think His Pants Are on Fire

Historically, treatment programs for sexual abusers have not only insisted on "total honesty"; they have more often than not insisted upon it from day one of treatment. More and more, programs are starting with treatment readiness programming designed to acclimate individuals to treatment and allow time for therapeutic alliances to form before diving into these dark, Stygian waters. Moreover, complete disclosures of sexual offense histories do not necessarily serve to reduce recidivism; some treatment programs have been enjoying considerable success with so-called "deniers" groups (Levenson, 2011).

As for the tendency toward deception, first of all, it is important to recognize this not as a moral failing but rather as a psychological defense. It is no doubt an adaptive one, at least at one point in time acquired "for good reason," as cognitive behavioral therapist Christine Padesky (2005) might say. I like to use the image of the "open door" to navigate through unknown waters that could likely contain some elements of deception. When I first interview an individual charged with sexual offenses, I explain that generally an individual entering treatment may be reluctant at first to admit to all his criminal activity; I encourage the individual to be as truthful as he feels comfortable, reminding him that I will "leave the door open" for future admissions. That door never closes for me. In this way, the individual can save face; I don't need to accuse him of being a "liar." I simply note that it is my practice to keep the door open for future admissions and disclosures that generally come as the individual feels more comfortable with me and with the therapeutic process.

Honesty is a virtue loudly brandished in any treatment of people who have engaged in criminal behavior. But let us look at this from a different angle. To be sure, deception is part of the pathology of people with antisocial personality disorders and therefore a natural treatment focus. But how honest, really, is a stark proclamation *without context*? Human beings are complex creatures, and the only way to truly understand the acts we commit, in order to get a grasp on how to prevent future commissions, is to deepen an understanding of that complexity. That takes time, but that is closer to complete honesty. Moreover, nothing offers more potential

for appreciating human complexity than art, in all its forms. We can paint the demons we seek to understand, then bring them into three dimensions in a lump of clay, then talk with the figure, and directly ask it pertinent questions, such as "Why are you here? What do you need?" We can engage art the way an artist would and receive its responses in like form. In my experience, while conversation can be utterly misleading, art never lies.

Boundaries, Transference, and Countertransference

Boundary crossing happens every day in treatment programs for sexual abusers. No one is immune to being caught in a boundary crossing. As human beings, we all have personal vulnerabilities. Many sexual abusers—who, by the way, have personal vulnerabilities of their own—often seem able to identify vulnerabilities in others and to use the knowledge in service of their pathology with awesome skill and finesse. When we look at the larger picture, we ought not be astonished. It stands to reason that individuals who have arrived at a point of being in treatment for sexually abusive behavior have probably had poor boundaries their entire lives—including poor modeling of boundaries and violations of their own personal boundaries. Some lack the vaguest clue about how to establish, maintain, or manage boundaries in a healthy ways. Everyone involved in the treatment of sexual abusers must be vigilant to boundaries for his or her own safety and well-being but also for the purpose of *providing a corrective experience* that will help clients address these important treatment issues. When we become "too friendly" or even sexual with clients, we not only cross a line of legal and professional ethics, we also do the client no good and may do him considerable harm. Colluding with a boundary violation reinforces pathology. It helps no one to give in to a boundary violation.

Consider a client with a long history of being sexually abused who bases his entire sense of self-worth on his sexuality. Imagine how powerful it would be to have the treatment professional he is trying to seduce respond firmly and with genuine caring, "Nothing sexual is going to happen between us. However, that is not to say we cannot have a good professional relationship. I value you for the many excellent personal qualities you possess, including the progress you have made so far in treatment. Let's base our relationship on that."

Expect boundaries to get crossed, and think about how you will deal with that when it happens—not *if* it happens, *when* it happens. It's an occupational hazard in this work. Roofers fall off of ladders; people working in sexually charged treatment environments are prone to boundary crossings. When things do happen to you, it's a good time to seek clinical supervision. Red flags should rise if you notice yourself falling into any of the following thinking, feeling, or behavior patterns:

- I have personal problems that trouble me when I am at work.
- The thought occurs to me that I get more appreciation from clients than I get at home.

- I feel disconnected from or even estranged from my treatment team.
- An individual insists he did not commit the crimes he is charged with, and I honestly wonder if he might be telling the truth.
- A client seems overly friendly. I can't be sure, but today I think he winked at me.
- I notice that I am making exceptions, not keeping boundaries clear.
- I let a rule slide and tell myself, "It's just a little rule and doesn't really matter—besides, no one else needs to know."
- I have a vague feeling that a client may be flirting with me, but it's so subtle that I can't quite put my finger on it.
- I find myself automatically blushing and smiling, without meaning to, when a good-looking client compliments me. I don't want anyone to see my reaction, so I hurry away and don't tell anyone.
- I have a hard time saying "no" to certain individuals with whom I work.
- I don't understand the rules I'm told to uphold; they don't make sense to me and, quite honestly, I don't think they are entirely fair.
- I know I crossed a boundary with someone, but I don't know how I could possibly go back and correct it.

Remember, none of these items are necessarily indications that you have done anything wrong. Rather, they are simply signs that it is a good time to speak with someone about what is happening, whatever it may be. Secret-keeping is the worst thing to do when you feel vulnerable to boundary crossings. Also, these red flags are applicable to any combination of male-female interaction or where there exists same-sex attraction. If you are a male heterosexual therapist working with male sexual abusers, do not be fooled into thinking you are immune. You may be an easier target, depending on the situation and your own vulnerabilities—not only for sexual advances but also for supporting other kinds of client rule-breaking.

Finding a supervisor or someone else on your treatment team to talk with when you first notice anything amiss is the best antidote to falling into a trap—the sooner, the better. And self-care is the best prevention when it comes to avoiding boundary violations. The following tips will help prevent or diminish the severity of boundary violations.

- Take care of yourself and your own emotional well-being.
- Be aware when you are not feeling up-to-par and let others know. You don't have to tell your life story; just give others a heads-up when you feel emotionally vulnerable. Understand that it happens to everyone, and ask for what you need.
- Ensure safety in every situation you enter. Speak up about any misgivings you have regarding what you may be asked to do or with whom you may be asked to interact. Listen to that "twist in the gut," even if you do not understand the origin.
- Practice perspective-taking. That is, examine your own actions from other points of view. Routinely ask yourself, for example, "What would my supervisor, peer or someone I respect think or feel about the action I am about to take?"
- Be direct with clients, and let them know when they have crossed a line, in a calm way that supports their treatment goals.

- Learn how to go back and "reset" a relationship with a client after a boundary crossing.
- Be wary of underinvolvement as well as overinvolvement. Both are detrimental to clients' treatment experiences.

Finally, know your own cognitive distortions ("thinking errors"). Everyone has them! If you hear yourself thinking any of the following, it is a safe bet that it is a distortion.

- "They're evil, subhuman, not like me." (marginalizing, dehumanizing)
- "Treatment never works." (generalizing, all-or-nothing thinking)
- "It's just a small rule." (minimizing)
- "No one will find out." (secret-keeping)
- "This guy is different, special, not like the others." (romanticizing)
- "I'm the only one who really cares or can help this man." (grandiosity)
- "He really cares about me." (romanticizing)
- "I am helpless. He has power over me." (victim stance)
- "There's no way I can get out of this." (catastrophizing)
- "No one will believe him anyway." (marginalizing, feeling powerful)
- "It won't matter if I do this; I can handle it." (grandiosity)

If you, like me, are hopeful that change is possible, you may, paradoxically, be *more* vulnerable to disappointment in some ways, because you expect more, and the depth of the therapeutic process may make it easier for you to dwell in your own swamp. How do you survive your own masks and wounds, build your own bridges? You do your own inner work and become more aware of your own temptations to cynicism, grandiosity, and also others' judgments of what is "real."

Remember, too, that treatment teams working with this population are stronger than the sum of our parts. When we rely on each other to get ourselves through rough spots, the whole program becomes stronger, and the men we serve get better too.

A Continuum of Sexual Abuse

The term "sex offender" elicits strong responses from people, and understandably so. Many of us upon hearing that term immediately imagine a worst-case scenario. We might conjure up, for example, the image of a frighteningly intelligent, unfeeling, vicious predator, who indiscriminately plucks innocent strangers off street corners and drags them, utterly terrified and defenseless, to a secret lair to inflict bizarre sexual tortures. This is the sort of image we most often find presented in movies and television but least often find in actual fact.

At another extreme, we may find a young person I'll call "Ricky." Let us say he is your 19-year-old nephew. Ricky goes to a party where he meets and falls head-over-heels for a girl. Maybe he knows she is 14, maybe he doesn't. She looks well-developed to him, and it frankly does not occur to him to ask her age. He just wants to be close to her, touch her, smell her hair. The girl finds herself swept off her

feet by his attentions at the party and later starts sneaking out of the house to meet him. You know the rest of the story. The relationship becomes sexual, the girl's parents find out about it, and they press charges. They are justified in doing so, of course, because a 14-year-old simply does not possess the maturity to consent to a sexual relationship. The most current research tells us that her brain—especially those areas involved in self-control, planning, and good judgment—will not be fully developed until she is 25 years old (Walsh, 2004). Wait a minute—that means the 19-year-old has ways to go as well before he is fully capable of mature, adult judgment. Hold that thought.

The continuum of sexual offending is indeed broad and varied. At one end, we find sadistic acts that include various forms of physical harm and sexual penetration. At the other end, we find "noncontact" offenses involving Internet porn, indecent exposure, window-peeping, breaking into a home to steal and masturbate to lingerie, or engaging a young child in a sexual conversation or showing pornography to that child. On that same continuum, we find a female babysitter who asks a boy to rub her crotch outside her clothing; a developmentally delayed fellow who brushes up against women in crowded malls for sexual pleasure without their ever knowing it; an elderly woman who grabs and kisses nursing home orderlies when they least expect it; and a senator who has had too much to drink and pinches the buttocks of a waitress in a bar. We also find incest, prostitution-related crimes, and "date rape" on this continuum.

All these offenses, every one of them, are punishable by law, and perpetrators of these crimes occupy our jails and prisons. Most of them get released after they have served their time. The highest risk offenders receive treatment within prison or on an outpatient basis by order of the court. And dramatically increasing numbers of individuals responsible for committing crimes on this broad continuum—both treated and untreated individuals—find themselves civilly committed as "sexually violent persons," indeterminately. In recent years, we have cast a wide net in this regard.

It is a natural response to cast a wide net when a terrible thing happens that strikes fear in the public psyche. When such a thing happens, we tend to lose sight of the broad continuum of sexual abuse, and we also tend to generalize and demonize sexual abusers as a group. Suddenly, "sex offender" becomes a single dehumanized thing in the public mind, a thing of which we feel we must rid ourselves at all costs. Human shadow writ large.

And indeed, it is costing us a great deal, particularly in the current economic climate with scarce resources. Thoughtful people know that broad-brush responses to "lock them up and throw away the key," though perhaps understandable in one regard, are in fact poorly founded and difficult to justify.

I am not alone in this view. Even victim advocates like Patty Wetterling have taken up the cause to defend reasonable approaches to the difficult challenges that face us in the field of sexual abuse and its treatment. Studies of abused children reveal overwhelmingly that although their parents typically call for harsh punishment of their alleged abusers, the children themselves want their abusers *treated*. They want Daddy or Uncle or Grandma or that lady "who used to be so nice to me" to change—to "get better and stop doing bad things."

There is good news. Individuals who commit sexual offenses are benefiting now from treatment (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010) and are increasingly demonstrating the ability to become productive, contributing members of society. State-of-the-art therapies, supervision, and community support during gradual, step-by-step transitions back into society all exemplify approaches that have improved over time in their effectiveness for reducing the rate of recidivism among those who have committed sexual offenses.

Sexual abusers vary widely in their risk to reoffend. Estimates suggest that sexual offenders will sexually reoffend in their lifetimes, at rates considerably lower than rates of reoffense for other types of violent offenders, and rates dip even lower when sexual abusers receive treatment. A study conducted in Minnesota in 2009 revealed a recidivism rate of only about 13 % for untreated offenders, a rate most find surprising, but that rate actually drops to a mere 5 % with treatment (Duwe & Goldman, 2009).[5]

"It takes a village" to address an undertaking of this scope, an undertaking that has high stakes for all of us. Clinicians, security professionals, law enforcement, members of local communities, and indeed the very men at the center of this drama, who by and large come to recognize their past mistakes and want to become better people, are coming together to bring the best practices they know to the task of building innovative solutions.

There are those who believe that some sexual abusers should never be released. Certainly, some clients have more deeply entrenched pathologies than others, but in a classic psychological "reframe," it may be more appropriate to consider that we practitioners may not have developed adequate technologies to treat those more difficult cases.

I have never been one to say "never" to anything, and I have been impressed more than once by the resilience and strength of the human spirit as it seeks healing, sometimes in surprising ways.

Certainly, public safety must be preserved, and an evaluation of risk is always part of a decision to reintegrate treated sexual abusers back into the community. Ironically, many of our current laws and policies, like sex offender registries (Letourneau, Levenson, Bandyopadhyay, Sinha, & Armstrong, 2010; Spoto, 2011) and residency restrictions (Blankstein, 2010; Dorin, 2010), in fact do little to prevent sexual violence. We can go a long way still to bring a more sensible eye to the treatment of sexual abusers.

[5] Using a retrospective quasi-experimental design, this study evaluated the effectiveness of prison-based treatment by examining recidivism outcomes among 2,040 sex offenders released from Minnesota prisons between 1990 and 2003 (average follow-up period of 9.3 years). Results from the Cox regression analyses revealed that participating in treatment significantly reduced the hazard ratio for rearrest by 27 % for sexual recidivism, 18 % for violent recidivism, and 12 % for general recidivism. These findings are consistent with the growing body of research supporting the effectiveness of cognitive-behavioral treatment for sex offenders.

Why We Should Bother Doing This Work

Are you like me? When I find myself grappling with my position on a difficult issue, like whether or not to release people who have engaged in terribly hurtful acts of sexual abuse from civil commitment, I think about the kind of person I want to be. I have listened to loud, angry voices from people who vehemently oppose such releases. I feel my heartstrings pulled by emotional descriptions of hurts suffered. And yet, I know that I do not want to be a person who is closed and numbed by pain nor a person filled with vengefulness and hate.

The kind of person I want to be believes that meaningful change is possible. The kind of person I want to be does not judge another person by the worst act he or she has ever committed. If I can muster the courage to move beyond wanting to hide that "worst act" from my own view and everyone else's, then I would like the opportunity to find a purpose in it, to grow beyond it, and to have the privilege of contributing something worthwhile to the world as a way of making amends—something I would perhaps be unable to give had I not endured and learned from *my* most painful experiences.

The kind of person I want to be moves thoughtfully through life, not with vengefulness and hate, but neither with blind and careless disregard for common sense and fairness and public safety. I want to be a person who moves with caution and compassion. I want to be, as Sister Helen Prejean urged, a person who is able to "hate the sin, but love the sinner."[6] In my best hours, when I have been personally hurt, I hope I can move with grace enough to offer myself the gift of forgiveness of another.

This is the kind of person I want to be. And in all my dealings, the best people I know want the same. It is my good fortune that embracing life as an artist and practicing expressive arts therapy helps me to be that kind of person.

References

Amos, T. (2011). *Tori Amos quotes*. Retrieved December 11, 2011, from http://www.brainyquote.com/quotes/authors/t/tori_amos.html

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17*, 19–52.

Andrews, D. A., Bonta, J., & Wormith, S. J. (2006). The recent past and near future of risk/need assessment. *Crime and Delinquency, 52*, 7–27.

Baumeister, R. F. (Ed.). (1993). *Self-esteem: The puzzle of low self-regard*. New York: Plenum Press.

[6] This sentiment was echoed in the 1995 movie, *Dead Man Walking*, the autobiographical account of Sister Helen Prejean, a Roman Catholic nun, and her special relationship with a prisoner on death row. The film consolidates two different people into one character whom Prejean counseled on death row. Near the end of prisoner Matthew Poncelet's life, Sister Prejean focused her words: "I want the last face you see in this world to be the face of love, so you look at me when they do this thing. I'll be the face of love for you."

Beckett, W. (2009, October 28). *Sister Wendy's grand tour: Rome*. [Video File] Retrieved October 12, 2011, from http://www.youtube.com/watch?v=JyqrrMfYoDA&feature=related

Bhangu, D. S. (2011, October 10). *Listening to music lessens anxiety in cancer patients*. Featured Health News. Retrieved October 15, 2011, from http://www.topnews.in/listening-music-lessens-anxiety-cancer-patients-2337859

Blanchard, G. (1995). *The difficult connection: The therapeutic relationship in sex offender treatment*. Brandon, VT: Safer Society Press.

Blankstein, A. (2010, November 4). Law restricting where sex offenders can live is unconstitutional, L.A. judge rules. L. A. Retrieved December 3, 2011, from http://latimesblogs.latimes.com/lanow/2010/11/law-restricting-where-sex-offenders-can-live-unconstitutional-la-judge-rules.html

Brown, S. (2010). *Play: How it shapes the brain, opens the imagination and invigorates the soul*. New York: Avery.

Campbell, J. (Ed.) (1976). *The portable Jung* (R. Hull, Trans.). New York: Penguin Books.

Carey, L. (Ed.). (2006). *Expressive and creative arts methods for trauma survivors*. Philadelphia: Jessica Kingsley.

Doherty, P. (2011). Men and psychotherapy: A whole-hearted approach. NASW sponsored presentation, October 7, University of Minnesota, St. Paul, Minnesota.

Dorin, C. (2010, April 13). The case against sex offender residency laws. New Hampshire State House Alert Number 9. Retrieved December 3, 2010, from http://cursor.eprci.com/stories/2010/04/13/alert_9

Duwe, G., & Goldman, R. (2009). The impact of prison-based treatment on sex offender recidivism: Evidence from Minnesota. *Sexual Abuse: A Journal of Research and Treatment, 21*(3), 279–307.

Fjerkenstad, J. (2010, April 14). *Personal conversation*. See also http://www.hermesweb.com

Fox, H. (2003). "Ripening seeds" column. *International Expressive Arts Therapy Association newsletter*. Springer, Issue #1 of 2, pp. 8–10.

Fox, H. (2009). *Sexual healing: Shining a lantern on the erotic experiences of two inveterate soul-seekers, the story of Marty and Lee*. Unpublished.

Fox, H. (2004). *Songwriting and self-discovery: A heuristic study grounded in the arts and supported by the theories of Carl Jung and James Hillman,* Doctoral dissertation. The Union Institute and University, School of Professional Psychology, Cincinnati, OH.

Fox, H. (f/k/a H. Barba), Knill, P. & Fuchs, M. (2005). *Minstrels of soul: Intermodal expressive therapy*. Toronto: EGS Press. (Originally published in 1995 by Palmerston Press)

Freud, S. (2000). The sexual aberrations. In J. Strachey (Ed. & Trans.) *Three essays on the theory of sexuality.* New York: Basic Books. (Progonal work published 1905).

Haaven, J., Little, R., & Petre-Miller, D. (1990). *Treating intellectually disabled sex offenders*. Orwell, VT: Safer Society Press.

Hillman, J. (1977). *Revisioning psychology*. New York: Harper Collins.

Jung, C. (1980). *The archetypes and the collective unconscious*, 2nd ed. (R. Hull, Trans.) Princeton University Press. (Originally published in 1959)

von Krafft-Ebing, R. (1886). *Psychopathia sexualia*. Stuttgart, Germany: Ferdinand, Enke.

Letourneau, E., Levenson, J., Bandyopadhyay, D., Sinha, D., & Armstrong, K. (2010, September). *Evaluating the effectiveness of sex offender registration and notification policies for reducing sexual violence against women*. Washington, DC: U.S. Department of Justice. Retrieved December 3, 2011, from https://www.ncjrs.gov/pdffiles1/nij/grants/231989.pdf

Levenson, J. (2011). But I didn't do it! Ethical treatment of sex offenders in denial. *Sexual Abuse: A Journal of Research and Treatment, 23*(3), 346–364.

McGrath, R., Cumming, G., Burchard, B., Zeoli, S., & Ellerby, L. (2010). *Current practices and emerging trends in sexual abuser management.* Brandon, VT: Safer Society Press. Retrieved October 15, 2011, from http://www.safersociety.org/uploads/WP141-Current_Practices_Emerging_Trends.pdf

Malchiodi, C. (2010). *Trauma-informed art therapy (TI-AT).* Retrieved October 8, 2011, from http://www.cathymalchiodi.com/Trauma Informed Art Therapy.html

Marshall, W. L. (1971). A combined treatment method for certain sexual deviations. *Behaviour Research and Therapy, 9*, 293–294.
Marshall, W. L., Marshall, L., Serran, G., & O'Brien, M. (2011). *Rehabilitating sexual offenders*. Washington, DC: American Psychological Association.
Marshall, W. L., & Laws, D. R. (2003). A brief history of behavioral and cognitive behavioral approaches to sex offender treatment: Part 2. *The modern era. Sexual Abuse, 15*, 93–201.
Miller, S. (2005). *Achieving clinical excellence: Empirical lessons from effective practitioners*. Evolution of Psychotherapy Conference, December 8, Anaheim, California.
Nanda, U. (2011). Effect of visual art on patient anxiety and agitation in a mental health facility and implications for the business case. *Journal of Psychiatric and Mental Health Nursing, 18*, 386–393.
Padesky, C. (2005). *Workshop on homework and personality disorders*. Evolution of Psychotherapy Conference, December 7, Anaheim, California.
Piaget, J.-P. (1962). *Play, dreams, and imitation in childhood*. New York: Norton.
Serok, S., & Blum, A. (1983). Therapeutic uses of games. *Residential Group Care and Treatment, 1*(3), 3–14.
Spoto, M. (2011, July 23). *2 N.J. teens labeled sex offenders for life after 'horseplay' incident*. Retrieved December 3, 2011, from http://www.nj.com/news/index.ssf/2011/07/teens_sex_offenders_horseplay.html
Storr, A. (1983). *The essential Jung*. New York: MJF Books.
Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford Press.
Walsh, D. (2004). *Why do they act that way: A survival guide to the adolescent brain for you and your teen*. New York: Simon and Schuster.
Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. *Aggression and Violent Behavior, 7*, 513–528.
Ward, T., & Hudson, S. M. (2000). A self-regulation model of relapse prevention. In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Re-making relapse prevention with sex offenders: A source-book* (pp. 79–100). Thousand Oaks, CA: Sage.
Ward, T., Polaschek, D., & Beech, A. (2006). *Theories of sexual offending*. New York: John Wiley & Sons.
Wilde, O. (1969). *The artist as critic: critical writings of Oscar Wilde*. (R. Ellmann, Ed.). New York: Random House.

Chapter 5
Exploring Gender Identity with Photography: A Multilevel Treatment Approach

Sana Loue

Introduction

This chapter focuses on the use of photography as a vehicle to explore issues of gender identity, gender presentation, and sexual orientation among individuals who self-identify sexually as a member of a sexual minority group. The first portion of the chapter lays the foundation for what is to follow, with a discussion of sex, gender, and sexual orientation. I then move to examine how photography has been used in social work in the past in a variety of settings. This is followed by a discussion of how photography can be utilized to explore issues of gender identity, gender presentation, and sexual orientation. The final section of the chapter describes how photography was used in a project conducted with African American sexual minority young adults in Cleveland, Ohio, as a means of exploring both individual and group identity.

Gender, Sexual Behavior, and Sexual Orientation

Gender—what constitutes masculinity and femininity—is socially constructed (Kimmel, 2003; Stoller, 1968). Gender has been defined as

> a multidimensional category of personhood encompassing a distinct pattern of social and cultural differences. Gender categories often draw on perceptions of anatomical and physiological differences between bodies, but those perceptions are always mediated by cultural categories and meanings…Gender categories are not only "models of" difference…but also "models for" difference. They convey gender-specific social expectations for behavior and temperament, sexuality, kinship and interpersonal roles, occupation, religious roles and

S. Loue, J.D., Ph.D., M.P.H., M.S.S.A. (✉)
Department of Epidemiology and Biostatistics, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106-4945, USA
e-mail: Sana.Loue@case.edu

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3_5,

> other social patterns. Gender categories are "total social phenomena"…; a wide range of institutions and beliefs find simultaneous expression through them, a characteristic that distinguishes gender from other social statuses. (Roscoe, 1994, p. 341)

In contrast, gender role is everything that a person does to represent to others the degree to which he or she is male, female, or androgynous. This includes, for example, how one dresses, how one communicates both verbally and nonverbally, the roles one plays in the family and community, one's sexual feelings and to whom the individual directs those feelings, and how one experiences one's own body, as it is defined as masculine or feminine within the relevant society (Nanda, 1994). One's private experience of gender role is one's gender identity; the development of that identity is a function of the dominant cultural norms, the individual's particular circumstances, and cultural influences (Harris, Torres, & Allender, 1994). Essentially, then, gender identity represents the internal experience of masculinity or femininity (Ashmore, 1990; Spence, 1985), while gender role represents its external expression (Nanda, 1994).

The term sexual minority and all that it includes are actually much broader than many people may realize. Sexual minority is defined here to encompass individuals who identify as homosexual, gay, or lesbian; bisexual; transsexual; transgender or gender nonconforming; intersex; queer; questioning; men who have sex with men (MSM); men who have sex with men and women (MSMW); women who have sex with women (WSW); and women who have sex with men and women (MSMW). Additionally, depending on the context, sexual minority may also encompass individuals whose sexual practices include fetish, sadism-masochism, and/or submission-dominance. However, it is important to recognize that sexual behavior does not equate to sexual orientation. The term "men who have sex with men," for example, does not define either bisexual or homosexual men, but includes them both, as well as men who may self-identify as heterosexual but who may have sex not only with women but also with men for pleasure; in exchange for drugs, shelter, food, or money; due to the unavailability of alternative sexual partners; or due to an imbalance in power within an interaction or relationship.

Using Photography in Social Work Practice

Photography was one of the key strategies used by early leaders in social work in their advocacy efforts on behalf of underprivileged and disenfranchised communities and individuals. As an example, the sociological photographer Lewis Wicks Hine (1874–1930) joined forces with Jane Addams, Florence Kelley, and Lillian Wald in the National Child Labor Committee to document the exploitation of women and children in industry (Denzer, 1988; Huff, 1998). As yet another example, the social worker Paul Kellogg (1879–1958) utilized photographs by Hine in the Pittsburgh Survey, a six-volume report funded by the Russell Sage Foundation that detailed the lives of working people in Pittsburgh. As the creator of the journal *Survey Graphic*, Kellogg used photographs to portray the lives of industrial workers and rural life in America during the 1920s and 1930s (Huff, 1998).

The use of photography in therapy, known as phototherapy, has been in existence in some form since the 1850s, when photography was used with hospitalized psychiatric patients as a form of visual therapy (Glover-Graf & Miller, 2006). In this context, we see how photography can be used *with* clients and communities, in contrast to its previous use *for* individuals and communities. Since that time, photography has been used therapeutically with military servicepersons, the elderly, refugee children, and individuals with developmental disabilities, visual difficulties, AIDS, and chemical dependence (Glover-Graf & Miller, 2006; Koretsky, 2001; Perchick, 1992; Yohani, 2008). Used in a therapeutic setting under the direction of a trained therapist, photography can help the client address difficult situations and facilitate change.

Unlike art, which is often viewed as the artist's subjective interpretation of what he or she sees or as a construction of reality, photography is perceived as being more factual, a realistic rendition of events. Susan Sontag noted in her well-known publication, *Photography Notes*, that

> A photograph passes for incontrovertible proof that a given thing happened. The picture may distort; but there is always a presumption that something exists or did exist, which is like what's in the picture. Whatever the limitations…or pretentions [sic]…a photograph—any photograph—seems to have a more innocent and therefore more accurate relation to visible reality than do other mimetic objects. (Sontag, 1977, pp. 5–6)

(For a discussion of bias in photography, see Becker, n.d.).

Using Photography with Individual Clients

Photography can be used in a therapeutic context with historical photographs, photographs taken by the client in the therapeutic context, and photographs of the client. Historical family photographs

> can be used in a variety of ways: (1) to discover resources, both physical and emotional within the family; (2) to clarify apparent sources of problems, for example, in management or communication; (3) to investigate aspects of the personality as revealed in interpersonal relationships, and/or (4) to clarify relationships or dynamics alluded to in other sources of information, for example, in family history or individual reports. (Sedgwick, 1979, p. 138)

Picture taking by the client allows the therapist to better understand the client's world and the significance and meanings attributed to events, places, and persons by the client. Discussion with the client of photographs that he or she has taken can facilitate therapist-client communication and help the client to develop appropriate communication skills (cf. Gee, 1975). Picture taking may also be helpful to clients with tenuous connections to reality, in that it may serve as a mechanism to concretize events and people (Wolf, 1978).

Accordingly, it is important that the therapist refrain from interpreting the client's photographs and use them, instead, to explore their significance and meaning with the client. The focus is not on the photographic product itself; rather, the photograph offers a vehicle for the client to engage in self-reflection and for the therapist to understand through discussion with the client dimensions of the client and his or her life that might not otherwise be visible to others (Merrill & Anderson, 1993).

The process of using photographic portraits taken of clients by others in a therapeutic setting has also been reported to yield beneficial effects. Miller (1962) found that hospitalized patients with schizophrenia increased their socialization after he took photographs of each of them and returned them to the clients. Spire (1973) reported that his use and discussion of full-length photographs twice a week with hospitalized older women following psychotherapy led to the patients' improvements in communication and interpersonal relations. It is unclear, however, whether the beneficial effects obtained resulted from the visual information that was available to the clients about themselves from the photographs or from the attention and caring demonstrated by those who viewed the clients' photographs and whether it was the picture viewing or picture taking that was responsible for the reported improvements (Hunsberger, 1984).

Self-portrait photography may be especially effective in helping clients in their exploration of their self-image. The use of photography in this way allows clients to see themselves as themselves, to clarify values, and address issues related to self-esteem, self-confidence, and self-acceptance (Hogan, 1981; Weiser, 2001). As an example, Stewart (1979) reported that the use of photography with a middle-aged widow who suffered from anxiety, low self-confidence, and a distorted body image helped the client to understand the family origins of her negative self-image and ultimately led to an improvement in the client's self-concept and level of self-acceptance.

Using Photography with Groups

The use of photography may also confer benefits in a therapeutic group setting. It can facilitate the construction of group identity by group members, thereby providing an alternative to the construction of the group by outsiders (Oravec, 1995; cf. Kolossa, 2004); validate, reinforce, or alter group identity, cohesion, interaction (cf. Bounds, 1994; Oravec, 1995); facilitate the development of a group consensus with respect to the interpretation of the group (Oravec, 1995); and serve "as a call for individual and collective action to address marginalized aspects of human potential" (Hocoy, 2007, p. 23). Research has found, for example, that the self-concept of male youths who had been adjudicated as juvenile delinquents improved following an exercise in which they took instamatic snapshots of each other over five sessions (Fryrear, Nuell, & Ridley, 1974).

Photography and Community Organization

The use of photography by members of a community can help participants to identify, represent, and enhance their community (Wang, 2003). Individuals can discuss the meanings of the images, what those images may reveal about their community to others, and how they wish their community to be and to be portrayed. As an advocacy

strategy, it has been termed photovoice, and is premised on Freire's critical consciousness, in that it allows individuals to critically examine the images that they have taken, express their experiences, and utilize this awareness to advocate for their community (Wang & Burris, 1997). The method also derives from health promotion principles and feminist theory, which theorizes that power is held by "those who have voice, set language, make history, and participate in decisions" (Wang, Cash, & Powers, 2000, p. 82).

Photovoice has been used with youths to facilitate communication with policymakers regarding the levels of violence in their neighborhoods and spur the acquisition of funding for violence prevention (Wang, 2006; Wang, Morrel-Samuels, Hutchison, Bell, & Pestronik, 2004) and with shelter residents to document their situations, promote critical dialogue, and raise the awareness of policymakers and the general public with regard to issues affecting homeless persons (Wang et al., 2000). Photovoice has also been utilized in research with individuals to document their health and the environmental factors that they believe impacted their health status (Jurkowski & Paul-Ward, 2007) and has been found to promote more positive attitudes toward social services programs (Marshall, Craun, & Theriot, 2009).

A number of difficulties have been identified in the use of photovoice. First, the extent to which participating individuals are actually representative of their communities may not always be clear (Wang et al., 2000). Second, both the safety of those taking the photographs and the loss of privacy of the photographers and others in the community must be considered.

Exploring Issues of Gender and Sexual Orientation

Using Photography

Photography can serve as a useful medium in therapy to explore issues related to gender identity, gender presentation, and sexual orientation. Mamary and colleagues found in their research with African American MSM who did not self-identify as gay that photovoice can serve as a mechanism through which the men could explore the challenges associated with maintaining their sexual health and the stigma associated with nonheterosexual orientation (Mamary, McCright, & Roe, 2007). A number of the men who participated in their study, for example, had children; one of these men indicated that he did not want to be embarrassed in front of his son because of what he might have done. A number of men commented on the apparent paradox of having to maintain secrecy around their sexual relations with men because of the stigma and having to engage in sex with men in public places because of the stigma and the associated difficulty of otherwise finding sexual partners.

In the context of individual therapy, photography permits a centric-eccentric perspective, that is, a focus on one's center and a recognition that one's center is only one of many centers. Photographic images are bound up with knowledge of the self. Photography can facilitate a recapture of the self after secondary trauma, recognize

that individuals hold and reflect multiple identities simultaneously and may choose to emphasize each differentially, and provide a repertoire of self-images, allowing individuals to try on various images to assess "fit" (Oravec, 1995). As Oravec (1995, p. 439) noted, "Individuals may consider the portraits not as mirrors but as experimental tools as they modify and successively 'try on' a variety of images tangentially associated with themselves." Photography permits the in-depth examination and negotiation of a range of images' meanings: private/public, positive/negative, and shifts of meaning as the context and audience change (Newbury, 1996). Photography also acts as a mechanism of socialization and the sharing of social values and provides validation for the individuals through witnessing by the photographer.

When used strategically in the therapeutic setting, photography can serve as a means of communication and self-exploration. Conducting a self-evaluation through photography necessarily prompts an examination of one's own expectations of how one "ought" to look. Additionally, participants in the process can utilize photography to evaluate the internally formulated and externally imposed standards inherent in their choice of images, for example, the impact of sex, class, sexual orientation, gender role, gender orientation, ethnicity, and race. "All too often therapists heal what is already wounded and do not attend to the milieu which wounds and rewounds again and more deeply" (Junge, Alvarez, Kellogg, & Volker, 1993, p. 149). Helping the client to understand which of his or her standards are internally formulated and which have been externally imposed by their environment is critical to the client's development, individuation process, and mental health.

Discovering One's Identity

Clients who are exploring their sexual and/or gender identities may wish to examine a variety of issues and/or develop strategies to address troubling difficulties. These include gender identity questioning and sexual orientation questioning; family rejection due to sexual identity; rejection by one's faith community; childhood sexual and/or physical abuse; self-hate, which may manifest as cutting, eating disorders, or body image disorders; partner violence; depression and other mental illness; substance abuse; homelessness; suicidal ideation and suicide attempts; violence; HIV/STI risk; a lack of health insurance and consequent lack of access to medical and/or mental health care; and stigma. This is not to suggest that every client who is exploring his or her sexual identity will present with any or all of these issues. However, many of these issues are common to individuals with a minority sexual identity due to the continuing prejudices and discrimination that exist within our society and the frequent refusal to recognize individuals' identity.

It is important, therefore, that therapists working with individuals who ultimately self-identify as members of any number of sexual minority groups understand that clients may go through various stages in their efforts to define themselves and the type of romantic/sexual relationships that they would desire. One such model, formulated by Coleman (1981/1982), delineates five distinct phases. This model

reflects researchers' understanding of the developmental trajectory identified in studies that were conducted primarily with self-identified gay men. The extent to which it applies to individuals of other sexual identities remains unsettled.

Phase 1 consists of a process of sensitization, pre-coming out, and emergence. During this phase, the client may feel socially different, alienated, and alone; experience ambiguous same-sex attractions; sense strong heterosexist norms in the surrounding environment; fear being noticed; keep his or her thoughts and feelings private; feel depressed; and communicate conflict through behavioral problems and suicidal attempts.

Recommended psychotherapeutic interventions with the client during this phase may include a demonstration of empathy with the client's feelings; destigmatization of the feeling of being socially different; treatment for depression; efforts to address associated behavioral problems; provision of an appropriate referral for medical consultation where indicated, for example, for medications for severe depression; interventions to prevent suicide; and assessment to rule out the existence of any serious psychopathology.

My client, who I shall call Walter, exemplifies this phase. At the time that I first saw Walter, he was in his mid-teens and was questioning his sexual identity and his sexual orientation. He told me that he wasn't sure if he was gay or not. His school counselor had diagnosed him with depression but, despite thoughts of suicide, Walter denied feeling depressed. I conducted a suicide risk assessment with Walter and referred him to a free medical clinic for further evaluation for medication. Walter and I had numerous discussions about what it would mean in his life if he were gay.

Phase 2 has been referred to as one that involves identity confusion, identity comparison, coming out, and acknowledgement. Clients may feel sexually different during adolescence; experience an increasing sense of alienation; question their identity; escape homoeroticism through substance use; attempt to assimilate into their heterosexual peer groups; become an antigay crusader; overvalue approval from heterosexuals; and grieve the apparent loss of a heterosexual blueprint for their lives, for example, marriage and children. Psychotherapeutic interventions that may be helpful during this phase include empathizing with the client's confusion; exploring with the client the personal meaning of confusing information; discouraging the client from engaging in premature self-labeling; exploring with the client his or her fears and anxieties; mirroring the client's intrinsic worth; providing material to dispel stereotypes about gays, lesbians, and other sexual minorities; reframing sexual minority status as positive; helping the client to identify receptive supporters; providing a referral to affirming clergy as necessary; and assessing the client for substance use and referring or intervening as appropriate (Coleman, 1981/1982).

Because many of the client behaviors during this and other phases may resemble behaviors associated with serious mental illness, it is critical that the therapist conduct an assessment to determine whether the client is experiencing a crisis associated with sexual identity or whether the client's behaviors and perceptions are symptoms of a mental illness. As an example, serious psychopathology may be mistaken for a sexual identity crisis in the case of a client who engages in indiscriminate sexual

behavior, but who may be doing so as a symptom of hypomania or mania, regardless of his or her sexual orientation. Conversely, a sexual identity crisis may be mistaken for serious psychopathology when, during a sexual identity crisis, a gay individual who is fearful or hypervigilant may appear paranoid. Further, a sexual identity crisis may either exacerbate or precipitate the onset of serious psychopathology, such as when a psychotic individual who is gay-oriented may decompensate during sexual identity crisis and become paranoid (Gonsiorek, 1981/1982).

These were some of the issues that had to be teased out with my client who I will call Trevor. Trevor first presented to me at about the age of 19. He indicated that he was having financial problems and relationship difficulties with one of his many girlfriends. He talked about his difficulties with a series of male roommates and how most people just didn't understand him. Each of his roommates had been gay, but Trevor denied any sexual or romantic feelings toward any man and insisted that he liked only women. I learned about the physical violence that characterized his birth family; his eviction from his apartment, which he attributed to his landlord's dislike of him rather than his nonpayment of rent for more than 3 months; and his perceived persecution by his supervisor at his job. It became increasingly clear that Trevor was somewhat paranoid and a detailed assessment suggested that he might have bipolar disorder. One day, Trevor casually referred to his boyfriend who, he said, he met while he was hanging out. He also informed me that he had decided to join the navy because it would provide him with a good opportunity to meet men with whom he could have romantic and sexual relationships. Further exploration with Trevor of the many issues he presented with confirmed that he was experiencing both a sexual identity crisis and behaviors indicative of hypomania.

Phase 3 involves the development of identity tolerance, the assumption of identity, exploration, and finding community. The client may acknowledge the probability that he or she is gay, lesbian, or of another sexual identity other than heterosexual; begin to tolerate his or her new identity; acknowledge his or her social, emotional, and sexual needs; seek out individuals of a similar sexual identity; begin to selectively self-disclose; experience a developmental lag such as being in adolescence regardless of the client's actual chronological age; and find a peer group or community. Psychotherapeutic interventions that can be utilized include validating the client's perception of his or her probable self-identity, providing insight with respect to the process of identity formation, offering the client information about community resources, facilitating the client's decision-making about self-disclosure, rehearsing self-disclosures regarding identity in therapy, providing education about human sexuality, offering perspectives on first relationships, assisting the client in the completion of adolescent tasks, continuing to facilitate the client's individuation from parents and/or others, helping the client to construct his or her new personal and social identity, and reframing potential rejection as an external problem (Coleman, 1981/1982).

One of my clients, who I refer to here as Winston (not his real name), was just at this stage when he first came to see me. In his late teens, he had only recently acknowledged to himself that he wanted to live as a woman but did not want to change his biological sex; Winston identified as transgender. When he began wearing makeup and women's clothing, his mother evicted him from her house, threw out

his clothes, except for his jeans which she kept for herself, and called the police, claiming that Winston was trespassing. Intervention with Winston included connecting him with supportive community resources, assisting him to locate suitable housing arrangements, exploring with him issues of self-identity and sexual orientation, and addressing issues of abandonment and grief.

During *Phase 4*, the client begins to accept his or her new identity and form new commitments and first romantic-sexual relationships. The client now accepts rather than tolerates his or her new self-image, increases the frequency of contact with other individuals of similar sexual identity, clarifies his or her sexual desires and emotional needs, reconceptualizes his or her identity as normal and natural, increases his or her desire to self-disclose to others, and selectively discloses in selected situations. Often, the client may have unrealistic expectations for first relationships. Psychotherapeutic interventions during this stage include supporting the client's active involvement in the relevant community, reframing the concept of kinship to include intentional (chosen) family, and facilitating the client's efforts to balance merging and individuation.

Some writers have suggested that a therapist might encourage the client during this phase to adopt an identity label, at least on a temporary basis (e.g., Ritter & Terndrup, 2002). However, because this approach may bring about increased, rather than decreased, difficulties for the client, it is important to weigh seriously the potential implication of this suggestion with respect to the specific client. As an example, one of my clients presented me with the following issue:

> I am a 51-year-old man whose gender role is male, sexual orientation is homosexual—however, I prefer gay or queer since the word homosexual was a scientific term used to pathologize same-sex attraction—and gender identity is female … Also, in light of the fact that sexism still exists and is very prevalent in our society, do you … have any recommended reading from the perspective of someone whose gender identity is female to navigate and be as successful as possible in our society as we know it?

One of the issues for this particular client was whether he "should" label himself gay based on his sexual orientation or transgender based on his gender identity. In working with the client, we explored together his need for any label, regardless of which label he might choose to use; the existence of gender role, gender identity, gender expression, and sexual orientation along a spectrum, rather than as categorical constructs; and the implications in the client's life of relying on more fluid constructions of gender and sexuality. In exploring these issues, the client found that it was the fact of imposing any label that was creating the most consternation for him because any label limited how he felt he must present himself to others and what he could claim as part of himself. (For a discussion of the difficulties inherent in labeling or categorizing an individual's gender or sexual orientation, see Loue, 2006, pp. 54–85).

It has also been suggested that the therapist might assist with the development of a conscious selection of passing strategies. Some individuals, including therapists, ascribe to the belief that one must acknowledge and affirmatively make known one's sexual orientation and gender identity at all times. This perspective on openness, while perhaps representing the ideal situation, fails to consider the context in which a client may be living. In some situations, disclosing one's sexual orientation may

be "too much information," resulting in job loss, harassment, loss of visible family support or friendship, and/or violence. Accordingly, it is important that the circumstances of self-disclosure be safe. Similarly, the development of and reliance on passing strategies must also be done safely. A male-to-female transgender individual may be able to pass safely as female in some situations, but in others, such as dating men without advising that she is still biologically male, may leave the individual vulnerable to violence.

Some clients may indicate a need for couples counseling. Although there is disagreement among therapists with regard to this issue, I suggest that your client and his or her partner be referred to another therapist for couples counseling. Providing couples counseling after having had a longstanding therapeutic relationship with one of the partners may raise fears in the second partner that you and the initial client are in alliance against him or her. Additionally, the initial client may have unrealistic expectations that you will always be in his or her side, so to speak, because of your preexisting relationship, regardless of any explanation that you may provide regarding the nature of couples counseling.

Phase 5 has been identified as one involving the development of pride in one's own identity, integration, self-definition, and reintegration. The client may distinguish and dichotomize between people based on sexual orientation and identification, exaggerate the importance of other individuals of like gender identity or sexual orientation, indicate a preference for his or her new identity, immerse himself or herself in the culture of those with a similar sexual orientation or gender identity, and feel a greater sense of security in his or her integrated identity. The client may also move away from an "us versus them" philosophy and, instead, discriminate on the basis of perceived support. Psychotherapeutic interventions during this stage may include validating the client's pride in identity, encouraging the client's celebration of his or her new integrated identity, assisting the client in his or her effort to reframe the past in order to maintain continuity in life, advancing to issues of genuine intimacy, and addressing the developmental issues of adult life. Depending upon the client's situation, it may also be important to discuss the negative repercussions associated with a refusal to pass as gender conforming, for example, in the work environment. The client's selection of a residence may also have implications that may be examined. For example, residence in a heterosexual family-oriented neighborhood provides a very different living environment than does residence in what has been euphemistically called a "gay ghetto."

Case Study

The Setting

This photography project was conducted in Cleveland, Ohio with a group of African American men who have sex with men between the ages of 16 and 24 who were attendees of local drop-in center for minority sexual minority youth. An understanding

of the context in which they lived is critical to understanding why photography was utilized in this project.

Since 1980, the proportion of Black/African Americans in Cleveland has grown to comprise more than one-half of the city's population, while the overall population has declined. Slightly more than 40% of the city's population is White, and the remaining 9% or so includes Hispanics/Latinos, Asians/Pacific Islanders, and Native Americans (United States Bureau of the Census, 2000). African Americans constitute the majority population within 17 of 36 neighborhoods. Cleveland was and continues to be considered by many to be heavily segregated on the basis of race.

Cleveland's 2003 poverty rate was 31.1%, which represents almost three times the national 12.7% level of poverty. Lower economic prosperity, the deterioration of the tax base and quality schools, and a relative lack of job opportunities have contributed to Cleveland's dubious status as one of the three poorest major cities in the United States; Cleveland was awarded the title of "Nation's Poorest Major City" for the years 2003 and 2005 (Smith & Davis, 2004; Webster & Bishaw, 2006). Two-thirds of African American and Hispanic youth live in severely distressed areas. Three-quarters of youths living in predominately African American neighborhoods were in homes in poor condition (Salling, 2006). The foreclosure rate in Cleveland during the first 4 months of 2006 was 95 per 100,000 residents, a rate that was surpassed only by Detroit and Dallas-Ft. Worth and that was more than three times the national annual foreclosure rate of 29 per 100,000 residents (Fitch, 2006).

Two-thirds of Cleveland neighborhoods with predominately African American populations are located in areas that lack a threshold number of primary care physicians. Based on Health and Human Service Department regulations, much of eastern Cleveland can be officially designated as Health Professional Shortage Areas (HPSA). A majority of African Americans in all of Cuyahoga County reside in these HPSA areas (Lenahan, 2005). The relative unavailability of treatment services is concerning for a number of reasons. African American teens in Cleveland appear to be more sexually active and take greater risks during and among sexual encounters. Chlamydia is the most frequently reported sexually transmitted infection in the United States, Ohio, and Cleveland (Centers for Disease Control and Prevention [CDC], 1996; Cleveland Department of Public Health [CDPH], 2007; Ohio Department of Health, 2007). In Cleveland, African Americans experience the highest annual incidence rates for Chlamydia and gonorrhea compared to White non-Hispanic and Hispanic residents. More African Americans have HIV/AIDS than any other race or ethnic group in Cuyahoga County and Cleveland (CDPH, 2007).

In addition, there have been and continue to be high levels of stigmatization and ostracism of nonheterosexuals in minority communities and high levels of ostracism of non-White sexual minorities in Cleveland's lesbian-gay-bisexual-transgender-queer (LGBTQ) community. Since 2007, there have been multiple murders and drive-by shootings of minority MSM and an apparent increase in numbers of attempted suicides.

At the time that the photography project was initiated in 2010, I was aware, through my interactions with many young African American MSMs, of the relatively

high prevalence of suicidal ideation, suicide attempts, homelessness, and untreated mental illness that is experienced by many individuals in this population. The anxiety that prevailed among individuals was exacerbated following several murders of transgender African American males, drive-by shootings of the drop-in center that they frequented, and an "exposé" in a local newspaper that resulted in the outing and homelessness of several center attendees. Many of the individuals had experienced abuse in their birth families and/or with partners, and many lived in neighborhoods and situations characterized by ubiquitous violence. The shootings of their friends and acquaintances had further traumatized the young men. As Shore (2007, p. 189) noted,

> The shame and fear that arises in the face of experiencing horrors can seriously threaten the possibility for interpersonal connection and struggle. To find a way to clearly and safely express such experiences may not always be so simple or possible. Accepting a horrible reality involves tremendous struggle and pain. A person can only engage in such struggle in accordance with the level of internal strength and external support available. To be meaningfully engaged in this type of struggle involves tolerating ambiguity, as well as fear and confusion.

Photography offered the young men the possibility of exploring and affirming in a safe space, and completely within their control, their identity as they wish to be defined. The provision of a space that was safe and protected, both physically and psychologically, was of critical importance at the individual, group, and larger community levels. Higher rates of psychiatric disorders have been found in the African American community, with more than one-third of the African American MSM population meeting the criteria for anxiety disorders. African American males are at exceptionally high risk for adverse mental health outcomes involving self- and other-directed violence, which many of the youth had already experienced. Suicide is the third leading cause of death among African American youth between the ages of 15 and 24 (American Association of Suicidology, 2004), and many of the project participants had attempted suicide themselves, experienced suicidal ideation, and/or had had friends or family members who had committed suicide. Suicide risk is particularly escalated among African Americans living in areas of high occupational and economic inequality between Whites and African Americans (Burr, Hartman, & Mattson, 1999); among those whose families were characterized by incest, physical abuse, sexual abuse, and poor social cohesion (Hernandez, Lodico, & DiClemente, 1993; Summerville, Kaslow, Abbate, & Cronan, 1994); and among nonheterosexually identified youth (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Rotheram-Borus, Hunter, & Rosario, 1994)—all of which characterized the youth who would be participating in the photography project. Also, MSM, including transgender individuals, may be at increased risk of developing a mental illness and frequently experience rejection, discrimination, and isolation. They may also face significant barriers to treatment, including lack of health insurance, provider insensitivity and bias, and stigma associated with both mental illness and MSM identity.

The Process

The project was conducted over a 3-month period. It was not presented as therapy or treatment, which would have been rejected out of hand due to the stigma that is often associated with therapy or counseling, but as a way of "thinking about who you are and how you would like others to see you." The project sought to help participants explore (1) their self-representation, (2) their representation of their sexuality to others, (3) the implications of their self-representation in the larger context, and (4) how best to negotiate their self-representation across diverse audiences. These goals were thought to be particularly important at the time the project was initiated because of the violence that was being directed against African American MSM and the personal difficulties and challenges that many of the youth were experiencing. Additionally, the project sought to empower the participants, who are often the focus of representation by others.

Attendees at the drop-in center were offered the opportunity to participate. I, as the photographer, was a witness to their various self-portrayals, as they dressed and posed in any number of ways. All of the photos taken of each individual were developed and reviewed privately with that individual. This review opened the door to reflect on the following questions:

- What does this photo tell you about yourself?
- How does this image make you feel?
- What do you like/not like?
- What does this image tell other people about you?
- Are there things it says that you don't want others to know?
- Are there things it doesn't say that you do want others to know?
- What might be the effect of this image on other people?

This discussion with each participant was critical to their self-exploration and understanding. As Weiser (1988, p. 345) notes,

> Photographs and the process of taking and interacting with the prints…give youth "a better picture" of themselves and…bring their lives "into sharper focus." Since "seeing is believing" and "a picture is worth a thousand words," "seeing for yourself can be a powerful tool when input from others is not relevant or accepted."

Also, the taking of the photographs and the subsequent discussion served to validate each participant's identity and intrinsic worth as a unique individual.

Once each individual had selected the photo or photos that he wished to share with the larger group of participants, the photos were gathered together for a group review. At that time, the following questions were posed to group members for discussion:

- What do these images together tell other people about all of you?
- How do these images together make you feel about your group?
- What do all of you like/not like?
- What does this image tell other people about you?

- Are there things it says that you don't want others to know?
- Are there things it doesn't say that you do want others to know?
- What might be the effect of this image on other people?

These group discussions helped, first, to reduce each individual's sense of aloneness, alienation, and differentness in that the discussions were conducted with and among persons who identified similarly. The group focus on the picture taking and evaluation provided a unique opportunity to come together as a small community and to identify supporters within that community.

Following these individual and group reviews and discussions, participants could decide the fate of their own photographs. A few of the photos were discarded by their respective owners. Some participants asked that I hold on to their photos for safekeeping, convinced that either the photo would not be respected by others or that they would die before the age of 30 and I would be someone who remembered them as they were. Some participants requested that I frame the photo for them, which I did. Others requested that their photo image be blown up into poster size; these were installed as part of a permanent exhibit in the drop-in center. Finally, a number of participants contributed their photos, either anonymously or by name for inclusion in a volume focusing on minority MSM.

The ability of each individual to determine whether and how their photographs were to be preserved afforded them a sense of control. The photographs reflected who they were and the participants' disposition of them determined who could and could not see them as they saw themselves and wished to be seen.

Project Evaluation

The photography project appeared to be a success in a number of ways. First, all of the participants welcomed an opportunity to speak with me, the photographer and witness, about their photographs and, indeed, their lives and why they had posed as they had and selected a particular image as their favorite. Almost all participated enthusiastically in the group discussion. Individuals appeared to develop greater insights into how to remain safe when self-disclosing and self-representing. Finally, there seemed to be an increased sense of solidarity and support among the participants.

Various factors contributed to the project's success. First, there was no "right" or "wrong" portrayal; the focus of attention remained not on the photographic product, but instead on the meaning attributed to it by the individual who was the subject of the portrait (cf. Merrill & Anderson, 1993). I, as the photographer, did not interpret images, but instead used the photographs as a vehicle for communication with the individual and, if the client permitted, with the group as a whole (cf. Glover-Graf & Miller, 2006). The project was conducted in a "safe and protected space," the drop-in center with which the youth were familiar and which offered a space in which they could be themselves without external input. The decision regarding the fate of the photographs was completely that of the individual whose picture had been taken.

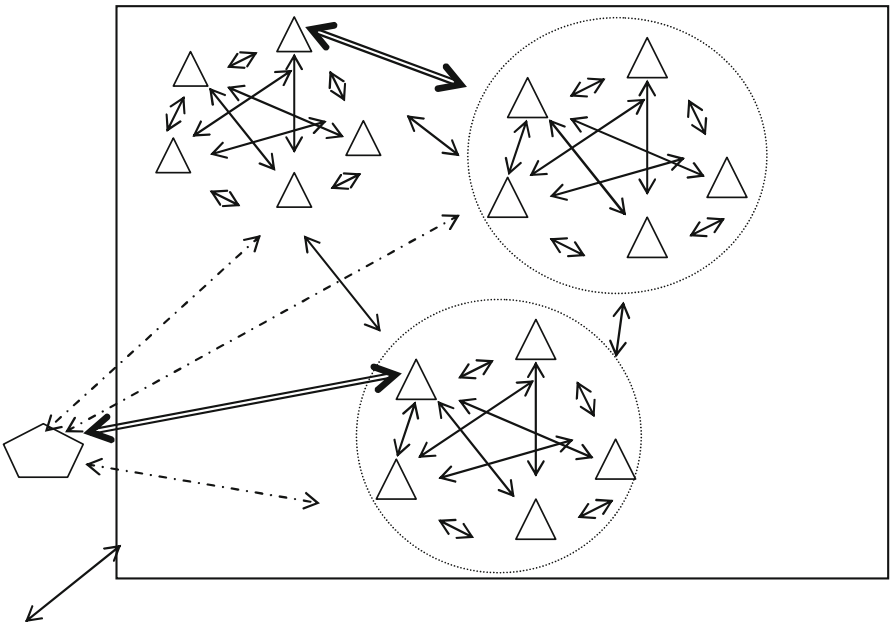

Fig. 5.1 *Diagrammatic representation of therapist-individuals-groups-community dynamics*. *Triangles* individuals, *circles* various groups-in-formation, *large square* community-in-formation, *hexagon* therapist, *largest square* larger community in which the community-in-formation exists. Relationships extend between individuals, groups, larger community, community-in-formation, and therapist simultaneously

Finally, the implementation of the project on both the individual and community levels facilitated not only individual discovery and heightened self-awareness but also the concretization of the group's identity and sense of solidarity.

Ethical Issues

A number of ethical issues arose during the course of the project that bear mentioning. The first is that of my multilevel role; not only did I have a relationship with each of the individual participants and the group as a whole as a therapist, but I also served as the photographer of the "project." Additionally, the intraindividual dynamics are necessarily intertwined with the dynamics of the group and the community in which the group is situated (see Fig. 5.1).

However, the issues presented by each individual cannot be addressed holistically apart from the experiences of the group and the attitudes and actions of the larger community. This necessitates the assumption for the therapist, when warranted, of a role as an activist on behalf of the client and the client community.

Although such a multilevel, multifunction role may be somewhat radical for some mental health professionals (Hocoy, 2007), it is clearly within the accepted—and indeed expected—parameters of social work practice. Indeed, the preamble to the revised Code of Ethics of the National Association of Social Workers enjoins social workers to be "cognizant of their dual responsibility to clients and to the broader society." The Code further provides:

> Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability. (National Association of Social Workers, 2008, 6.04(d))

Nevertheless, the assumption of such a multifaceted role demands that we, as therapists, recognize and address our own intrapsychic issues and take care that we are not projecting them onto our clients and others, thereby creating further injustices.

Additional ethical issues relate to informed consent to participate in the photography project itself and informed consent to use the client's image. A number of the participants were under the age of 18, but parental consent was not thought to be necessary for various reasons. First, the project was not conducted as therapy, although there may have been therapeutic benefit to participants. Second, even if it could be considered therapy, the state of Ohio, like some other states, permits minors to receive a minimum number of counseling services without parental knowledge or consent. Finally, parental consent would not have been an option since many of these particular individuals were homeless and/or had been estranged from their families specifically because of their sexual orientation and their parent(s)' sometimes violent response to this revelation. This issue was addressed by exploring with each individual the potential implications of participating individually and in the group discussions and the options available for access to and disposition of the photographs. Each individual was asked to explain in his own words how participation might impact him and his relationships and what risks it might present.

Ownership of the images was also discussed with each client. It was agreed that I could retain a copy of each image for my files, but that any other use of the photo, such as in a presentation, supervision, or publication, would require the individual's written informed consent, which must include complete details regarding the proposed usage. It was also agreed that the client would own a copy of each photograph taken of himself but that he could not have access to the images taken of other individuals unless they chose to make that available.

The photo taking sessions triggered traumatic memories for two individuals. When this began to occur, we immediately ceased the photo taking and focused on the issue(s) that had arisen during the course of the session. One individual, in particular, was impacted by the photo taking, and he began to speak about his family's negative comments about his physical appearance, his cutting, and his internalized issues related to body image; his cutting and purging had until that time remained well-hidden from his parents, his friends, and his case manager. We used this as an opportunity to begin exploring the source of his negative self-image and his need to cut.

There exists, as well, the potential to exploit the participating individuals and the group through the use of their images. This can be addressed through continual self-monitoring by the therapist and through consistent adherence to an informed consent procedure that requires communication to the client of the purpose of the photography and the use to which an image is to be put and which allows the client complete control regarding its use. Competent supervision may also be key to continued self-examination by the therapist of his or her motivations and expectations vis-a-vis the client.

Conclusion

Photography can be used to augment traditional social work practice to explore issues related to gender and sexual identity. Through the use of photography, the client can address questions such as Who am I? Who am I in relation to___? Who am I in the context of ___? Photography provides a mechanism through which clients can "try on" different representations of identity, identify a greater range of "self," and explore how and why they choose to self-identify and self-present and the implications of these decisions within their life context. Through this process, individuals who may have felt alone, alienated, and marginalized may gain a sense of validation, affinity with others, self-acceptance, and empowerment. The therapist who serves as a nonjudgmental and supportive witness to this process provides an alternative voice to those whose voices were raised only in rejection and dismissal.

References

American Association of Suicidology (2004). *African American suicide fact sheet*. Washington, DC: Author. Retrieved May 25, 2009, from http://www.suicidology.org.

Ashmore, R. (1990). Sex, gender, and the individual. In L. Pervin (Ed.), *Handbook of personality: Theory and research* (pp. 486–526). New York: Guilford.

Becker, H. (n.d.). Photography and sociology. *American Ethnography Quasiweekly*. Retrieved January 26, 2011, from http://www.americanethnography.com/article.php?id=69.

Bounds, W. (1994). An easy way to get an ex out of the picture—and no lawyer! *Wall Street Journal*, June 16, at B1.

Burr, J. A., Hartman, J. T., & Mattson, D. W. (1999). Black suicide in U.S. metropolitan areas: An examination of the racial inequality and social integration-regulation hypotheses. *Social Forces, 77*, 1049–1081.

Centers for Disease Control and Prevention (CDC). (1996). Ten leading nationally notifiable infectious diseases—United States, 1995. *Morbidity and Mortality Weekly Report, 45*, 883–884.

Cleveland Department of Public Health (CDPH) (2007). Cleveland (Only) HIV/AIDS prevalence report: Reported persons living with HIV/AIDS as of December 31, 2006 by selected characteristics, Cleveland resident cases, and prevalence per 100,000. Retrieved May 29, 2007, from Health Division, HIV/AIDS at http://www.clevelandhealth.org/.

Coleman, E. (1981/1982). Developmental stages of the coming out process. *Journal of Homosexuality, 7*(2–3), 31–43.

Denzer, K. (1988). The documentary imagination of Lewis Hine. *History Today, 38*(8), 49–55.
Fitch, S. (2006). Home foreclosure hot spots. *Forbes Magazine Online*. Retrieved May 29, 2007, from http://www.msnbc.msn.com/id/13086712/.
Fryrear, J., Nuell, L., & Ridley, S. (1974). Photographic self-concept enhancement of male juvenile delinquents. *Journal of Consulting and Clinical Psychology, 42*, 915.
Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., & Goodman, E. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatric Adolescent Medicine, 153*(5), 487–493.
Gee, E. N. (1975). Learning to be: A look into the use of therapy with Polaroid photography as a means of recreating the development of perception and ego. *Art Psychotherapy, 2*, 159–174.
Glover-Graf, N. M., & Miller, F. (2006). The use of phototherapy in group treatment for persons who are chemically dependent. *Rehabilitation Counseling Bulletin, 49*, 166–181.
Gonsiorek, J. C. (1981/1982). The use of diagnostic concepts in working with gay and lesbian populations. *Journal of Homosexuality, 7*(2–3), 9–20.
Harris, I., Torres, J. B., & Allender, D. (1994). The responses of African American men to dominant norms of masculinity within the United States. *Sex Roles, 31*(11/12), 703–719.
Hernandez, J. T., Lodico, M., & DiClemente, R. J. (1993). The effects of child abuse and race on risk-taking in male adolescents. *Journal of the National Medical Association, 85*, 593–597.
Hocoy, D. (2007). Art therapy as a tool for social change: A conceptual model. In F. F. Kaplan (Ed.), *Art therapy and social action* (pp. 21–39). London: Jessica Kingsley.
Hogan, P. T. (1981). Phototherapy in the educational setting. *The Arts in Psychotherapy, 8*, 193–199.
Huff, D. D. (1998). Every picture tells a story. *Social Work, 43*(6), 576–583.
Hunsberger, P. (1984). Use of instant-print photography in psychotherapy. *Professional Psychology: Research and Practice, 15*(6), 884–890.
Junge, M. B., Alvarez, J. F., Kellogg, A., & Volker, C. (1993). The art therapist as social activist: Reflections and visions. *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 148–155.
Jurkowski, J. M., & Paul-Ward, A. (2007). Photovoice with vulnerable populations: Addressing disparities in health promotion among people with intellectual disabilities. *Health Promotion Practice, 8*(4), 358–365.
Kimmel, M. S. (2003). Masculinity as homophobia: Fear, shame, and silence in the construction of gender identity. In P. S. Rothenberg (Ed.), *Race, class, and gender in the U.S* (pp. 213–219). New York: Macmillan.
Kolossa, A. (2004). *Haring*. Köln, Germany: Taschen.
Koretsky, P. (2001). Using photography in a therapeutic setting with seniors. *Afterimage, 29*(3), 8.
Lenahan, T. (2005). Shortage areas of primary medical professionals. *Public Health GIS and Information, 63,* 19–21. Retrieved May 29, 2007, from http://www.cdc.gov/nchs/data/gis/cdcgis63.pdf.
Loue, S. (2006). *Assessing race, ethnicity, and gender in health*. New York: Springer.
Marshall, H. L., Craun, S. W., & Theriot, M. T. (2009). The big picture: How social work can effectively utilize photographs. *Social Work, 54*(4), 317–325.
Mamary, E., McCrights, J., & Roe, K. (2007). Our lives: An examination of sexual health issues using photovoice by non-gay identified African American men who have sex with men. *Culture, Health and Sexuality: An International Journal for Research, Intervention and Care, 9*(4), 359–370.
Merrill, C., & Anderson, S. (1993). Person-centered expressive therapy: An outcome study. In D. Brazier (Ed.), *Beyond Carl Rogers* (pp. 109–128). London: Constable.
Miller, M. (1962). Responses of psychiatric patients to their photographed images. *Diseases of the Nervous System, 23*(1), 296–298.
Nanda, S. (1994). Hijras: An alternative sex and gender role in India. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 373–417). New York: Zone Books.

National Association of Social Workers (2008). *Code of ethics*. Retrieved January 2, 2012, from http://www.socialworkers.org/pubs/code/code.asp.

Newbury, D. (1996). Reconstructing the self: Photography, education, and disability. *Disability & Society, 11*(3), 349–360.

Ohio Department of Health (2007). *Data information warehouse*. Retrieved May 29, 2007, from http://dwhouse.odh.ohio.gov/datawarehousev2.htm.

Oravec, J. A. (1995). The camera never lies: Social construction of self and group in video, film, and photography. *Journal of Value Inquiry, 29*, 431–446.

Perchick, M. (1992, December). Rehabilitation through photography: The power of photography as physical & emotional therapy—Contribution of Josephine U. Herrick's volunteer service photographers organization to teaching photography to wounded World War II servicemen. *PSA Journal*, 13–15.

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York: Guilford Press.

Roscoe, W. (1994). How to become a berdache: Toward a unified analysis of gender identity. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 329–372). New York: Zone Books.

Rotheram-Borus, M. J., Hunter, J., & Rosario, M. (1994). Suicidal behavior and gay-related stress among gay and bisexual male adolescents. *Journal of Adolescent Research, 9*(4), 498–508.

Salling, M. (2006). Children living in severely distressed neighborhoods and poor housing. *Public Health GIS and Information,* 68, 19–22. Retrieved May 29, 2007, from http://www.cdc.gov/nchs/data/gis/cdcgis68.pdf.

Sedgwick, R. (1979). The use of photoanalysis and family memorabilia in the study of family interaction. *Corrective and Social Psychiatry and Journal of Behavior Technology Methods and Therapy, 25*, 137–141.

Shore, A. (2007). Some personal and clinical thoughts about trauma, art, and world events. In F. F. Kaplan (Ed.), *Art therapy and social action* (pp. 175–190). London: Jessica Kingsley.

Smith, R. L., & Davis, D. (2004). Cleveland No.1 in big-city poverty/Nearly half of children among the poor. *Cleveland Plain Dealer.* Retrieved May 29, 2007, from http://www.cleveland.com (archived) and UrbanOhio.com archives, http://www.urbanohio.com/forum2/index.php?topic=978.0.

Sontag, S. (1977). *On photography*. New York: Farrar, Straus, & Giroux.

Spence, J. (1985). Gender identity and its implications for the concepts of masculinity and femininity. In T. Sonderegger (Ed.), *Psychology and gender, Nebraska Symposium on motivation* (Vol. 32, pp. 59–95). Lincoln, NE: University of Nebraska Press.

Spire, R. (1973). Photographic self-image confrontation. *The American Journal of Nursing, 73*, 1207–1210.

Stewart, D. (1979). Phototherapy: Theory and practice. *Phototherapy, 6*, 41–46.

Stoller, R. J. (1968). *Sex and gender: On the development of masculinity and femininity*. New York: Science House.

Summerville, M. B., Kaslow, N. J., Abbate, M. F., & Cronan, S. (1994). Psychopathology, family functioning, cognitive style in urban adolescents with suicide attempts. *Journal of Abnormal Child Psychology, 22*, 221–235.

United States Bureau of the Census (2000). census of population, general population characteristics, Cleveland, Ohio, Summary File (SF1). Available at http://factfinder.census.gov.

Wang, C. (2003). Using photovoice as a participatory assessment and issue selection tool: A case study with the homeless in Ann Arbor. In M. Minkler & N. Wallerstein (Eds.), *Community-based participatory research for health* (pp. 180–196). San Francisco: Jossey-Bass.

Wang, C. C. (2006). Youth participation in photovoice as a strategy for community change. *Journal of Community Practice, 14*(1), 147–161.

Wang, C. C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior, 24*(3), 369–387.

Wang, C. C., Cash, J. L., & Powers, L. S. (2000). Who knows the streets as well as the homeless? Promoting personal and community action through photovoice. *Health Promotion Practice, 1*(1), 81–89.

Wang, C. C., Morrel-Samuels, S., Hutchison, P. M., Bell, L., & Pestronik, R. M. (2004). Flint photovoice: Community building among youths, adults, and policymakers. *American Journal of Public Health, 94*(6), 911–913.

Webster, B. H., Jr., & Bishaw, A. (2006). American community survey reports, ACS-02, income, earnings, and poverty data from the 2005 American Community Survey. Washington, DC: United States Bureau of the Census. Retrieved May 27, 2007, from http://www.census.gov/prod/2006pubs/acs-02.pdf.

Weiser, J. (2001). Photography techniques: Using clients' personal snapshots and family photos as counseling and therapy tools. *Afterimage, 29*(3), 10–15.

Weiser, J. (1988). Phototherapy: Using snapshots and photo-interaction in therapy with youth. In C. Schaefer (Ed.), *Innovative interventions in child and adolescent therapy*. New York: Wiley.

Wolf, R. (1978). The use of instant photography in creative expressive therapy: An integrative case study. *Art Psychotherapy, 5*, 81–91.

Yohani, S. C. (2008). Creating an ecology of hope: Arts-based interventions with refugee children. *Child and Adolescent Social Work Journal, 25*, 309–323.

Chapter 6
Understanding Clients with Alternative Expressions of Sexuality Using Music

Meghan Hinman

It can be a large undertaking for a therapist to begin treating issues in our clients that relate directly to sex because, as Americans, we live in a society that is uncomfortable with the topic of sex. Think about the way that our social mores and legal ordinances treat nudity and sexual expression (outside of traditional gender roles); consider the "acceptable" portrayals of sex and nudity in film (especially as compared to portrayals of violence); recall recent and ongoing political debates about sex education, contraception, and abstinence. As a culture and as individuals, we are generally not comfortable with sexuality. Our mainstream media uses sex to sell and to feed jokes in sitcoms—but it is a very different thing to sit down and have a frank conversation about how a person expresses his or her sexuality, acknowledging nudity, body fluids, physical pleasure, vulnerability, and everything else that sexuality implies.

Yet, as therapists, we must work through the cultural discomfort with this fundamental aspect of the human experience. Despite any cultural discomfort, sex is an essential part of human life and fundamental to general well-being (Arrington, Cofrancesco, & Wu, 2004; Bancroft, 1998; Ryan & Jetha, 2010). Clients come to see us, and we aspire to create the therapy space as one of acceptance and growth. It is not necessarily easy to make room for sexual content. When we do so, we are potentially opening the door to ways of being, thinking, and pursuing pleasure that fall outside of our comfort zones.

This chapter addresses work with clients who have alternative expressions of sexuality, but it is worthwhile to begin by considering what "alternative" might mean. Is there a "normal" sexuality? John Bancroft, a former director of the Kinsey Institute, tells us that Alfred Kinsey, still one of the most influential sex researchers in history, avoided use of the construct of normality. On the contrary, Kinsey strived for greater understanding and tolerance of sexuality that may be judged as abnormal (Bancroft, 1998).

M. Hinman, M.A., MT-BC, LCAT (✉)
e-mail: meghan.hinman@gmail.com

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3_6,

Kinsey's studies suggested that normality, at least in the 1950s, was established by the religious morality of upper social classes—a subjective measure to be sure (Bancroft, 1998). Over time, the measure of what is "normal" in the bedroom has drastically evolved. Sex acts that many Americans take for granted as normal and healthy have been, and in some states still are, prohibited by law. In 2003, the Supreme Court ruled that sodomy laws were unconstitutional (*Lawrence v. Texas*); prior to that decision, they existed in Alabama, Florida, Idaho, Louisiana, Mississippi, Oklahoma, Texas, Utah, and Virginia (http://glapn.org/sodomylaws/usa/usa.htm). However, despite the Supreme Court's decision, Virginia keeps some sodomy laws on the books, defining oral and anal sex as "crimes against nature" and classifying them as a class 6 felony (VA Code Ann. § 18.2–361 (2005)). Another Virginia statute, on the books until 2005, decreed that anyone who consensually engaged in sexual intercourse outside of marriage was guilty of a class 4 misdemeanor (Va. Code Ann. § 18.2–344 (1950)). Cohabiting without marriage is also currently illegal in Virginia (VA Code Ann. § 18.2–345 (1975)). Through these types of laws, state and national legislative systems attempt to establish sexual normality, but a glance at how the statutes have changed in just the last 10 years, and their variation from state to state reinforces the problematic nature of trying to define and enforce sexual normality.

And where does music fit in? Certainly, we can easily pinpoint the connections between music and sexuality. But they go far beyond the famous phrase, "sex, drugs, and rock 'n' roll." Music connects us to our bodies. Helping a client to slow down enough to tune in to the pulse, rhythm, and melodic contour of a particular piece of music also means helping them to tune in to the rhythm of their own heartbeat and body processes, perhaps in a completely different way than they ever have before, sexual freedoms and repressions aside. The contextual, relatable aspects of music—particularly through lyrics—are equally valuable. Music is always a powerful tool in the therapeutic space, but it can take on a particular relevance when working with concerns that relate to the body.

Explaining Alternative Sexuality

When I refer to alternative expressions of sexuality, I am thinking of sexual identities that manifest outside of mainstream understandings of how and in what context sexual pleasure should be obtained. There are many practices that could fit into such a descriptor depending on who is defining "mainstream"; however, for the purposes of this chapter, I will be addressing therapeutic work with members of what is sometimes referred to as the "kink" community and more specifically the areas of BDSM, fetish, and polyamory.

The acronym BDSM is designed to encompass several areas of what is and has been referred to as sadomasochism or SM, defined by Moser and Kleinplatz (2007, p. 35) as "a variety of sexual behaviours that have an implicit or explicit power differential as a significant aspect of the erotic interaction." Specifically, the letters in BDSM refer to bondage and discipline, dominance and submission, and sadism and

masochism. Practitioners of BDSM may be attracted to the sensory experience in interaction (including visual aesthetic and physical touch sensations), the emotional experience of giving up or taking control, or both. Roles are important in BDSM—an individual may assume the dominant role or the submissive role, or he or she may identify as a "switch"—a person who can and will play either role depending on the situation (Connolly, 2006; Kleinplatz & Moser, 2005; Moser & Kleinplatz, 2007; Powers, 2007).

A client who participates in BDSM may be exploring a variety of activities. There are various types of "impact play," in which one player strikes the other with his/her hand or various types of implements. For some, the administration of a prenegotiated, controlled pain experience appears to stimulate a feeling of pleasure, which is sometimes attributed to the body's natural endorphin response (Langdridge, 2007). Bondage can mean something as simple as restraining one partner's wrists during sex, or it can involve extravagant equipment. Bondage enthusiasts report a feeling of security in the containment (if they are the one being bound) and/or satisfaction and gratification at the feeling of control and power. The emotional aspects of play with dominance and submission can take many forms, usually through some kind of role play. The dominant partner gives instructions or initiates experiences that the submissive partner consents to submit to. Often, these role plays explore intense aspects of the human experience that would not be acceptable outside of the safe, consensual, prenegotiated play space, including exploitation, objectification, *simulated* anger/fear, rape, abuse, humiliation, torture, etc. For a more complete discussion of the roles, nomenclature, and general themes present in BDSM play, readers should see Moser and Kleinplatz (2007).

Fetishists are another group within the kink community. Although DSM-IV-TR defines a fetish as an erotic attachment to an inanimate object, it is my experience that many clients will use the word "fetish" to refer to any activity, object, or idea that evokes a strong sexual interest. (Many fetishists and sex-positive therapists also object to the listing of fetishism as a disorder.) Therefore, you might meet a client with a foot fetish, a leather fetish, a latex fetish, a spanking fetish, etc. There are large communities of leather and latex fetishists who socialize together in "fetish gear," sometimes with sexual play involved and sometimes not.

Polyamory is the third subgroup of the kink community that I would like to mention. Those who identify as polyamorous (or "poly") feel that they are best suited to partner with more than one person. Polyamory can take many forms and is called by many names (nonmonogamy, open relationship, swinging). A polyamorous individual may choose to have one primary partner with whom the pursuit of additional sexual/love interests is negotiated. Others may choose to have numerous loving sexual relationships without making any one relationship primary. In other situations, three or more adults may choose to pursue a relationship together, with commitment arrangements varying along a spectrum, similar to traditional couples but involving more than two people (Peters, 1996; Ryan & Jetha, 2010).

A client who is kinky may identify with one, two, or all three of these subgroups, or they may identify with none of them. There are polyamorous couples who have no interest in BDSM or fetish, and there are strictly monogamous couples and

individuals who practice BDSM and/or identify as fetishists. Within each subgroup, therapists will likely find wide variation from client to client in terms of how they identify and ascribe meaning to their sexuality.

It is valuable for therapists to be informed about this population, which I have mixed feelings about referring to as a "population" at all—the kink community is simply a group of adults with common interests, just like any other. As a group, I believe that they have more in common with other adults in general than with each other specifically. Many individuals who identify as having an alternative sexuality would not identify themselves as part of a kink community and/or would not want to be grouped with other kinky folks. There are varying degrees to which practitioners of alternative lifestyles connect their sexuality to their identity (Yost, 2010). However, there are some likely clinical commonalities that are important for therapists to be aware of.

First and most importantly, people with alternative expressions of sexuality often have sensitivity around the ways that they are "different" and the resulting shame that comes with any stigmatized behavior. Goffman (1963, p. 5) describes a stigma as "an undesired differentness from what we had anticipated." I believe that the shame is magnified for kinky adults because in their case the stigmatized behavior is also a sexual behavior. Our culture's discomfort with sex has an amplifying effect on the existing feeling of "differentness." Many kinky people have been fantasizing about their particular expression of sexuality since they were too young to identify the fantasies as sexual (Powers, 2007). It is, thus, a core part of the identity. Through media cues, negative outcomes with sexual partners and other life experiences, defensiveness and shame can become connected to that sexual identity.

It is thus essential that therapists approach any discussion of sexuality (with any client—not just those who have already identified themselves as kinky) with an open, accepting, and firmly nonjudgmental stance. Alternative expressions of sexuality have been pathologized by the mental health community for decades (note the paraphilias in the *DSM-IV-TR*), and many clients are suspicious and even fearful at the prospect of discussing sex with their therapists as a result. In my own work, I have come across clients who believed that if they told a closed-minded therapist about their sexual interests, they could be involuntarily committed to inpatient psychiatric treatment. The psychotherapy community has some work to do in terms of building trust with this group.

In their essay, "Is SM Pathological?" (2007), Kleinplatz and Moser explore the listing of sadism and masochism as sexual disorders in the *DSM-IV-TR* and *ICD-10* (American Psychiatric Association, 2000). For example, according to the DSM-IV-TR, several disorders (sadism, voyeurism, exhibitionism, etc.) can be diagnosed if a person has certain sexual urges, *and* the urges are being enacted upon others who do not consent. Certainly, we can agree that hurting others without their consent would be pathological behavior, but I believe there are other diagnoses (such as antisocial personality disorder) that may be more appropriate in many of these circumstances. Pathologizing a sexual minority simply adds to the social stigmatization experienced by that minority, which then contributes to the "distress" that is another criterion of diagnosis.

Yost (2010, p. 80) notes that "some negative public perception of SM may be due to the fact that sadism and masochism are diagnosable disorders." I agree that the

decrees of the psychiatric community affect the attitudes of the public, contributing to societal stigma. That stigma, in turn, has a profound negative effect on the stigmatized group. Goffman (1963, p. 5) addresses the space between a stigmatized person and the "normal" society with this passage:

> By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents… We tend to impute a wide range of imperfections on the basis of the original one….

This quote reminds me of the excruciating pain that I know can come with a stigmatized behavior, and it highlights so much of how we see alternative sexuality portrayed in our culture. When it is represented on television, the character with alternative sexuality is often a murderer, a Satan worshipper, or a sociopath (Barker, 2007; Yost, 2010). Our own *Diagnostic and Statistic Manual* holds our stigma theory, exacting just what it is about a person with an alternative sexuality that makes them pathological. And these societal choices affect the adults that we may eventually be treating in our psychotherapy practices.

As trained therapists, we know that any expression of sexuality between consenting adults that contributes to intimacy, connection, and mutual pleasure is healthy. Kinky sex is no more likely to violate those criteria than traditional sexual activity. Sexual behaviors that involve physical pain or that play with other painful aspects of the human experience may evoke associations with violence, but just as the difference between healthy intercourse and rape is consent, the difference between BDSM and violence is consent. Furthermore, the themes of dominance and submission are present in the everyday lives of all human beings. Easton (2007) cites a phrase she has heard, stating that BDSM is "power play for fun rather than profit." Our society tends not to pathologize the business person who purposely inspires fear in his junior associates or the police officer who overenthusiastically takes down the suspect. As therapists, we need to understand that there is no more pathology in a client who enacts these themes in his or her bedroom than in one who does so for his or her socially acceptable livelihood. And we have to be ready to communicate that understanding to our clients when needed.

In the last 60 years, numerous writers have identified various types of pathology that they claim can be associated with alternative sexualities, including anxiety, depression, obsessions, PTSD, and borderline personality disorder. However, many of these studies have been evaluated by other researchers and critiqued as nonempirical, hypothetical, and often based on single-case studies (Connolly, 2006; Kleinplatz & Moser, 2005). In my experience, clients with alternative expressions of sexuality have the same range of issues that bring them to therapy as clients who do not identify themselves as having alternative sexuality: anxiety, depression, relationship issues, addictions, obsessions, and compulsions. Connolly (2006) surveyed a group of BDSM practitioners and found higher-than-average levels of histrionic features, narcissistic features, and nonspecific dissociative symptoms but no evidence of a higher prevalence of clinical disorders. In my experience, the only specialized issue that this group has is their sensitivity to judgment, although that is certainly the case for many if not all marginalized groups.

A commonality among members of this group that is potentially available to deepen the therapeutic process is their access to rich personal and sexual fantasies. If trust is established and the client does not fear the therapist's judgment, the content of fantasies and play scenarios can open doors to deep insight for therapist and client (Easton, 2007). Imagine a fetishist who feels safe enough to explain to the therapist his draw to the artificial, blemishless appearance of his partner in latex gear or a submissive woman who shares her fantasy of a dominant man who can "just know" what she might need in the bedroom and initiate the activity without her having to ask for it. The content and its meanings will always be unique to each individual, of course—but therapists and clients who can discuss these fantasies together may discover important themes and patterns that relate to the client's past experiences and reasons for pursuing therapy.

Assessing Safety

Assessing the physical and emotional safety of a client who participates in alternative expressions of sexuality can seem challenging at first. However, it is important to know that kinky people generally place a high value on consent and safety. A motto of the community is "safe, sane, consensual" (Powers, 2007). Because some types of play rely on the eroticism of feigned resistance, a "safe-word" is usually established to allow the submissive person to indicate that they need or would like for play to stop (Connolly, 2006; Easton, 2007; Kleinplatz & Moser, 2005; Moser & Kleinplatz, 2007; Powers, 2007). Of course, just like in any relationship, abusive and unsafe situations can happen, and relationships and emotions can be complicated. I have developed several lists of questions that therapists can use as a guide when assessing the safety of a client who participates in BDSM, fetish, or polyamory activities.

If you have a client who is participating in BDSM or fetish activities, the following questions can help to guide you in assessing his or her physical safety:

- Do you know enough about your activity partner to trust him/her to respect your limits and be attuned to your physical cues?
- Have you discussed your "limits" (areas or types of play that are not allowed) with your partner?
- Does the dominant partner have experience with the type of play that you are exploring?
- Do you have a safe-word?
- What other steps are you taking to assure that you remain physically safe and healthy during your play?

Emotional safety may be more complicated for clients to assess for themselves. Some clients derive great sexual pleasure and emotional release from experiencing difficult emotions in a controlled, eroticized environment with a cherished other. However, this can become unsafe if a client's emotional triggers or past traumas are activated during the play. An important aspect of emotionally safe BDSM play is

"aftercare," the practice of nurturance, cuddling, and debriefing after the play "scene" is completed. For some, aftercare can be the difference between a satisfying, connecting erotic experience and one that feels traumatic and hurtful. The following questions, in addition to those listed above, may be helpful when assessing a client's emotional safety during BDSM play:

- Do you and your partner practice aftercare?
- Are you and your partner aware of each other's history and emotional triggers?
- What would each of you do if one of you had a strong emotional reaction to your play?

Depending on the client's history of trauma and the stage of the therapy, the therapist may inquire about what specifically happens during BDSM scenarios so as to best assess what the client is experiencing and what, if anything, they might be reenacting. In some cases, such as with a client who is extremely traumatized, it may be worthwhile for the therapist to advise the client to avoid certain types of play. In my experience, BDSM enthusiasts are passionate about maintaining the truth of the "safe, sane, consensual" mantra and are often willing to make adjustments in order to abide by it.

If a client is exploring polyamory, there are different questions that are worthwhile for a therapist to ask to assess physical and emotional safety. Some of these questions include:

- What agreements have you made with your partner(s) about practicing safe sex and avoiding sexually transmitted infections?
- How were the terms of your relationship negotiated, and how do you feel about the final agreement?
- How do you communicate with each other about your sexual encounters with other people?
- How do you communicate with casual partners about the terms of your relationship?
- How do you and your partner(s) deal with jealousy when it arises, or how will you address such feelings if they come up?

Just as in monogamous couples, communication is essential for polyamorous unions. In a healthy polyamorous relationship, participants acknowledge and work through jealousy. In monogamous relationships, infidelity is typically experienced as a betrayal, and in polyamorous relationships there usually are still limits that the partners set together. Breaking these agreements can be an equivalent betrayal to infidelity in a monogamous relationship. In some polyamorous relationships, a couple allows each other to pursue outside sexual relationships but have a "don't ask, don't tell" policy. In other relationships, the agreement exists with the understanding that the partners will tell each other about what happened later. The important thing is that the partners have communicated about expectations and come to a mutually acceptable understanding, with room to renegotiate if needed.

A further note about assessing safety: it is worthwhile for any therapist who is working with sexuality to avoid assumptions that their clients are educated about

sex and its physiological processes or about sexual health. In my experience, adults with alternative expressions of sexuality are well versed in this information because they often interact with a kink community over the internet if not in person, and such topics come up in discussion. Their interest leads them to do more research, reading, and other pursuing of sexual information than other clients might. However, many adults in the general population are not adequately educated about sexuality, and this is important for therapists to consider.

Getting Comfortable with the Work

To work effectively with this population, it is important to begin by assessing your own comfort level with sexuality. This includes examining your knowledge base about sexuality in general (including anatomy, physiology, puberty, sexually transmitted infections, safe sex, and contraception), common sexual practices (vaginal intercourse, anal intercourse, fellatio, cunnilingus, petting, masturbation), and common sexuality concerns (sexual dysfunction, sexual compatibility between couples, sexual fantasies), in the context of both heterosexual and homosexual individuals/couples. Clients often expect that therapists (and other health professionals) will be knowledgeable about sexuality, and professionals also believe that this is important, but frequently that is not the case (Harris & Hays, 2008; Weerakoon, 2008).

Knowledge contributes to a therapist's comfort level with sexuality, but it is not the only consideration. Knowledge alone is not enough to prepare a therapist for work with sexuality—a therapist must also be able to tolerate his or her own anxiety relating to sexual issues, whether those sexual issues belong to the therapist or the client (Harris & Hays, 2008). This anxiety may be magnified in some therapists when working with adults with alternative expressions of sexuality, due to media and societal messages about "perverts" or discomfort with some of the intense themes present in alternative sexual play (Barker, 2007).

It is important for therapists to consider any experiences they may have had that contribute to their attitudes about sexuality, including personal experiences with abuse as well as past clinical work with sexual offenders or victims. Working with adults with alternative sexuality is not the same thing as working with abusers or victims, but it is possible that some themes may recur in the context of pleasure rather than victimization. The effective therapist must be able to maintain awareness of their possible reaction to these themes and their juxtaposition with fantasy and sexuality.

Working with a client who is part of a polyamorous relationship may also be difficult for some therapists. It is important to be aware of your own feelings about monogamy, jealousy, and infidelity. A colleague of mine worked with a woman who was involved in a polyamorous triangle with a married heterosexual couple. In therapy, this woman disclosed a variety of experiences, positive and negative, that she went through in her relationship. My colleague eventually became convinced that the wife in the married couple was being coerced into the polyamorous relationship by her husband, and began to think obsessively about this wife, even outside of

sessions with her client. In sessions, she would talk to her client about how women who let their men have sex outside of the marriage were really doing so because they were being abused. Eventually, my colleague realized how much she was alienating her client by focusing on this other woman and disregarding information her client had given her about the consensual agreement among the three of them. She was responding less to the issues of her own client and more to what she related to in her perceived picture of the wife. By this point, though, she had seriously damaged her client's trust and the feeling of safety in the therapy room.

Supervision becomes essential when working with sexuality and, in particular, when beginning work with adults with alternative expressions of sexuality. Harris and Hays (2008) found that a combination of sexuality education and supervision increases therapists' comfort level and ability to engage effectively in sexuality discussions.

It is easier to find educational opportunities and supervision that pertain to sexuality in general than it is to find the same resources that deal specifically with alternative sexuality. However, there are a few online resources that therapists can explore to enrich their knowledge and comfort level with this topic.

The National Coalition for Sexual Freedom (NCSFreedom.org) is "committed to creating a political, legal and social environment in the US that advances equal rights for consenting adults who engage in alternative sexual and relationship expressions." Their website has a wealth of information about alternative sexuality, including the KAP list, which is a directory of "kink-aware professionals." The list includes therapists, doctors, accountants, lawyers, and other professionals and may be an effective way to locate a therapist who can provide supervision for working with adults with alternative expressions of sexuality.

The Community-Academic Consortium for Research on Alternative Sexualities, or CARAS (carasresearch.org), has an endeavor called the BDSM and Therapy Project, which provides training videos for counselors and therapists addressing "culturally competent care when working with clients who express BDSM sexuality." The BDSM and Therapy Project also works with the BDSM community to help them become educated consumers of psychotherapy and receive quality services when they are needed. CARAS is a general informative resource about alternative sexuality, and its board reviews and highlights research projects related to this topic.

Education and support networks developed for practitioners of alternative sexuality are another possible source of information. In San Francisco, the Society of Janus (soj.org) provides a locus of information, support, and sex-oriented classes for its members and the community. In New York, the Eulenspiegel Society (tes.org) focuses on providing safe spaces for adults with alternative sexualities and provides support meetings and classes. FetLife (fetlife.com), an online network that serves individuals in the alternative sexuality community all over the world, is a third possible resource for general information about alternative sexuality. FetLife is similar to Facebook but designed specifically for this community. Members can make "friends," designate who they are in a relationship with, share pictures and status updates, create and join groups, and contribute to online discussions. All three of these organizations make confidentiality and safety a priority and seem to have great respect from their members for that consideration.

Using Music

The case for music therapy as a clinical intervention has been made repeatedly and in a variety of contexts (including Aldridge, 1989; Austin, 2008; Nordoff & Robbins, 1971; Robarts, 1994; Wheeler, 2008). In practicing individual psychotherapy with adults, I have found that music helps my clients to feel more grounded and connected to themselves. It gives them a means of expressing the emotions and experiences that they do not have words for. Sometimes, using music can be frightening—a step outside of the comfort zone—but often my clients experience it as nurturing, empowering, and profound in its ability to facilitate intimacy and rapport.

In *Psychology of the Arts* (1972), Kreitler and Kreitler note that it is the elements of tension and release, central aspects to the human experience, that make all art forms so emotionally moving to human beings. Music "induces in the open-eared and openhearted listener a continuous cycle of expectation, disappointment, surprise, and fulfillment. It is this phenomenon which makes the emotional impact of a musical experience so powerful and its verbal description so difficult" (Kreitler & Kreitler, 1972, p. 144). In other words, music mimics the human experience. What would make for a better tool for self-exploration, insight, and understanding?

Robarts (1994) points out the role of sound, and a kind of musical interplay, between infants and their early caregivers, or "early musical introjects." Infants are aware of their mothers' presence (or absence) because of that musical interplay, and music therefore becomes an important element of how human beings relate to each other. Numerous authors (including Aldridge, 1989; Austin, 2008; Newham, 1998; Nordoff & Robbins, 1971; Priestley, 1994; Robarts, 1994) have pointed to a client's musicking as a source of diagnostic information as well as (within the context of a therapeutic relationship) a path toward growth and change.

I believe that the contextual meanings that humans bring to music are equally as powerful as its inherently moving qualities. Most humans have powerful associations with music as they relate to various times of life, important relationships, and personal struggles and triumphs. This also makes music a powerful tool for therapy, as the recollection of memories can bring greater self-understanding, and the elicitation of feelings can provide release and relief (Austin, 2008).

Furthermore, music is felt in the body (Austin, 2008; Goodill, 2009; Robarts, 1994). Creating music requires bodily engagement, including the use of breath and voluntary muscle groups. Being in the body means coming closer to physical sensations and emotions, which are so often the key to healing. When concerns relating to sexuality are on the table, understanding and working with the body take on new significance.

In adults who have alternate expressions of sexuality and may therefore have lived with feelings of stigma, exclusion, and shame, music can be an equalizer and a connection with humanity. Song lyrics can and do encapsulate the experience of those feelings and many others, giving individuals who may have felt isolated a voice to relate to. Many of the themes that are present in the sexual play previously

discussed in this chapter (dominance, submission, control, surrender, sexualization) are explored in popular music, which provides both a normalizing feeling and a discussion point from which to learn more.

Getting Comfortable Using Music

Social workers can use music as part of their practice with great success. Music therapists have specific training for interacting with clients within the music and for using it with a range of client populations, but music can be used therapeutically by social workers in a manner that focuses more on the social worker's therapeutic skills and the inherent healing qualities of music without crossing out of his or her scope of practice.

If you have never had musical training, you may be intimidated by the prospect of using music as a therapeutic tool. By the same token, those who *have* had musical training may be equally intimidated due to their exposure to musical pedagogy and its accompanying judgments about an expected quality of musical performance, music theory understanding, or "appropriate" musical genres. This feeling of intimidation is a wonderful place to begin as you consider using music in your practice because most clients will approach the idea of using music in a clinical situation with similar feelings of trepidation for the exact same reasons.

In order to use music effectively in clinical practice, it is important to connect with the idea of music as an essential aspect of the human experience. Music has existed in every known culture since the dawn of humanity (Wheeler, 2008). When we use music in therapy, we are tapping into a profound locus of human expression. The purpose of this modality is not about creating, experiencing, or interpreting music in a "correct" way but feeling the authenticity of what is spontaneously elicited with music—sounds, images, emotions, body sensations, memories, and more.

You can observe this approach to music in young children, who will often create music spontaneously, with improvised songs and dances that emerge as a natural expression of creativity (Hargreaves, 1996). One way to increase your comfort level with using music in the therapeutic space is to emulate this unselfconscious approach on your own. Try simply vocalizing, not to create a song or cohesive piece of music but to express yourself with tones and rhythms, and words too if you so choose. If you already play an instrument, sit down and try a free improvisation, with no goal other than experiencing spontaneous expression of sound.

Breathing is an important part of creating music, especially when using the voice, and an important way to increase your comfort level with music is to practice breathing every day (Austin, 2008). Pick a regular time each day, perhaps first thing in the morning or right before bed, and for 5–10 min, lie down flat on your back, with your whole body supported. Put one hand on your stomach so you can feel your diaphragm expand as you breathe in, and contract again as you exhale. Breathe slowly and deeply. When you feel ready, you can begin to make a sound as part of your

exhale. Continue the slow cycle of deep breathing, and make a sound—any vocal sound—each time that you breathe out.

You can also increase your comfort level with using music in the therapy room by connecting more with your own favorite music. Put on a recording of your favorite song, and sing along with it. Breathe deeply as you sing, and feel the effect of the music on your mind and body. You can also pay attention to recorded music or songs that feel meaningful to you, or that get stuck in your head, and use them as a tool to look inward at your own feelings, wounds, conflicts, and attitudes. Start a journal in which you write down any songs that feel meaningful, and examine how they may be relevant to your personal journey. Notice your reaction to the music's tempo and to the sound textures that you hear in the song. Then look carefully at any lyrics, noticing which ones catch your attention and which ones elicit an emotional reaction. Journal about any images, memories, or insights that emerge to you during this process.

If you can feel comfortable creating and being with music without judgment, you can help your clients to do the same thing. Be ready to address self-judgment when the topic of music is initiated. Many adults remember a school music teacher who told them to "mouth the lyrics" instead of singing during a school choral concert, or some other early negative experience that left them feeling musically deficient. You may need to provide some reassurances. I like to tell my clients, "This is music for your heart and soul." The music you create or interact with in session needs to be fully divorced from the American Idol-type judgment process and evaluation criteria.

A therapist who uses music in psychotherapy must also be aware of the potential potency of this modality and careful about how and when music is used. Music can have a wonderfully positive effect, but it also has the potential to cause harm, like any other powerful tool. Before using music, it is important to realize its ability to evoke intense feelings in clients—feelings sometimes more intense and overwhelming than the client is ready to experience (Austin, 2008). For some music interventions with some clients, you will want to assess how grounded and, conversely, how fragile the client is on a given day before initiating a music intervention.

Music Interventions

Tuning in to the Speaking Voice

Austin (2008, p. 32) writes about "the music in the speaking voice" and how tuning in to a client's speaking voice, and working with it using breath, can provide important information for a therapist and assist in effective treatment. As a music psychotherapist, Austin understands and explains the voice in musical terms.

When attending to a client's speaking voice, it is worthwhile to tune in to the client's tempo, or the speed/pace at which he or she speaks. Consider dynamics, or the loudness and/or softness of the speaking voice. Phrasing can be assessed by noticing changes in intensity over the course of a sentence, whether the client tends

to cut herself off a lot, if there is a smooth or legato quality as she speaks, or if her words are staccato (short and separated). Melody is often apparent as well: Do his sentences tend to lead downward in tone as he talks, or do they curve upward as if every statement is a question? Also be aware of the tone quality of the speaking voice. Is it relaxed, breathy, constrained, nasal, pinched?

There is no pat, interpretation guide for understanding the music in the speaking voice. A therapist must simply tune in to the information, consider potential symbolic meanings, and combine them with knowledge about the client and clinical intuition.

To work with the speaking voice, breath work is a valuable tool. When clients breathe deeply, they develop a greater connection to their body and their emotions (Austin, 2008; Goodill, 2009). To use the voice as part of breath work, have the client make a sound as he or she exhales. When I use this technique, I usually breathe with the client to provide a model for how to use the sound and remain open to whatever feels best. One time, a client laughed and told me that she had been focusing on making the "right" kind of exhaling sound, as learned in her yoga class—not too loud, staying within a certain vocal range, and fairly short-lived so as not to take up too much time. Hearing me exhale loudly, going up and then down through my vocal range, made her smile and feel more free to be expressive in the sounds that she was making.

Vignette: Jack

Jack is a professional man in his late 30s who came to therapy for support with what he identified as envy and rage. Although his sexuality had been oriented toward BDSM since he first discovered that it existed, he was engaged to a woman who was not interested in BDSM and had "no libido." After a conversation between the two of them in which he explained how important his sexuality was to him and she indicated that she was unable to express her own sexuality, she gave him permission to pursue experiences without her. Yet, he had never been able to persuade himself to attend social events or public play events. Instead, he would stay home and seethe about what he was missing out on. He felt so overwhelmed by these feelings that he decided that he needed to seek support.

In time, I learned to see Jack as very expressive, but especially in the beginning of our work together, his voice seemed constrained and nasal, as if he were always holding on to something. He was also extremely intelligent and tuned in to an intellectual understanding of himself. What he was not able to do was tune in to his body. When I asked him to breathe, he almost seemed to ignore me. When I asked him what he felt, he would respond by telling me a story instead of identifying an emotion. When I asked him to pause, he would barely rest a moment before continuing on.

Eventually, about a month into our work, I insisted that Jack stop talking and breathe with me. After a few breaths, he was able to identify a tightness across his chest and shoulders. We breathed together, and I asked him to make a sound when he exhaled, modeling the behavior by doing it myself first. Jack's face welled with emotion, and he told me that he felt like he was experiencing the breaking of a dam. He identified feeling like a martyr, as he believes his mother had behaved, putting aside all of his own feelings so that his partner would be okay. Together, we continued to work with this new information.

Using Instruments

Small percussion instruments (including maracas, hand drums, small xylophones, tone blocks, rain sticks, etc.) can be useful in a therapy session not only for playing music but also for the subjective interpretations that can be made about their sounds and the symbolic meanings that can be ascribed to their sounds, visual appearances, or textural qualities. Clients may have associations with the sounds that an instrument makes, or potentially with the instrument itself, that can provide information and contribute to the therapeutic process (Bruscia, 1987; Priestley, 1994).

Drumming is utilized by many mental health professionals, including music therapists, to reach a variety of therapeutic goals (Crowe, 2004; Longhofer & Floersch, 1993; Winkelman, 2003;). Drumming can be empowering and grounding and can facilitate connection to self and other (Austin, 2008).

Vignette: Melanie and Victor

Melanie and Victor are a couple in their mid-30s who came to see me for help with their sex life. When they first started therapy, they had had sex once in the last 6 months, and they were both frustrated, dismayed, and worried about the health of their relationship, which had never been sexually satisfying for either of them. They chose to pursue therapy with me specifically because of my use of music. They felt that they had already discussed their problem too much, and that they needed to stop using words and going around in circles.

In an early session, I invited them to explore the variety of percussion instruments that I have in my office, and to each choose one that they would like to play. The most interesting thing about this exercise was Melanie's choice of the rain stick and what she had to say about it. After playing the instrument for a little bit, she commented, "I really do like the rain stick, and I find them relaxing, but as I listened to myself playing I realized that it does have a harsh sound. And I think sometimes I can be harsh." A discussion was stimulated about Melanie's tendency to blame Victor for their sexual difficulties, and he was able to tell her, for the first time, how much her criticism affected his ability to initiate and enjoy sex.

Vignette: Nathan

Nathan is a professional, a husband, and a father in his late 30s. He came to therapy in an effort to figure out whether his sexual interests were getting out of hand. He had many fetishes and other alternative sexual interests, but his problem was that he sometimes was unable to be in a room with a woman without thinking sexual thoughts, to the point of losing his ability to concentrate on anything else. He was at the beginning stages of identifying a sex addiction.

Learning more about Nathan was challenging because he was very distrustful and concerned about revealing personal information to me. Gradually he opened up more and more. One of the first things that we identified together was his compartmentalization of his life into three spheres that did not intersect with each other: home, work, and sex.

Nathan had many stages of exploration and recovery ahead of him, but one of the things we worked on in early therapy was exploring those three compartmentalized

lives and three compartmentalized selves. I asked him to choose an instrument from those available in the office to represent the three areas of his life. He explored the various sounds available and then made his choices. He picked a cabasa (a Latin American instrument, played by rubbing or shaking so that metal beads slide across a textured surface) to represent his home life, smiling as he commented, "With three little kids, it's always chaos there!" To represent work, he chose a guiro (another Latin American instrument, played by rubbing a stick along a textured surface) and said, "Also chaos… but in a completely different way. It gnaws at you—but it's still good." For his sexual life, he chose the drum. He told me that he knew the drum was the only instrument that could represent this part, because it was like a low drumbeat, always present underneath everything else. These insights about his compartmentalized life represented Nathan's first steps on the road to understanding his feelings, the way he used sex to "check out" from difficult feelings, and what he truly wanted for his life.

As therapy continued, Nathan and I worked together with drumming. I found that it was difficult for him to tolerate the intimacy of playing music together (this was no surprise). When he did play the drum, he had a tendency to dissociate during the music, repeating one particular rhythm over and over and entering a sort of trance-like state, unconnected to the room, me, or even himself. This became a powerful metaphor in Nathan's process as he examined why and how he dissociated himself from the here and now and what he could do to tolerate more presence and relationship.

Music Listening

Soothing music for relaxation during tense moments is a simple way to integrate music into psychotherapeutic practice. If you do not play an instrument yourself, you can use recorded music. Many genres may be appropriate, though it is best to choose something with a slow tempo and without lyrics. Folk melodies and simple classical music (fewer instruments, a melody that is not complex) are often good choices for facilitating a supportive, relaxed atmosphere.

Lingham and Theorell (2009) found that self-selected stimulative music resulted in aroused physiological responses (including increased heart and respiratory rates) and feelings of joy in their study sample. Self-selected sedative music had a less predictable response, but it did induce both aroused and sedative emotions. Many other authors (including Austin, 2008; Krout, 2007; Robb, 2000; Wheeler, 2008) have addressed the benefits of music listening as a means of achieving relaxation in a variety of treatment environments.

Vignette: Melanie and Victor

Several months into therapy, Melanie and Victor found out that they were pregnant. They were excited, but overwhelmed. They were not planning to have children for several more years, and they were not financially prepared. When they came in to see me, the anxiety of each of them was palpable. Melanie was worried about miscarrying, which several of her friends had experienced with early pregnancies, along with her general anxiety about the life changes ahead. On top of that, she

was feeling extremely physically ill. Victor was clearly the more excited of the two, but he was worried about Melanie's lack of enthusiasm. Both of them expressed fears that now they would never be able to overcome the issues with their sex life. Although they had made tremendous strides, they had concerns about the sustainability of the changes that they had already made.

As they talked about all the anxieties they were each holding and Melanie looked increasingly nauseous, I realized that it was important to provide a nurturing intervention to offer some relief for the rising anxiety level in each of them. I took out my guitar, asked each of them to sit back comfortably and close their eyes, breathing deeply. I talked them both through a few slow breaths, and then I began to play soft chords and hum a soothing melody. After a few minutes of music, I stopped playing and both clients appeared more relaxed and grounded. Additionally, they both shared imagery scenes that came to them as they listened: for Melanie, a loving scene of their new family taking a walk around the neighborhood together; for Victor, a romantic picnic for just the two of them, both feeling happy and relaxed.

Spontaneous Song Recall

Unconsciously induced song recall, or having a song "get stuck in your head," is one easy yet powerful musical intervention. Many psychodynamic therapists, including Freud and Jung, have written about the psychological significance and potency of musical pieces (instrumental or vocal) that suddenly become part of our consciousness (Diaz de Chumaceiro, 1998). Asking your client to pay attention to music that sticks with them and to bring these pieces in to discuss in therapy can be extremely valuable for the therapy process.

To work with a song, have the client bring in a recording of the music, and have the text of any lyrics on hand. It is important to work with the exact version or recording of the song that the client relates to (Loewy, 2002). When you listen to the piece together, take in the overall mood and sound first. Let yourself respond to the tempo, dynamics, textures, and harmonic changes, and see what you both notice.

You can then go on to discuss the potential meanings within the lyrics. Lyric discussion is a frequently utilized technique in music therapy (Bruscia, 1998). Clients will often be able to tell you immediately what they are able to relate to in the song lyrics. If not, you can lead a discussion by asking them to point out lines or passages that catch their attention in either a positive or negative way. I have worked with some clients' songs in which the lyrics were extremely important and relevant to the clients' process, and in other cases the general themes of the song were more germane, with just a few lyrics that rang true to the client's current process. Lyric analysis in individual psychotherapy can, in my experience, be very similar to dream interpretation in both process and result.

Vignette: Lilliana

Lilliana is a married, professional woman in her late 20s. She and her husband have an arrangement in which she is encouraged to pursue sexual relationships

with other men. She uses this opportunity to explore her interest in BDSM, which her husband does not share, and maintains a long-distance relationship with an older, married man in another state. In their relationship, she plays the submissive role, and the married man is dominant. Because most of their interactions take place over the phone or internet, their sexual connection is explored through shared fantasies of abuse, objectification, control, and rough sex. Their relationship vacillates between extreme highs, where their thoughts and feelings seem completely in synch, and extreme lows, where he becomes distant and rejecting and Lilliana spirals into panic and depression. Lilliana came to the therapy with the intention of learning to understand more about herself and her difficult relationship patterns. I suggested that she pay attention to songs that became spontaneously "stuck in her head," and several weeks later, she brought me a song by Ani DiFranco entitled "Loom," which had been with her for a full week.

The first thing that I noticed about "Loom" when she played it for me was the intense, quick, almost manic-sounding guitar part. To me, it seemed reminiscent of the qualities of her relationship. Quickly Lilliana and I together tuned in to the lyrics. They describe a relationship with a married man in which the speaker is promising to "be nice" and behave well if the man will let his guard down and allow her to come physically and emotionally closer. Lilliana identified most with the line, "I wanted to take up lots of room, I wanted to loom." In the journaling about the song that she shared with me, she identified her pattern for sexual relationships: "Meet intimidating, smart, arrogant, Dom guy with lots of power. Seduce said guy. Attempt to get to level of closeness by baring soul, having no boundaries, being good, giving everything. Be passive aggressive, manipulative, darling, addictive. Attempt to wrap guy around finger. Then bang head against wall in frustration when he doesn't give me everything, complete access, all of it, like I wanted. Throw tantrums, get freaked out. Lather, rinse, repeat."

A closer look at this desire for no boundaries and its descriptions in the lyrics eventually led Lilliana to her mother, who never allowed Lil to have boundaries of her own. From early childhood, Lilliana's mother shared everything with her and expected the same in return. Her father was emotionally absent. Lilliana ended up feeling completely abandoned and unseen, lost in her mother's bottomless need, and craving her own boundaryless attention. With the married man, Lil experienced some of that boundaryless attention because of the complementarity of their sexual fantasies. But she was also repeating the heartache of that enmeshed closeness—the loss of her own sense of self. She often had a difficult time advocating for her needs in her relationships; she often resorted instead to manipulation tactics, the only way that she could communicate with her parents, instead of direct communication.

Over the next year, Lilliana explored her relationships with both of her parents and the conflicts that she had acted out with many men over the course of her life. She began to advocate for her needs more in both her marriage and her relationship with the married man.

Conclusion

Music is a powerful tool in working with adults with alternative expressions of sexuality. Its ability to engage the body along with the mind and to provide a different, sometimes less direct, path to insight makes it an obvious choice for use in a clinical setting. Numerous techniques are available to clinicians with varying levels of experience with the study of music.

Developing comfort with music techniques and sexuality content is essential for effective work using music with this population. Therapists who wish to work with this population have an obligation to become familiar and comfortable with their own relationship to sex and sexuality, as this self-awareness is key to helping any client to explore his or her own material. Techniques that utilize music can only be implemented successfully if the therapist has personal familiarity with the process of looking inward, relaxing the body, and discovering insight using music.

References

Aldridge, D. (1989). A phenomenological comparison of the organization of music and the self. *The Arts in Psychotherapy, 16*, 91–97.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: American Psychiatric Association.

Arrington, R., Cofrancesco, J., & Wu, A. W. (2004). Questionnaires to measure sexual quality of life. *Quality of Life Research, 13*(10), 1643–1658.

Austin, D. (2008). *The theory and practice of vocal psychotherapy: Songs of the self*. Philadelphia, PA: Jessica Kingsley Publishers.

Bancroft, J. (1998). *Alfred Kinsey's work 50 years later*. Retrieved September 15, 2011, from http://www.iub.edu/~kinsey/about/images/Intro%20to%20Female%20vol.pdf.

Barker, M. (2007). Developing a tool for training about SM. In D. Langdridge & M. Barker (Eds.), *Safe, sane and consensual: Contemporary perspectives on sadomasochism* (pp. 261–270). New York: Palgrave MacMillan.

Bruscia, K. E. (1987). *Improvisational models of music therapy*. Springfield, IL: Charles C. Thomas Publishing.

Bruscia, K. E. (1998). *Defining music therapy* (2nd ed.). Gilsum, NH: Barcelona Publishers.

Connolly, P. (2006). Psychological functioning of bondage/domination/sadomasochism (BDSM) practitioners. *Journal of Psychology and Human Sexuality, 18*(1), 79–120.

Crowe, B. (2004). *Music and soulmaking: Toward a new theory of music therapy*. Lanham, MD: Scarecrow Press, Inc.

Diaz de Chumaceiro, C. L. (1998). Unconsciously induced song recall: A historical perspective. In K. E. Bruscia (Ed.), *The dynamics of music psychotherapy* (pp. 335–364). Gilsum, NH: Barcelona Publishers.

Easton, D. (2007). Shadowplay: S/M journeys to our selves. In D. Langdridge & M. Barker (Eds.), *Safe, sane and consensual: Contemporary perspectives on sadomasochism* (pp. 217–228). New York: Palgrave MacMillan.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Simon and Schuster Inc.

Goodill, S. W. (2009). Breath: The constant dance. In R. Azoulay & J. Loewy (Eds.), *Music, the breath and health: Advances in integrative music therapy* (pp. 265–275). New York: Satchnote Press.

Hargreaves, D. (1996). The development of artistic and musical competence. In I. Deliege & J. Sloboda (Eds.), *Musical beginnings: Origins and development of musical competence*. New York: Oxford University Press.

Harris, S. M., & Hays, K. W. (2008). Family therapist comfort with and willingness to discuss client sexuality. *Journal of Marital and Family Therapy, 34*(2), 239–250.

Kleinplatz, P., & Moser, C. (2005). Is S/M pathological? *Lesbian and Gay Psychology Review, 6*(3), 255–260.

Kreitler, H., & Kreitler, S. (1972). *Psychology of the arts*. Durham, NC: Duke University Press.

Krout, R. E. (2007). Music listening to facilitate relaxation and promote wellness: Integrated aspects of our neurophysiological responses to music. *The Arts in Psychotherapy, 34*(2), 134–141.

Langdridge, D. (2007). Speaking the unspeakable: S/M and the eroticisation of pain. In D. Langdridge & M. Barker (Eds.), *Safe, sane and consensual: Contemporary perspectives on sadomasochism* (pp. 85–97). New York: Palgrave MacMillan.

Lingham, J., & Theorell, T. (2009). Self-selected 'favourite' stimulative and sedative music listening– how does familiar and preferred music listening affect the body? *Nordic Journal of Music Therapy, 18*(2), 150–166.

Loewy, J. (2002). Song sensitisation: How fragile we are. In J. Loewy & A. Frisch-Hara (Eds.), *Caring for the caregiver: The use of music and music therapy in grief and trauma*. Silver Spring, MD: AMTA.

Longhofer, J., & Floersch, J. (1993). African drumming and psychiatric rehabilitation. *Psychosocial Rehabilitation Journal, 16*(4), 3–10.

Moser, C., & Kleinplatz, P. (2007). Themes of SM expression. In D. Langdridge & M. Barker (Eds.), *Safe, sane and consensual: Contemporary perspectives on sadomasochism* (pp. 217–228). New York: Palgrave MacMillan.

Newham, P. (1998). *Therapeutic voicework: Principles and practice for the use of singing as a therapy*. Philadelphia: Jessica Kingsley Publishers.

Nordoff, P., & Robbins, C. (1971). *Therapy in music for handicapped children*. London: Golancz.

Peters, K. (1996). *Polyamoury 101: Consensual non-monogamy for the 21st century*. Retrieved October 22, 2011, from http://www.polyamoryonline.org/articles/polyamoury_101.html.

Powers, H. (2007). *Bias in psychotherapy with BDSM clients.* Master's thesis, California State University, Hayward, CA. Retrieved September 15, 2011, from http://www.heatherpowers.com/vitae.html.

Priestley, M. (1994). *Essays on analytical music therapy*. Phoenixville, PA: Barcelona Publishers.

Robb, S. L. (2000). Music assisted progressive muscle relaxation, progressive muscle relaxation, music listening, and silence: A comparison of relaxation techniques. *Journal of Music Therapy, 37*(1), 2–21.

Robarts, J. (1994). Towards autonomy and a sense of self: Music therapy and the individuation process in children and adolescents with early onset anorexia nervosa. In D. Dokter (Ed.), *Arts therapies and clients with eating disorders*. London: Jessica Kingsley Publishers.

Ryan, C., & Jetha, C. (2010). *Sex at dawn*. New York: HarperCollins.

Weerakoon, P. (2008). *On-line sexuality education and health professionals students' comfort in dealing with sexual issues*. Retrieved September 9, 2011, from http://hdl.handle.net/2123/5002.

Wheeler, B. (2008). Music therapy. In F. T. L. Leong, E. M. Altmaier, & B. D. Johnson (Eds.), *Encyclopedia of counseling* (Changes and challenges for counseling in the 21st century, Vol. 1, pp. 305–308). Thousand Oaks, CA: Sage Publications Inc.

Winkelman, M. (2003). Complementary therapy for addiction: "Drumming out drugs". *American Journal of Public Health, 93*(4), 647–651.

Yost, M. R. (2010). Development and validation of the attitudes about sadomasochism scale. *Journal of Sex Research, 47*(1), 79–91.

Chapter 7
Hearing Myself: Songs and Improvisation with Inner-City Adolescents Dealing with Sexual Abuse History

Mechelle Chestnut

Introduction

When I was in graduate school studying music therapy, music therapy with adolescents with emotional issues and popular music was exciting and interesting. There seemed to be very little of it discussed in the field's literature, and I found this peculiar—helping teens cope and find newer, healthier ways of relating with music just made sense to me. I could identify with the needs and the work somehow. Upon completion of classes, I saw an advertisement for a music therapist position in the Jersey City Public Schools—working with elementary and middle school children with developmental, emotional, and social issues. And summers off, health benefits, and pension! I took the interview with my hair back in a slick ponytail, wearing a very serious-looking black blazer that I had rushed out to buy the night before. My nervousness and lack of professional experience must have gotten the better of me because I did not get the job. And that turned out to be a wonderful thing.

I did in fact work in several hospitals after that with myriad populations and gained my requisites for applying for and receiving board certification and state licensure. So, a couple years after my first interview, I returned for another. This time, I had accumulated in the brief span of two years, much more experience professionally, had acquired certification and licensure, and had come to see that working in nonmedical environments was more my suit. I showed up formal but much more colorful and more *me* the second time through. I was excited; I had lots to say about my approach and my interests, and I was offered the job. That was in September. After 6 months of taking teacher certification tests and background checks, I finally showed up in a snowstorm in February for my first day.

After the staff settled in, I was brought to a room in the basement that had been empty because the teacher was on maternity leave. I set myself up, rearranged the

M. Chestnut, MA, MT-BC, LCAT (✉)
Jersey City Public Schools, 32 Windsor Place, Brooklyn, NY 11215, USA
e-mail: therapyinmusic@gmail.com

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3_7,

room, and made it as amenable as I could, considering I had only the keyboard and rhythm sticks the music teacher gave me. I did not know anyone, and I did not know which children to work with. I observed classes, the building, staff, and administrators. This school, a temporary placement for me, was K-8th grade. The middle schoolers intimidated me, so I focused on the elementary school-aged children. And before long, I received referrals, even for the final few months of school.

The following school year, I was sent to my original placement: a brand new middle school. The school is in a residential urban area. Most of the students qualify to receive free or reduced federal lunches due to low-income status. Once again, I knew no one, neither staff nor students. And no one at the school had received word that they would have a music therapist so my arrival was a surprise. During the nearly 5 years I have served at this facility, with the counseling staff and administration, I have cultivated a music therapy service that focuses on the emotional needs of children across educational levels: special, general, and gifted education. I pull students from their classes for individual therapy sessions, sometimes dyads. For some time, I was confused about my role and what I could give. The students displayed so many different needs: emotional, organizational, physical, academic, social, and behavioral. I found myself at times acting like a guidance counselor. At other times, I was more of an organizational coach, helping the students organize their book bags and lockers and folders. After a while, I made a decision that the students with all their needs will be okay if I give what I can give. And that is music therapy—songs, improvisation, recording, psychoeducation.

I have worked with hundreds of teens, and there have been times when the essence of the sessions has stayed in my consciousness and, more often, my unconsciousness well after school is out. I have experienced induced countertransference, my own feeling responses to sessions, and triggers of my own unresolved issues. In therapy, supervision, and Vocal Psychotherapy training, I had been asked, "Why do you work where you work? It is no coincidence that you are there with this population." I thought I knew the answer early on: I must have middle school-aged conflicts that I need to face.

Well, in general and very simply, yes this is true. As time went on, however, I received more specific information about my mission. Over the years, I learned that as a teen, I had been quite isolated and awkward. I, too, grew up in an urban area (my area seemed to have fewer resources). The effects of addictions, insecure attachments, and abuse were pervasive throughout the local society including the adults, friends, and family that surrounded me. Music truly was the thing that gave me something different to do; being a musician was a new life for me. I was a gifted musical child and excelled at music and academics. I received frequent and ongoing praise from teachers and family and promotion for playing music, something that really seemed effortless and fun. People from around the state befriended me, other teens who had drastically different lives than I from wealthy suburban places. I traveled the world performing, being free, and having fun. My best friends were made through my love of music. And it was through music that I moved to New York and eventually met my husband—also a musician. So my belief in the power of music to bring opportunities was quite strong. But that was not all.

So far all the children I have worked with suffer from the effects of addictions; sometimes, they have used chemical substances themselves or, more often, their self-esteem, communication, and relationships have been affected by the addictions of their friends and family members. The way this manifests is uniquely different for each person. But it was there nonetheless. Working directly with this and being surrounded by it in the community, I came to believe that I had to deal with my life and how I had been affected by the addictions of friends and family. It was very clear that if I did not look at this huge shadow of mine, then I could not possibly meet the children where they were. I would instead reenact my personal needs and eventually burn out.

Once again, I thought I finally answered the question of why I was there. But one day at the end of the school year when things were not going the way I envisioned, I sat at my desk and the question popped up: "Why am I here?" An answer so potent came to me that some air was knocked out of my stomach. There was no longer any doubt: I unconsciously placed myself in a general education school to help general education students get ahead, all to repay a debt I felt I owed to my brothers for having attended a special music and academic school and for receiving the opportunities afforded to me by music. I finally saw that I had placed and kept myself in a perpetual state of guilt and debt, despite the fact that my brothers had opportunities in sports that I am now only beginning to carve out for myself. As of the time of this writing, this revelation has been the deepest and most true. *This* is why I have been here. So, now what is a therapist to do? Therapy. From a most clear, available, and open position, I could be the most present, reflective, and honest I had ever been. My awareness of my feelings and reactions as differentiated from that of my clients had heightened significantly. I also learned that I was in need of returning to music for me, for sharing and giving to others outside of music therapy. Over the years, my participation in my musical life had dwindled drastically. My adult friends might have known I was a musician if I told them but not because they ever heard me play or sing. Seeing the children venture into their music experiences, often for the first time in music therapy, or sometimes witnessing the exceptionally gifted musical clients emerge, I was reminded of myself and felt hypercritical for the support I gave them and not myself. Soon I felt limited in what I could give others as a result of depriving myself. And then there were also the children who would ask, "Are you a musician? What happened?" or "Come on! You're not getting it!" These were some of the most humbling experiences because I saw through the children how much I was musically suffering. And it was affecting my work. I tried to answer as honestly and simply as I could: "I'm not sure. But you're right, that didn't sound so great. I'll try another instrument."

I share all of this here to give a real perspective on how deeply and unconsciously motivated a therapist can be to work in a particular modality, with a certain population, in a specific geographic and socioeconomic climate. School hours and summers off are great, and working with children at a school can seem familiar. But one need not be fooled that it is an easy way to work. The work is very challenging yet rich and rewarding, requiring presence, fullness, honesty, and a conscious self. In order to truly serve these inner-city teens without my unconscious needs interfering, I have had to search through the depths of my spirit fearlessly and persistently with

the aid of therapy, supervision, advanced training, and support groups. I wish such a loving, rich, and interesting journey of awareness to anyone interested in working with this amazing group of people.

Part I: Music for the Client

Music Therapy Overview

Beginnings of the Profession of Music Therapy

The early 1800s saw the first known references to music therapy. Psychiatrists and physicians wrote about the therapeutic application of music and documented clinical music interventions and research efforts. The early part of the next century ushered in the formation of several professional associations, which provided music therapy's first journals, books, and programming. However, none of the established associations maintained very long.

Music therapy as a clinical profession in the United States had its roots with World War I and II veterans. Musicians playing for war veterans saw that further training was needed to address the traumata expressed in music. In response, the first academic program was created at Michigan State University in 1944. Within several years, the National Association for Music Therapy (NAMT) was founded in 1950, and it flourished for over four decades. In 1971, another professional association, the American Association for Music Therapy (AAMT), was formed. It was similar to NAMT, with its own operating procedures and publications, but with differences in educational and clinical philosophies. In 1983, the Certification Board for Music Therapists (CBMT) was founded. CBMT maintains standards of competency for current practices for certified music therapists. Finally, in 1998, NAMT and AAMT associations merged into one unified professional organization, the American Music Therapy Association (AMTA). AMTA is the main advocacy source for music therapy in the United States and publishes journals and books by and for its constituency (American Music Therapy Association, 2011).

Music Therapy, Music Psychotherapy, and Vocal Psychotherapy

The field of music therapy is quite broad in scope. Like other mental health professions, music therapy reaches people of all ages in various stages of health. Music therapists work in homes for the aged, in- and outpatient hospitals, hospice centers, residential facilities, schools, day treatment programs, and private practice. Music therapy clients may live with developmental differences, cognitive impairments, neurological disabilities, acute and chronic medical conditions, acute and chronic mental health issues, addictions, and more. No prior knowledge of music is necessary to be a music therapy client.

There are numerous definitions of music therapy, depending on the national organization, institution, or individual. Bruscia (1998a, p. 20) offers a working definition of music therapy:

> Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change.

He notes further that music therapy is a process-oriented modality that takes time; it is not an isolated event or series of events in music that are helpful for oneself or another. Music therapy in fact necessitates assessment, treatment, and evaluation. Music therapy process can even be described as "developmental, educational, interpersonal, artistic, musical, creative, or scientific" (Bruscia, 1998a, p. 20). Furthermore, music therapy is practiced by music therapists, not other clinicians using music. To indicate so would put one at risk of legal action by associations, licensing and certifying bodies, and public interest groups.

Music psychotherapy is a subset of music therapy. Music psychotherapy is "concerned with helping clients find meaning and fulfillment in their lives" (Bruscia, 1998a, p. 213). In verbal psychotherapy "…the client and therapist use verbal discourse as the primary means of communicating, developing a relationship, and working towards established goals. In contrast, in music psychotherapy, the client and therapist use music experiences as well as verbal discourse towards these ends…" (Bruscia, 1998a, p. 214). In discussing connection in the therapeutic process, Austin (2008, p. 193) states that:

> A dependable connection with someone (the therapist) who is perceived as safe enough and good enough to provide a corrective emotional experience is essential if deep and lasting change is to occur. This good-enough mother-therapist companions the client through the unconscious to retrieve and reconnect to lost or hidden aspects of the self. The music, the sounds and the singing facilitate the client-therapist relationship and the client's relationship with his or her self. Likewise as trust is developed and the client-therapist relationship grows stronger, clients are able to take more risks and delve more deeply into their own interiority and this is reflected in the singing, the songs and the vocal improvisations.

In such a safe therapeutic alliance, "[The] process of spontaneously music-making taps into every human being's natural propensity to create and respond to sounds expressively and aesthetically…it is a way of free-associating with or projecting oneself onto sounds" (Bruscia, 1998b, p. 5). Bruscia (as cited in Bruscia, 1998b) went on to say that playing instruments, rather than using the voice, displaces and projects the inner, feeling self and the voice onto the instruments thereby giving the self and the voice various sound ranges and possibilities of expression. He said that the voice allows the body to give and receive sensory feedback from itself—with creation of sound from the inner self brought out for feedback from the observing self. Thereby, the inner self is projected out with the voice. Similarly, Bruscia (1998b, p. 9) stated:

> Songs are ways human beings explore emotions…They articulate our beliefs and values… They allow us to relive the past, to examine the present, and to voice our dreams for the future…they are our musical diaries, our life stories. They are the sounds of our personal development.

Austin (2008) pioneered and cultivated the music psychotherapy model of Vocal Psychotherapy. "Vocal Psychotherapy is the use of the breath, sounds, vocal improvisation, songs and dialogue within a client-therapist relationship to promote intrapsychic and interpersonal growth and change" (p. 13). This model is informed by the theories of trauma, addictions, psychodrama, object relations, and Jungian psychology. In Vocal Psychotherapy, the primary concern is the voice as it is the primary musical instrument and is housed within the body. Vocal Psychotherapy, then, is a logical method of treating clients who have experienced trauma, abuse, and other violations of the body. The focus on the voice is especially pertinent since so often the most healing connections in therapy are made through the voice (Austin, 2008, pp. 20–21):

> Singing can provide clients with an opportunity to express the inexpressible, to give voice to the whole range of their feelings. Singing meaningful songs often produces a catharsis, an emotional release, due to the effect of the music, the lyrics and the memories and associations connected with the song. The self is revealed through the sound and characteristics of the voice. The process of finding one's voice, one's own sounds, is a metaphor for finding one's self.

While much of Austin's model is beyond the scope of this chapter, there are aspects of Vocal Psychotherapy that can be adapted for social workers and other non-music psychotherapists such as singing favorite songs and listening to songs. She asserted that while songs can often tell something about the client's state of being, they may also reveal something about the transference.

Music Therapy and Trauma

The term "trauma" may encompass a wide range of experiences from acute events to chronically unmet dependency needs and breaks in attachment bonds in infants and children, also known as developmental traumas. In any event, these children may experience a fissure in the sense of self with the accompanying terror and confusion as a result (Austin, 2002; Kalsched, 1996). Pavlicevic (2002), in her observations of unhealthy attachment in children in violent areas of South Africa, noted that children with unhealthy attachments who have experienced trauma will often act out violently or destructively to others or the self when witnessing another in a helpless or frightening situation. She indicated they cannot tolerate this apparent "difference" between themselves and the other and thus attempt to destroy the "difference" or "otherness" when in fact it is actually their "sameness" or feelings that are so difficult to bear and that which they seek to obliterate.

Music accesses memories and feelings (Swallow, 2002). Austin (2002) noted that singing is restorative. Singing facilitates deep breathing, slowing of the heart rate, and calming of the nervous system, resulting in relaxation. This is especially useful in supporting a client to feel and express feelings. Otherwise, restriction and control of our breathing can allow us to control our feelings or access to them. Moreover, singing is an activity that engages a wide array of human processes including affective, cognitive, and physiological (Aigen, 1998). "By encouraging the clients to use music, both clients and music therapist have the possibility of gaining access to parts of the client's unconscious world, where there may be found

threatening and painful memories, but also possibilities of converting feelings of shame, anger and helplessness into a creative force that eventually brings power and healing" (Amir, 2004, p. 97).

Adolescents strongly identify with their musical preferences, and their favorite singers can become role models. Listening to music, singing, rapping, and composing are all ways that teens can safely express feelings in a nonthreatening way without necessarily talking directly about their feelings or experiences (Austin, 2007). However, some children in music therapy may appear apathetic to the music or the process. They may say they "don't care" about the music, or they may hand off their opportunity and power to choose to the therapist by saying "whatever you want" (Lang & Mcinerney, 2002).

Schools are often the hub for inner-city families to receive information, assistance, and even therapy for children affected by exposure to violence. The therapist in a school setting, working with traumatized children and families throughout the day and every day, optimizes therapy by maintaining and offering emotional support and open, empathic and nonjudgmental responses. Creative arts therapies have the capacity to bypass defenses and access and bring forth unconscious material to work with creatively in the present (Camilleri, 2007).

Music Therapy and Sexual Abuse

Traumatic memories are often suppressed for survival needs; if the memories are in the consciousness, then they are usually kept secret (Amir, 2004). "Sometimes the therapist's quality of listening itself creates the kind of space and stillness in which a child or adult may begin to hear themselves with a fresh awareness" (Robarts, 2006, p. 251). The choice of instruments and the manner in which the instruments are played are extensions of the child's emotional state and expression. "Music animates a host of sensory experiences that brings all kinds of feelings and behavior into the theatre of play" (Robarts, 2006, p. 252). However, the therapist or child himself or herself may have to contain or close up the experience if the intimacy that arises is too much too soon for the child to safely work with. Music can seem benign. However, the music itself and the experience in the music can be made detrimental and unsafe if they are in any way imposed upon a client, especially a child with a history of sexual abuse. The music, just as in nonmusical experiences in therapy, should be client-directed and contained and guided by the therapist. Experiences in music can offer opportunities for play, touch, and exploration of sensations when practiced in a safe, therapeutic musical framework (Robarts, 2006). Music experiences created and witnessed by the client and therapist may facilitate a safe and approachable way for anger and rage to be expressed, feelings that are often repressed and suppressed in sexual abuse and traumatized people. Children who experience posttraumatic stress symptoms often lose interest in activities and avoid or simply are unable to talk about their feelings (Camilleri, 2007). Activities in therapy, such as music listening or playing music, can help express feelings without talking and thus help the therapist to meet the client where he or she is.

Inner-City Adolescents and Sexual Abuse

Children are "at risk" when they have experienced or may experience any of the following due to traumatic events: anxiety, depression, addiction, unemployment, academic decline or failure, incarceration, or death (Camilleri, 2007). According to the American Psychological Association (n.d.), "sexual abuse is unwanted sexual activity, with perpetrators using force, making threats or taking advantage of victims not able to give consent." Perpetrators may be strangers but are more often someone who is familiar to the child, such as a friend or family member. Child sexual abuse may include intercourse, oral sex, sodomy, voyeurism, prostitution, or exposure to pornography (Kauffman, Bay, & Williams, 2009). Sexual abuse knows no boundaries. Children of every race, ethnicity, nationality, gender, and socioeconomic status are at risk and experience sexual abuse. The American Academy of Child and Adolescent Psychiatry indicated that child sexual abuse is reported over 80,000 times per year, a number estimated to be exponentially lower than actual incidences of sexual abuse. The lack of reporting may be due to fear of retaliation, reprimand, or abandonment (American Academy of Child and Adolescent Psychiatry, 2011). Symptoms of sexual abuse may include but are not limited to anxiety, fear, posttraumatic stress signals, sleep disturbance and nightmares, suicidality, negative thinking about one's body, sexual acting out, or unusual avoidance or interest in sexual issues (American Academy of Child and Adolescent Psychiatry, 2011).

Music Therapy Interventions for the Social Worker

Music Therapy Interventions: Why They Work

Creative, improvised music can mirror, reflect, and support the client. Repeating and joining in on melodies, words, rhythms, dynamics (sound volume), articulation (short, smooth), and tempo (how fast or slow) reflects the client's music expression and thus reflects the client's self. This reflection of the musical rises, falls, and shapes are an integral component of healthy attachment (Bowlby, 1988; Stern, 1998). Such creation of healthy attachment experiences may happen in therapy and be essential in repairing the client's sense of self, safety, and trust. Creative music making requires participants to express intentionality, to make choices, and to interact. Music invites unconscious material to the present (Robarts, 2006). Songs are like dreams; they are windows into the unconscious (Austin, 2008). While Robarts (2006) asserted that actively singing in music therapy may develop the client's capacity for singing and declaring oneself presently in relation to others, I would add that presenting songs to listen to and have others witness is also a declaration in words of one's state of being, however passive. The national Child Welfare Information Gateway, a division of the Children's Bureau of the Administration on Children, Youth and Families, recognizes music therapy and other creative arts therapies as viable options in the treatment of children who have experienced sexual abuse (Child Welfare Information Gateway, 2008).

Music Interventions Appropriate for Social Workers

There is an array of music interventions that are appropriate for social workers and non-music therapists to employ with clients. To be clear, these are music interventions for social workers, not music therapy.

Music Listening

Music listening for relaxation is a great resource when done with appropriate music. Song choice is ideally left to the client. However, there may be circumstances in which the therapist's choice of song can be useful. Some teens may persistently shrug their shoulders and say they "don't care" or they "don't know what to listen to." Sometimes they will outright say, "You choose" or "What do you want to listen to?" When this has occurred over several sessions, it may be an opportunity for the therapist to bring in a song that could strengthen the client-therapist rapport. Sometimes, a song may "pop up" in the consciousness of the therapist while working with the client. It is no doubt that this presentation contains information for the therapist. However, it does not necessarily mean that that song is appropriate for use with the client, especially when working with adolescents or anyone under 18.

Before introducing the song to the client and in the relationship, the therapist should be sure that: he or she knows the lyrics and understands their meaning, there is an understanding of the musical structure and the emotional content, there is knowledge of the artist's background (known abuse or addictions), and the therapist is aware of his or her own identification with the song and/or artist. Questions for the therapist to consider before introducing a song are: What do I hear? How do I feel listening to this song? Would it be appropriate for me to introduce this song to an adolescent in this setting, even if I feel it might be relevant? Can I imagine myself sharing with the client's parents, my colleagues, and my supervisor that I brought this song into the work? While in music therapy it can be appropriate and helpful to the therapeutic process when the clients bring in songs with explicit content, it is generally inappropriate for the therapist to do so, especially if the song has sexual content or undertones.

Additionally, it is advisable not to engage in the practice of trying to guess what music or songs or artists the client enjoys. This can be an exhausting and unproductive activity with clients who are particularly guarded and resistive to therapy. Additionally, it could also at a very early stage in therapy reveal the therapist's biases and stereotypes of the kind of music expected of the client and could be detrimental to the therapeutic alliance. If there are any songs that seem particularly pressing and consistently appear in the therapist's consciousness, it is recommended that the therapist bring this material to supervision, with a music therapist when possible.

The most benign way for the therapist to choose music is for relaxation purposes. If relaxation seems warranted, the therapist may choose music to support this experience. Music for relaxation is ideally musically simple. The melody, harmony, rhythm, tempo, and dynamics are consistent and vary little. More specifically, the

melody repeats and is simple and easy to follow. The harmony is simple and familiar, with very little dramatic changes or developments. The rhythm is stable, consistent, and reliable. The tempo is at about a walking pace and stays steady. The dynamics are about medium volume, neither too loud nor too soft, and are rather consistent and undramatic. And lastly, ideally, this music would be without words since words may distract the client intellectually from focusing on relaxation and embodiment. As with any music the therapist introduces, the therapist would first listen to and experience one's own relaxation experience to test out the music. How did I feel before the music? How did I feel during? After? Did anything in the music disrupt my relaxation or draw my attention away from myself?

The music would be about five minutes in length. The client would be guided to sit comfortably as the music begins, and the therapist would sit across from the client and briefly guide the client to relax the body and close the eyes if he or she would like. The therapist may then sit and experience the music while observing the client. When the music is finished, the therapist may invite the client to wiggle one's fingers and toes, slowly come back into the room, and open the eyes. The therapist would inquire how the client is now, how the client experienced the relaxation, and what, if anything, the client noticed about himself or herself during the music. Sometimes, adolescents who experience this safe, calm, and supported way to relax simply fall asleep. That can be very meaningful for traumatized teens to experience such safety with their bodies and to get the rest that they most probably truly need.

Another form of music listening is listening to the music the client introduces and shares. The therapist may invite the client to bring in his or her favorite music. If the therapist has the proper equipment (see "Office Logistics"), then the therapist could facilitate song sharing in the current session, via an mp3 player or a computer through quality speakers. The therapist and client would listen to the song together. The therapist would listen for the lyrics; the emotional quality of the music; the quality of the rhythm, harmony, and melody; and the intensity of the voice. The therapist may also notice one's own response to the music or familiarity with the song. If it is a song that is intimate to the therapist, the therapist would attempt to detach in the moment from his or her memories and associations and listen and receive it as openly as possible. The therapist could then ask various questions to learn more about the relationship between the client and the song: "Why did you choose this song? What do you like about it? How can you relate to this? Is there anything about this that you have in common? When do you listen to it? How often do you listen to this song? Do you sing along?" Some teen clients may have answers for these questions, others may not. In either case, this verbal processing can shed more light on the state of the client's consciousness and being. If it seems helpful, the song could be listened to again. After listening, the therapist would reflect what she heard and observed—without interpretations or judgment.

Singing

Another option is to invite the client to sing along with the song in the session. It can be meaningful for the relationship if the therapist also sings along even if the song

is unfamiliar. In this case, the therapist could attempt to hum or sing the melody along with the chorus to "be in it" with the client. If the client seems open to it after several sessions, the therapist may invite the client to continue bringing in such precomposed songs for singing and recording if the client chooses (see "Office Logistics"). Once the recording is completed, the client and therapist would sit and listen. The therapist could then ask "How is that to hear yourself? What did you hear? Was it how you expected? How so?" Some teens use this as an opportunity for self-depreciation or even self-abuse. The therapist intervenes here and reflects this process. In doing so, some teens are actually expressing their discomfort in being witnessed and vulnerable and safe. Not unrelated, some teens may be reenacting their abandonment issues by abandoning and abusing themselves before the therapist would. So it is vitally important for the therapist to use this as an opportunity to reinforce the safety and consistency of the relationship, reflect the courage the client demonstrated, and offer the client alternatives to view and talk about themselves—effectively offering resources of strength for the client.

Music Composition

Ask the client if he or she has written songs. If so, the therapist can invite the client to bring in such songs to sing and record. As this may be particularly personal, this intervention may be more effective when employed later on in the course of therapy. The therapist could also listen to the song post-session without the client to see if the same things come up when listening with and without the client. If new material surfaces while listening without the client, then this could indicate induced countertransference.

Similarly, for teens who demonstrate some propensity toward music or for the teens who have attention issues and often receive reprimand and punishment for tapping, inviting the client to share what they do in the session can be useful. The therapist might notice or receive information that the client hums often or that the client is active in music at home, in school, or in the community. To invite the client to sing a favorite song in the safety of therapy can at first be off-putting, intimidating, or even frightening for some clients. This is an opportunity for the therapist to indicate that she has noticed her humming or has heard about her musical involvement and is curious to witness this part of the client. Of course with any client, especially one who may have experienced sexual trauma, the therapist need not press the issue. The sharing is voluntary, and the client may share at his or her discretion. The important thing is to reflect what the therapist sees and to invite more of that part to show itself in therapy. For the adolescent who taps away in school or at home and gets in trouble, therapy is an excellent place for that energy to be expressed and supported. The therapist reflects her observations of the tapping, rhythm, and energy and that perhaps there is some kind of beat there to share. The client can do whatever it is that he or she normally does when tapping: use pencils/pens, beat on a table, or clap. The therapist can ask if the client would like to play alone or to have the therapist join.

Witnessing and reflecting the client's energy, rhythm, intensity, and focus can be valuable. If the client would like the therapist to join, it is advisable that the therapist first listen to the client's rhythm and try to hear and connect with the client's musical pulse. Above all, it is a time for the therapist to be a participant observer, not to lose oneself musically or self-consciously. The therapist should remain attuned to the client's musical pulse and particular accents or rhythms and when possible, musically reflect what the client has done but without disruption or distraction from the client's self-expression. In short, the therapist's music would be kept simple. The therapist's music would be musically consistent, reliable, and reflective. As with the teen who sings in sessions, this is a great opportunity to offer recording. Another option is to present to the client the possibility of adding more musical elements in the recording process, such as lyrics (sung or spoken), melodies, harmonies, additional rhythm lines, and dynamic contrast. This work supports the client to further explore, develop, and value one's gifts and self.

Music Recording

Music recording is another music intervention that can be done simply, although it will take time on the clinician's part to learn how to use it before bringing it into therapy. Music recording can be a great tool for reflection and witnessing. It is also an opportunity for the client to spend time and energy in work that is creative and meaningful and that can be shared with others.

Once the client agrees to recording himself or herself, the therapist can guide the client in setting up the recording equipment and software, testing the sound levels to be sure the equipment is working properly, and even making a brief test recording and listen back for the final system check. At the beginning and ending of the recording, leave a few seconds of silence so that there can be a clean beginning and ending to the music. At times, clients can and will play or sing straight through and will be happy with what they have done. Other times, clients may feel they have made a mistake and stop, or they will simply try again and continue successfully. Perhaps a client will need to practice a particular musical segment for a moment before recommencing recording, or they may want to give up. In the case of the latter, while prematurely ending is an option, this is another opportunity for offering resources. The therapist can take time to inquire about what is happening internally, particularly with any self-destructive and self-sabotaging thinking that may be happening before and during the recording. A technical solution could be to cut out the segment the client does not want and rerecord just that segment and reinsert it into the larger work. This can be easily learned by tutorials and online forums. Clients who have experience with music recording may know how to do this and can share their knowledge with the therapist.

After the client has decided that the recording is complete, the next stage is editing. Editing will require the therapist's knowledge of the recording software's options for editing: fading in and out, raising or lowering track volumes, adding echo or reverb, or other effects. If the therapist attempts to learn this in session, this

process will take up valuable clinical time. The therapist who is familiar with these features can easily demonstrate these options for the client to then utilize and decide for himself or herself.

Once editing is complete, the client may opt to burn the recording to disk to distribute. The client may wish to create artwork for the disk or disk cover (there are CD labels and software for label creation). Yet, today's adolescents often no longer use CDs but instead listen to and carry music on mp3 players, cell phones, and flash drives. If that is so, then there must be some secure method for moving the music file (the file could be in mp3 or aiff file format) from the therapy room to the client's device. The therapist could plan with the client who he or she would like to share this song with and why, so that the therapist can best understand the client's intentions for doing so and support him or her in practicing more secure and fluid boundaries.

Office Logistics

Certainly there are similarities between the therapy room of the social worker and that of the music therapist or other clinician incorporating music in the work. Ideally, in either scenario, there is comfortable seating for the client and therapist within a private confidential space and a general sense of order and safety. A therapist using music will also need to consider having space for the instruments and gear. Ideally, music instruments would be easily accessible for the client. It is advisable that the instruments not be stored away in a closet or hidden in their cases. You may wish to research with a professional how to properly and safely keep the instruments out (i.e., acoustic guitar on an acoustic guitar stand, keyboard on a keyboard stand).

Display and treat the instruments with care, as you would an important article of material or history, knowing that your clients may often project onto them. Maintenance of instruments will also be necessary: tuning and replacing guitar strings, replacing and retuning tunable drum heads, replacing worn instruments, and having spare parts available. Having a relationship with a retailer and/or music instrument dealer identified early in your practice may provide you with necessary support for instrument maintenance. If an instrument is truly broken, especially with a visible tear or crack, the treatment of this may be done with care and with the experience of clients in mind. For some clients, it may be therapeutically beneficial to see the instrument broken, project one's history onto it (i.e., abuse or loss), and work through feelings and say goodbye. It is contraindicated, however, to have broken, unplayable instruments remaining visible in the therapy room for an extended period of time. This could potentially induce the experience of neglect and/or deprivation for clients.

Ideally, instruments used in therapy would be of high quality. While many instruments are made affordable and are sold as "kits" or "bands," these instruments are often plastic with low quality of sound, resonance, and tactile experience. Such instruments that offer minimal aesthetic expressive opportunities will do just that for clients and for the therapist. High-quality instruments maximize opportunities for aesthetic experience, give more musical tools for the clinician, and acknowledge

the integrity and importance of musical expression. As high-quality instruments may seem expensive, it is suggested clinicians meet one's musical self and ability. For instance, a social worker who has played guitar may make the first purchase of a guitar to bring into the work. Instruments to consider for an initial investment may include: guitar, guitar stand, keyboard, keyboard stand, cajon, djembe, bongos, ocean drum, egg shakers, thumb piano (kalimba), and a 1–1.5-octave metallophone, glockenspiel, or xylophone with corresponding mallets.

Recording and listening gear may also be brought into the clinician's room. For music listening, one may offer a stereo with an auxiliary setting and cable that can be connected to an mp3 player or a speaker dock made specifically for mp3 players. Access to reliable internet on a computer may also facilitate music listening and video watching on sites such as YouTube. For music recording, a variety of free and purchasable software may be used. Check your computer for compatibility. There are also many microphone options available. Like instruments, microphone quality can greatly impact the quality of the music and experience. Some built-in computer mics are quite sensitive and work well. There are also USB computer mics that sound rather good. If the conventional microphones (that performers use) are preferred, then a microphone preamplifier would be needed. With any equipment or instruments, it is advised that clinicians take ample time to experiment and explore before placing in the therapy room.

The placement of the office and its surroundings is also a consideration. Generally, creating music or even listening to music yields sounds and vibrations that will carry through walls, floors, and ceilings. Not only may this be disruptive to others working nearby, this may also make the clients' musical content and process available for others to hear. While having a soundproof studio office is ideal (double walls, floors, and ceilings), this is not always possible even for music therapists to negotiate. In the meantime, to protect client confidentiality, the use of white noise machines may help. And of course, communicating beforehand with neighboring colleagues and businesses about the sound (even testing out the instruments) may help alleviate any disruptions or complaints particularly during sessions.

Case Studies of Interventions

Several case studies involving the use of music are presented here. The names and identifying information (including age, family information, country of origin, and life circumstances) about the following clients have been altered to maintain privacy and confidentiality rights.

Listening: Witnessing and Building Trust

Victoria was a 13-year-old eighth-grader who had emigrated from Brazil 8 years earlier. She was referred to music therapy by teachers who noticed that she often cried in class "for no reason." Frequently, she had a stern, vigilant look but would

occasionally break into a large smile. We met in music therapy for 7 months for biweekly sessions, or more often when needed.

In the beginning stages, Victoria cried often that she felt sad, that she had difficulty with her friends at school, and that she and her mother fought. We processed this in verbal therapy. I invited her to improvise her feelings with me. She declined. I asked what songs come to mind about these situations. She said none. I asked her what she wanted, and she said just to talk. One day, she shared that when she was a child in her home country she had been repeatedly raped by family members. Her mother learned of it and moved her to California for a year. But work opportunities were hard to come by and, with the help of a friend, Victoria's mother moved herself and her daughter across the country to Jersey City. Victoria cried as she recanted. She said her mother knew and helped her but not before placing some of the blame on Victoria for the abuse.

We worked through this verbally as she requested over several sessions, with much delicacy, reflection, and support. After several weeks, I asked if she wanted to play any instrument, and she said she wanted to learn the keyboard. I showed her scales and chords and introduced her to basic music theory (note names, intervals). This became a therapeutic lesson. That is, I instructed her how to play an instrument as if it were a lesson yet within the greater context of therapy and a therapeutic relationship. I explained that I would show her what I knew but that if she wanted to advance on the instrument, she could pursue actual lessons, which would be a bit different than our situation. She said she understood. This therapeutic lesson was a means of engaging Victoria musically and further strengthening trust and the therapeutic alliance. It was also an opportunity to reflect to her what she had so quickly learned about music and the keyboard for the first time to support her self-esteem.

Our sessions oscillated between verbal therapy and music, depending on what Victoria wanted. Other issues she brought into the work included questioning her sexuality, her feelings about fellow female students flirting with her, her concerns about her friend's possible pregnancy, and her witnessing of her uncle beating her cousins. As she often could spiral into a trauma vortex, much redirecting and resourcing were necessary as well as psychoeducation about the feelings and thoughts she experienced. While much of the work with this teenager was verbal therapy, over the course of our work, the time in music and her trust toward me increased. This was all made possible by listening, witnessing, and supporting her in the directions she chose to go, at the pace she chose to open up and trust. Our work together ended when she graduated from middle school later that year.

Lyric Analysis: Violent and Misogynistic Lyrics

Carl was a Latino boy I worked with from age 12 to13. He was referred to music therapy from the therapist at his previous school who had worked with him and his two sisters, one younger and one older. He was behind 1 year as he repeated the fifth grade. His parents were divorced, and he lived with his mother and grandparents

and an aunt and uncle. He and I worked with each other during sixth and seventh grades, before he moved out of the area.

Carl was often disheveled. He presented with a tick in every session: quickly rolling his eyes. The eye rolling did not seem to be the type of typical teenage aggressive eye rolling but rather a way perhaps to refocus, as it often occurred when I made eye contact with him during conversations. But generally, his eyes appeared distant. To every question I asked him about himself and school, he answered, "Oh, good," with a nod and a smile. I felt anticipation, and I thought he might be expecting something unpleasant from me as he said this. And I knew that things were not as good as he said. I had received reports from the teaching staff, administration, and other support staff that he was failing, that he often fell asleep in class, that he came in with marks on him from his mother beating him, that he was entirely disorganized, and that he apparently also hit his mother. Since we were in a school setting, I would bring up the reports I heard from his teachers. He often shrugged his shoulders and said he really did not know what was happening that he was failing. Talking often seemed to get us ahead very little.

Carl did respond to the offer to try out instruments. He moved about the room, trying the various percussion instruments, keyboards, and guitars. Eventually, he settled on the keyboard and we played together. Before playing together, I made sure to first ask if he would like us to play together or if he wanted to play alone. He chose together. And I also made sure to stay within the lower register (left side) and not intrude upon his personal and musical space as he played the middle and upper register (right side). I heard and played call and response with him. As he improvised, I heard short melodic and rhythmic patterns that I then repeated and elaborated on. This went back and forth. This was a means of reflection and letting him know in the music that I heard and saw him. After the music, I asked about his experience and he shrugged and said it was good and smiled. He said he did not notice the musical play between us.

Several weeks later, I learned that both he and his older sister who attended a nearby high school had both been sent out for psychiatric evaluation following their expression of suicidal ideation. He returned to school a few days later. When I met him in music therapy, he made no mention of it and again reported that all was good. He was not interested in playing. I asked if any songs came to mind. He said the song that came to mind was "Cleaning Out My Closet" by Eminem (Mathers & Bass, 2002). Being familiar with it, I knew in advance that the song contained explicit language. With him and with other underage clients who present such songs, I made it clear that it was okay for us to listen to it here in music therapy because we can then talk about it and try to understand it but that it is not okay to then continue listening to it or playing it or repeating the lyrics aloud at school. He said he understood and we listened. Since this song was familiar to me, I took a breath and asked myself, "What do I hear? What might this be saying for *this* client?"

As we listened, I heard an increasing intensity in the lyrical content, the tone of voice, and the music. I heard feelings of hurt, anger, and rage contained in neat pop/rap song form with an intro, verses and choruses, and an outro. I heard a man who was so hurt by his mother as a child that he continued to hold onto his rage against

her and tried not to reenact his past onto his wife and child, despite the strong urge. The artist also shares about the strong sense of illness that his mother projected onto him and the effects he experienced of her drug and other addictions. In addition, in keeping with the title of the songs, the narrator indicated that he was in process of cleaning out his closet, metaphorically, and that he apologized if he hurts his mother's feelings in process. I heard both rage and the need to take care of his mother. I also felt fear. I was fearful about how Carl would act out his own rage when he is bigger and stronger if he in fact had as much rage against his mother as the artist expressed. Will he become a sociopath? And being aware that I, a female about the same age as his mother, may represent a mother figure at times, I felt fear about how he might act out such mother rage at me. Musically, I rather enjoyed it. I liked the rhythm, the melody, motifs, harmonies, and musical arc.

When the song concluded, we sat for a moment as he looked at me with a smile and distant eyes as he so often did. I asked, "So what do you like about that song?" "Hmm, I don't know, I just like it." "Do you like the lyrics? The melody? His voice?" "Hmm, not sure." He quickly rolled his eyes and smiled. He said he wanted to listen to another song: *Candy Room*. The song is actually entitled *Candy Shop* (50 Cent, 2005). Despite my policy to listen to any song clients bring in, I had a distinct instinct to pause. I said that I first wanted to look at the lyrics. I took a few minutes to go to another computer and look up the lyrics. Sure enough, the lyrics appeared to talk explicitly about a man and a woman, possibly a prostitute, having oral sex and intercourse with the influence of alcohol. "Carl, I know you want to listen to this song, but this is a song I do not feel comfortable having us listen to because of your age and because we are in school." "Ok." "Tell me, what do you think this song is about?" "I don't know." "Well, what do you like about it?" "I like the video. It has a car with special doors that open so that you can escape." "Wow, who would be escaping and where or who would they escape from?" "I don't know. I just like the car."

After the session, I took time to listen to the song myself and to observe my own feelings and reactions. I liked the deep bass sound. The music for the verses and chorus were virtually the same, which I found uninteresting. Words such as shallow, tasteless, artless, and gross came to mind. I felt angry that this song was here for this child to relate to. This is my musical countertransference, i.e., countertransference with the music, not just with a person. Questions formed: How did he relate to this? Is all this anger mine? Is some of it his? I then recalled how throughout our sessions I often felt unusually angry toward him. This information helped me see that I had been experiencing anger as induced countertransference and, most probably, as some of his own anger and rage. But what about the sexual lyrics? Was this saying something for him more directly? Perhaps, but rather than me creating a picture of sexual abuse, I must wait for the painted picture to be presented.

In future sessions, Carl sometimes rocked forward and backward in a jerking motion, as if jolted from behind. He also had a fresh red mark on his face and ink tattoos of hearts with arrows and guns and skulls on his arms. He said it stood for "shot through the heart." While this could be a benign teenage trend, the team decided that given his and his family's history and the history of involvement of the

local authorities, we would send him out for psychiatric evaluation and investigation. In this case, given the physical and emotional traumas he experienced in his short life, it is likely that at some point he may have experienced sexual abuse, especially in light of his song choice and his rocking rhythm. The local authorities were actively involved in his case, and he and his siblings were removed from the home and placed in foster care.

Singing: Engaging and Reflecting

Shannon was referred to music therapy by the school social worker due to behavioral issues in class. She scored very high on a trauma inventory the social worker administered. Shannon was an East Indian-American 13-year-old girl who was quiet and nervously smiley. She had moved to Jersey City a few months earlier from Boston, MA, where she had lived with her mother. Her mother said she could not have Shannon anymore because of Shannon's bad behavior. Her father also declined having her with him because his live-in girlfriend did not get along with Shannon. So her maternal uncle took her in.

Shannon attended music therapy for several weeks, although she chose not to play any instruments. She often shrugged at her options saying, "I don't know." I asked her about school and activities. She answered briefly. After about 1 month, I was unsure how I could be of service to her and felt a bit of a failure at not knowing how to engage her more actively, verbally or musically. It was then that she entered the music therapy room and said that she wanted to sing a song. I offered to play along in some way. She declined saying that she wanted to sing a capella (without instruments). She surprised me with her clarity and focus and apparent courage to be so musically vulnerable, considering that we had not played or sang anything in the weeks before.

We set up the recording equipment, and she got in place and I sat as she sang. Her voice was strong and in tune at times and unstable and off pitch at others. When she sang louder, she appeared more invested than when she sang quietly, when she seemed unsure. When she was finished, she returned to her usual demure, nervously quiet state, looking down. I smiled. I had many questions: How did you learn to sing? Do you take voice lessons? How did you learn that song? What was that like for you? She said she sang at home while doing chores or sitting at her computer. She had never taken voice lessons. She learned the song simply by listening and singing along. I reflected that it was apparent that she enjoyed singing and had worked at learning the notes and the style. She smiled brightly. She said that in her mind she heard herself belting out songs and sounding really good and free. She noted that this was in contrast to how she actually sounded. I said I understood what she described and asked how she felt about this discrepancy. She said it was frustrating. I informed her that we could work on her singing if she would like. She nodded.

Shannon continued bringing in songs to sing and record a capella as the weeks passed for the remainder of the school year. Eventually, she agreed to learning vocal warm-ups. To do so, we sang scales and moved our bodies to the pulse of the music. Initially, her arm movements were constricted and limp, as if appearing to give up.

She said she was embarrassed and felt silly doing these exercises. I said we did not have to do them but that they were helpful to keep her voice and throat strong for singing. She agreed to continue, and she was more engaged in the movements and seemed more focused. She was often disappointed and displeased with her voice. We worked on self-care (vocal warm-ups) and loving her voice even if it was imperfect to her—loving her unique gift with its unique qualities. She reluctantly accepted this idea. I modeled singing for her: singing loudly, softly, making mistakes, breathing technique, and making silly vocal sounds. She often laughed and looked in disbelief at my sounds. But she persevered and tried my suggestions.

As Shannon worked on her singing, she often began aggressively and at concert tempo, rather than beginning slowly and working up to speed. I coached her in breathing and choosing a slower tempo to work out techniques or problematic sections. She practiced this with me. She resumed practicing, and when she noticed she was acting aggressively, she breathed and slowed down. Our relationship and interactions were based on music.

Meanwhile, outside of music therapy, I learned from school staff that it was learned and reported to authorities that she had been in a relationship with a young adult male. Sometime after that, she was staying overnight in a distant city with another adult male well over 18 years of age. Shannon called a family member to rescue her because the man had just beaten her and thrown her down a flight of stairs. By the end of the school year, she had expressed suicidal ideation, survived after having jumped out of a moving vehicle, and admitted to using marijuana, alcohol, and ecstasy.

After this series of traumata, Shannon often opted neither to play nor sing. She instead wanted to sit in the bean bags and pillows and sleep as she sometimes did not sleep well at home. In these sessions, I offered to play quiet music for her while she rested. She agreed. I improvised a lullaby on the keyboard, with no more than two or three chords and a simple melody. She said she liked sleeping to music. In this format, resting to music is a form of self-care and in therapy is a way to learn to have awareness and acceptance of the need for it and to value caring for oneself. Musically, even though she was a teenager, the lullaby can be fitting for anyone going to sleep and resting. It can be especially useful for traumatized clients who still have the need to be safe and have their needs, such as sleeping, met. Additionally, my playing of the lullaby is a way for me to directly support her self-care and kept us actively engaged in music, even in her resting state.

Part II: Music for the Therapist

Music Listening

Music is in the background of many of our everyday experiences. We hear it in the department store; deli; elevator; hotel lobby; restaurants; TV shows, films, and commercials; cars with windows down; and our own homes as we go about our business.

This can certainly be enjoyable and practical. However, for the practitioner interested in utilizing music listening in sessions, one should create the time and space for active music listening for oneself. That is, the clinician can incorporate active music listening into his or her repertoire of self-care activities at home, at the office, or both.

Often, music therapy and the therapeutic use of music are erroneously associated with harps and classical music, the therapist playing and calming the client, or "soothing the savage beast." While this type of calming experience may be useful at times, there are myriad ways to experience listening to any genre of music. As with clients, clinicians can meet themselves where they are by choosing a song that is near and dear. Choose a piece of music that you are listening to often. Create a listening station and a quiet, comfortable place with cushions, pillows, and blankets. The location may be your living room, your office, your bedroom, or wherever you feel cozy and will be uninterrupted.

Ideally, the music would be played through quality stereo speakers, but any medium available is certainly good enough. Before listening, allow yourself several minutes of meditation. Notice your breathing and any places in your body that you are holding, and when possible, let go of any tension or holding. When you are ready, turn on the music, close your eyes, and listen. Simply, notice what you notice. Go *with* the music. Witness images or colors, sensations, feelings, or shapes that come up. When judgment comes in, acknowledge it and set it aside. After listening, you may want to sit a moment and meditate. You may also want to write in a journal about your experience. You may also be interested in drawing. This can be done freely or with a mandala. In the case of writing or drawing, you may want to set these materials up prior to listening, so they are readily available for your immediate processing. Any material that comes up for you during and/or after listening may be useful to process further in your own therapy or supervision.

Music Making

"I can't sing, I'm tone deaf." Many people say this but most are not. Similarly, some decline participating in music, saying "I have no rhythm." Truly having no tone or rhythm is called amusia, a rare neurological condition, of which there are many different forms including rhythm and tone deafness (Sacks, 2007). If you feel you may have amusia for pitch, melody, or rhythm, you may want to see a neurologist to verify and receive clinical recommendations. For many, the self-diagnosed tone deafness and lack of rhythm may be merely attributable to lack of music education, fear of performance, or another factor. In this case, two actions may aid you: (1) remove the tone deafness and lack of rhythm diagnosis from your vocabulary and identity and (2) sing and play for fun, without judgment. If you continue to believe and share personally and clinically with clients that you are without tone and without rhythm, you will model such self-defeatist thinking and behavior and may discourage your clients from sharing or participating musically with someone

who has declared themselves musically unavailable. The more you can sing and play for fun for yourself without judgment, the more open and available you may be to witnessing and participating in your clients' music. You may be more able to support their expression, reflect what you hear and experience, and encourage them to musically explore, develop, and take risks.

Informing and Nurturing Your Inner Musician

Actively listening to recorded music and playing and singing for fun are certainly ways to nurture and inform your inner musician. Fortunately, there is an abundance of ways to continue this endeavor. Begin by taking yourself out to a live concert. Make a plan and commit to it. You may wish to bring a friend or family member or go alone or you may play and sing with others. This could look any number of ways: joining a choir, starting a band, having a weekly gig, or making a record (in your apartment, garage, or music studio). Research your favorite artists to learn about their musical, creative process by reading or watching interviews and videos of them. Take instrumental, vocal, and/or composition lessons. Highly skilled teachers can offer you guidance and structure as you explore an instrument or a song. It is never too late to start; one can never be too old to learn music for the first time. Take dance classes in the genre of music you love. If you love classical music, you may want to try ballet; try hip-hop classes if you love hip-hop, rap, or R&B; jazz if you love musicals. This may help you to embody the genre, style, and rhythms you love. Most of all, be gentle with yourself as you take risks and give your all to these new endeavors.

Conclusion

Adolescents and music go very well together. Music is a creative medium for teens to access and express feelings without invasion or intrusion. While professional music therapists are highly trained in utilizing and understanding finite elements of music learning, collaboration, improvisation, production, and performance, there are music interventions that may be employed safely by social workers who are inclined to bring music into one's practice. Music listening, lyric analysis, and singing are musical interventions that can be therapeutic in non-music therapy clinical settings.

As with verbal material, the musical interventions and the therapist's relationship with the particular musical styles and techniques would ideally be explored and understood as fully as possible with personal exploration of the media, therapy, and support groups as well as professional clinical supervision. A social worker may seek supervision within his or her field or seek supervision from a music therapist. Music interventions for the social worker of teens with a history of sexual abuse is a way to safely witness, reflect, accept, and foster creativity and trust in the therapeutic environment.

Personal Reflection

When I began writing this chapter, I took it on as a great opportunity to share what I know about a topic that is still taboo and difficult for many. And feeling very eager, I was sure that I would be on a regular writing schedule, happily showing up to write in depth about what I know about childhood sexual abuse and music. And while I did write occasionally, I had other projects that had to be completed first. Then I became pregnant—happily and willingly. Then I needed time to breathe as the winter holidays rolled around with much to do and many people to visit. By that time, I asked for an extension of the deadline and was unsure I would even make that. In the meantime, I had also lost the notes I had from supervision to help me write. When my clinical supervisor asked, "Is it hard for you to write this?" I grimaced and said, "Oh no, not at all."

Later that week, I had more awareness of myself as I wrote. I noticed I struggled to sit myself before the computer. After some time of sitting and writing, my body was quite tense, my shoulders held. My mind wandered off into my own life or other random thoughts. I finally admitted to myself, "Yes, this is hard to write." I then made it a point to put on my favorite pop music as I wrote to help me stay light and present and focused. I also checked in with my body to see if I needed to stand, stretch, relax, or get something to eat or drink. Much to the displeasure of others around me, I set up my writing station on my beautiful comfy couch, as I enjoyed that much more than on my metal office chair. And the words have come out much more smoothly and quickly ever since I made it a point to acknowledge that this material is triggering and that I need and can be gentle with myself every step of the way.

References

50 Cent. (2005). Candy shop [Recorded by 50 Cent and Olivia]. On *The massacre* [CD]. Santa Monica, CA: Aftermath-Interscope Records.

Aigen, K. (1998). *Paths of development in Nordoff-Robbins music therapy*. Gilsum, NH: Barcelona Publishers.

American Academy of Child & Adolescent Psychiatry. (2011). *Child sexual abuse.* Retrieved January 6, 2012, from http://aacap.org/page.wwname=Child+Sexual+Abuse&section=Facts+for+Families

American Music Therapy Association. (2011). *History of music therapy*. Retrieved January 6, 2012, from http://www.musictheraoy.org/about/history/

American Psychological Association. (n.d.). *Sexual abuse.* Retrieved January 6, 2012, from http://www.apa.org/topics/sexual-abuse/index.aspx

Amir, D. (2004). Giving trauma a voice: The role of improvisational music therapy in exposing, dealing with and healing a traumatic experience of sexual abuse. *Music therapy perspectives, 22*(2), 96–103.

Austin, D. (2002). The wounded healer: The voice of trauma: A wounded healer's perspective. In J. Sutton (Ed.), *Music, music therapy, and trauma: International perspectives* (pp. 231–259). Philadelphia: Jessica Kingsley Publishers.

Austin, D. (2007). Lifesongs: Music therapy with adolescents in foster care. In V. Camilleri (Ed.), *Healing the inner city child: Creative arts therapies with at-risk youth* (pp. 92–103). Philadelphia: Jessica Kingsley Publishers.

Austin, D. (2008). *The theory and practice of Vocal Psychotherapy: Songs of the self*. London: Jessica Kingsley Publishers.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. USA: Basic Books.

Bruscia, K. (1998a). *Defining music therapy* (2nd ed.). Gilsum, NH: Barcelona Publishers.

Bruscia, K. (Ed.). (1998b). *The dynamics of music psychotherapy*. Gilsum, NH: Barcelona Publishers.

Camilleri, V. (Ed.). (2007). *Healing the inner-city child: Creative arts therapies with at-risk youth*. Philadelphia: Jessica Kingsley Publishers.

Child Welfare Information Gateway. (2008). *Parenting a child who has been sexually abused: a guide for foster and adoptive parents.* Washington, DC: United States Department of Health and Human Services. Retrieved January 6, 2012, from http://www.childwelfare.gov/pubs/f_abused/f_abused.pdf

Kalsched, D. (1996). *The inner world of trauma: Archetypal defenses of the personal spirit*. New York: Routledge.

Kauffman, B., Bay, A., & Wilkins, G. (2009). *When your child has been sexually abused: What you need to know*. Long Island, NY: The County of Suffolk and The Long Island Committee on Sexual Abuse and Family Violence.

Lang, L., & Mcinerney, U. (2002). Bosnia-Herzegovina: A music therapy service in a post-war environment. In J. Sutton (Ed.), *Music, music therapy, and trauma* (pp. 153–174). Philadelphia: Jessica Kingsley Publishers.

Mathers, M., & Bass, J. (2002). Cleanin' out my closet [Recorded by Eminem]. On *The Eminem Show* [CD]. Santa Monica, CA: Aftermath-Interscope Records.

Pavlicevic, M. (2002). South Africa: Fragile rhythms an uncertain listenings: Perspectives from music therapy with South African children. In J. Sutton (Ed.), *Music, music therapy, and trauma: International perspectives* (pp. 97–118). Philadelphia: Jessica Kingsley Publishers.

Robarts, J. (2006). Music therapy with sexually abused children. *Clinical Child Psychology and Psychiatry, 11*(2), 249–269.

Sacks, O. (2007). *Musicophila: Tales of music and the brain*. New York: Knopf.

Stern, D. (1998). *Diary of a baby: What your child sees, feels, and experiences*. New York: Basic Books.

Swallow, M. (2002). The brain—its music and its emotion: The neurology of trauma. In J. Sutton (Ed.), *Music, music therapy, and trauma: International perspectives* (pp. 41–53). Philadelphia: Jessica Kingsley Publishers.

Chapter 8
Sandplay Therapy: A Way of Rediscovering Inner Wisdom in the Body and Psyche

Judy D. Zappacosta

Introduction

Sandplay therapy offers the possibility of healing from the wounding effects of sexual abuse on both psychological and physical levels. For both children and adults, unspeakable violence toward the body and psyche is difficult to address solely with verbal therapy. A clinician will be well served by having a variety of modalities to rely on when dealing with clients with abuse histories. It can also be both painful and potentially retraumatizing to rely on talk therapy to act as the primary healing agent.

Expressive therapies, particularly sandplay therapy, has become more and more accepted as a modality that offers a safe and protected space for the reparative aspects of healing to emerge. It is an accepted principle that sandplay, as a modality, provides a mediating process whereby conscious and unconscious material from the inner world of the psyche can be organized in new ways that offer healing and new outer stability to the developing personality (Kalff, 1980). Because sandplay therapy is both nonverbal and nondirective, it offers safe therapeutic space that reaches a preverbal, nonrational level of the psyche.

Unique to sandplay, containment is offered in three different configurations. It is offered within the parameters of the sandtray itself, within the therapeutic dyad, and within the therapy room, which provides a secure and insulated setting. The significance of a free and protected space for the client is implicit in sandplay, as is the idea that symbols used in the tray act as healing mediators. Using sand, water, many miniature toys, and symbols, a client is able to create within a rectangular box of sand a story, an image or imaginative picture. The old adage that says "A picture is worth a thousand words" is an apt description for imagery that emerges in the sand.

J.D. Zappacosta, MFT, CST-T (✉)
Sandplay Therapists of America International Society for Sandplay Therapy,
2820 Daubenbiss Avenue, Soquel, CA 95073, USA
e-mail: zappaj@sbcglobal.net

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3_8,

The therapist offers no immediate interpretation, and the creator of the sandplay is free to simply let hands, feelings, and choice of image lead the experience. It is both simple and profound in its ability to invite the natural healing qualities of the psyche to emerge. Therapeutic language develops through the use of sand and the spontaneous conversation that emerges out of the nonverbal experience. Sandplay therapists often report that the sandplay room is certainly not without conversation and discussion; however, it often grows through the experiences that develop during the sandplay process. In sessions where the sand is not touched, other verbal and expressive therapies may also be part of the therapeutic process. There is, however, a palpable silence that may emerge while a sandplay is created that offers a quiet and respectful interlude in the therapeutic process that can be witnessed and contained by the therapist.

Contrary to some beliefs regarding sandplay, the therapist is not required to be a totally silent witness to the process. Often, therapeutic language must be forged with a client that offers amplification of scenery, symbol, and a form of communication, and healing opens another layer of dialogue with the unconscious. This language and particular way of holding a dialogue can help anchor new understandings of inner experiences in the sand: "It is extremely important that the newly awakened energies are caught by the therapist and led into constructive paths" (Kalff, 1980). Many clinicians report thinking that they should have more to say or speak about. However, the client may be very focused building a scene in the sand, with almost no attention focused on the therapist in the room. At the same time, if the therapist's attention wanders to a bird outside the window, or loses concentration, the client may quickly respond to the loss of the therapist's focus with questions regarding where something in the room might be located. The client can feel the resonance and reverie being held in the room by the therapist. When this presence disappears with a lack of focus, it is likely that the client may acknowledge the loss in some way.

Dora Kalff (1904–1990), a Swiss psychotherapist mentored by Carl Jung, Margaret Lowenfeld, and various Eastern teachers, such as D.Z. Suzuki, developed sandplay therapy. Kalff believed that the safe and protected temenos created by the therapist allowed reparative aspects of the psyche to emerge in its most natural state. The sand, symbolizing matter, body, and mother (earth), contains all potentiality for an experience of renewal and regeneration. Kalff saw that sandplay therapy offered the same path of individuation to unfold within the personality as Carl Jung's psychology had shown to be evident in the natural stages of human development. Kalff found that disturbances occurring to the developing personality in the child and later with adults could be remediated with the use of sandplay therapy.

Kalff, at Jung's suggestion, went to London to study with Margaret Lowenfeld, a pediatrician and child psychiatrist. Building a collection of miniature toys, Lowenfeld offered children the medium of sand and water to create what she called "sand worlds." Lowenfeld also believed that the child's process should be followed rather than directed, and came to call the activity the "world technique." When Kalff returned to Switzerland, she integrated both Jung's individuation process and the "world technique" and called it sandplay (Friedman & Mitchell, 1994).

Clinicians and interns wishing to use sandplay therapy are strongly encouraged to do their own sandplay process with a trained and certified sandplay therapist. Dora Kalff felt it very important to have a personal experience in the sand. She would often tell students, "you can take no one further than you can take yourself" (Kalff, 1984). Today, a great variety of styles exist with the use of sandtrays. However, Kalffian sandplay remains true to its roots from Jungian psychology, Margaret Lowenfeld's world technique, and Eastern philosophy.

Using sandplay miniatures and imagery, stories are created in the tray, inviting unconscious contents to arise. The movement of the sand and symbols act as potent metaphors leading to potential new inner and outer landscapes. Sandplay invites a mediating space where unconscious energies are invited to emerge and transform, ultimately bringing new consciousness to the personality. The process may be both regressive and progressive in its development, allowing the ego time to heal and strengthen, as well as inviting a constellation of Self to appear in the tray as a symbol of deep renewal occurring within the psyche. Learning about nonlinear paths of healing within the psyche emerged out of Michael Fordham's (1957, p. 117) original theories of the changing states of integration and de-integration that manifest in early infancy. Likewise, in the psyche there are many changing states that appear throughout the process.

Because the hands are engaged in touching the sand, it also invites a regenerative relationship to the body, which has usually been deeply numbed in somatic reaction to sexual abuse. The safety of touching the sand can invite the body to begin to return to a more natural state of aliveness rather than living in varied states of dissociation and compartmentalization. Donald Kalsched, a Jungian analyst, has described the process in the following way:

> The psyche's normal reaction to a traumatic experience is to withdraw from the scene of the injury. If withdrawal is not possible, then part of the self must be withdrawn, and for this to happen the otherwise integrated ego must split into fragments or *dissociate*. Dissociation is a normal part of the psyche's defenses against trauma's potentially damaging impact. It allows life to go on by dividing up the unbearable experience and distributing it to different compartments of the mind and body. (Kalsched, 1996, p. 13)

Because sandplay therapy allows unconscious material to be externalized in the sandtray, tension, distress, and dissociation are given opportunity to both be expressed and then potentially transformed in the continuing process. It is not unusual for a particular symbol to be used in various ways and placed uniquely in different scenes, and then finally be used in a new configuration that neither client nor therapist could have predicted. "Movements and transformations rhythmically occur in dream life, imagination, creativity and play. If dreams, imagination or play become blocked or inaccessible, then intense psychic tension may arise, and chronic physical symptoms may suddenly emerge from otherwise unknown origins" (Zappacosta, 2004, p. 77). Sandplay therapy is a medium for clients with abuse histories that offers a return to natural rhythms and a renewed state of consciousness and encourages a sense of safety to inhabit or reinhabit the body.

Estelle Weinrib, a Jungian analyst who expanded on the theories of Dora Kalff, noted eight basic concepts that guide the use of sandplay:

1. Under normal circumstances, psychological development is similar for everyone.
2. The psyche consists of consciousness and unconsciousness, and the interaction between them offers a system of self-regulation. The psyche, like the body, has a tendency to heal itself.
3. The self is the totality of the personality and its most inner directive healing source.
4. The unconscious is the source of psychological life, in the same way that a mother is the source of all life. Because of this commonality, the return to mother/unconscious may be seen psychologically to be regressive or progressive, in service to psychological healing.
5. Psychological healing and expansion of consciousness are related but not identical. Healing implies, first, that there has been a wounding and possible impairment of natural organic function and that restoration and natural functioning are possible. Expansion of consciousness is the development of awareness and choice in actions that create insight and new behaviors.
6. Psychological healing is an emotional, nonrational phenomenon, which takes place on a preverbal level.
7. Both healing and the expansion of consciousness are desirable ends in psychotherapy, and sandplay deepens and accelerates the therapeutic endeavor. Two processes are at work, both regressively and with progressive movements toward new consciousness.
8. Natural healing processes are activated in therapeutic play, stimulating creative impulses within a free and protected space. The symbols used in sandplay become healing agents, acting as a mediating principle (Weinrib, 1983).

There is also a possibility of using water and sand together in sandplay therapy, and this alchemical mixing of both elements can afford ways of washing, clearing, purifying, and flooding which, for survivors of abuse, are potential ways of working with feelings of shame, disgust, and need to "make new again" the recurrent trauma and emotions held in both body and psyche. "Sand therapy, like art also provides opportunities for fluid or resistive activity, since water can be poured into sand trays; this allows the makers of sand worlds to shape, amass, mold, flood or otherwise experience wet sand" (Gil, 2006, p. 78).

Sandplay therapy provides an opportunity for reintegrating split-off and compartmentalized parts of the personality due to trauma and abuse. Symbols on the sandplay shelves all reflect archetypal energy, that is, a force that holds a magnetic-like charge, with both positive and negative poles. It is the ability to integrate the tension in the archetypal field of any given symbol that invites a new potential for integration and understanding. Symbols used in the sand can carry active archetypal messages that form transcendent bridges to healing. Symbols used in the sand become active transformative agents of healing during the therapeutic hour. The clinician is invited to hold and receive a client's experience as expressed in sandplay, even without full cognitive understanding in the moment by either the therapist

or client. It is in this nonverbal reverie that the mediating qualities of the symbol act on the unconscious, offering renewal and healing. Although the client may ask, "What does this mean?" as he or she stands before a sandplay scene, the clinician must have a comfort level established within him- or herself to be able to hold the moment, and offer the suggestion, "We just have to wait and see how these symbols may support your unconscious and your healing journey."

In an effort to understand symbols, clinicians are sometimes quick to buy a symbol dictionary, hoping for help in analyzing a sandplay scene. Although a symbol dictionary may provide interesting information and an expansion of knowledge, it is usually of little help in deciphering meaning in a sandplay scene because it lacks the ability to hold the context in which symbols have arisen. Symbols must be viewed fluidly to remain alive and vital in sandplay. Study and supervision hours keep symbols alive and moving, rather than concretized, by building understanding of their particular use.

Long ago, metaphorical stories provided tools for transferring knowledge orally around campfires, hearths, and within community. Story told in metaphor provided collective messages that imparted values, morals, and spiritual teachings. Historically, metaphor became a bridge between logic, affect, and imagery, offering a process that we now know engages both sides of the brain. Symbols, images, and other nonrational processes engage the right brain, whereas logic and language are processed in left-brain activity: "Metaphor often carries not only affect but insight as well, so that the therapist needs to do very little. It is more a question of attentive receptivity" (Siegelman, 1990, p. 78).

Explicit, intentional use of metaphorical understanding and language can amplify a healing symbol used in play. Metaphor becomes a nonthreatening way to contact particularly charged issues for the child and can help integrate nonverbal work and spoken language in a supportive, therapeutic way. Siegelmen (1990, p. 63) describes a therapist's role in this way: "Through the therapist's heightened listening and his willingness to stay with the metaphor and unobtrusively enlarge its deeper meanings, he [was] actually doing a great deal to further the therapeutic exchange."

Learning how to use metaphorical understanding and receptive language is crucial in sandplay. The secondary issue then becomes the timely way in which metaphor may meet and amplify a client's sandplay. Effective use of metaphor builds a rapport with the client that allows the clinician to communicate in a way that reaches both the person's conscious and unconscious. Rather than directly and cognitively discussing the painful aspects in the client's abuse history, the clinician can offer metaphorical statements that reach a client on multiple levels of consciousness and support the ongoing therapeutic process. When the clinician can join the process with metaphorical language, recurrent themes can be acknowledged and implicitly understood.

Many therapists offer sandplay therapy to children with comfort and ease, but, often, offering sandplay to adults seems more challenging. Most therapists build their comfort level with children, and as their expertise with this nonverbal therapy grows, they more easily present it as a possibility for adults. Whether working with adults or children, the following questions can be helpful to consider when using

sandplay therapy. As the questions are formed below, consider that each of these questions sets the tone for a safe and protected space, and the level of permission that is granted in sandplay therapy:

1. How does a child or adult client present themselves in the room? Does he or she visually take in the shelves, miniatures, sandtrays? Does he or she show immediate interest in touching the sand? Does it seem to cause any sensory overload? If so, having shelves covered at first may help.
2. Is there sensory comfort in touching the sand? Does it happen with ease, carefully, or not at all? Clients with disturbance around body image or sensory stimulation may be reticent to touch the sand. This is always respected.
3. How does the child or adult handle the miniatures? Is there a particular attention for the more fragile pieces within the collection? Clients with abuse histories sometimes do not recognize their own level of dissociation with touch. If one has not had his or her own body respected, it sometimes is difficult to show respect to objects, particularly, fragile or breakable pieces. There is never any judgment around pieces that may be broken. Therapists are encouraged to only have miniatures on their shelves that they will not have difficulty letting go of, should they get broken.
4. Is the sand contained in the tray while the person works? Often, children with anxiety or anxiousness work furiously in the sand without noticing how much is spilling outside the trays.
5. Are spills purposeful, impulsive, and noticed? Sometimes, there is a level of testing to see if the therapist can tolerate a "mess" that might be made in the sand.
6. Is hand/motor coordination an issue in the room?
7. Does the child or adult take ownership of the space and sandtrays or show tentativeness toward the opportunity to use the sand? Again, is there a comfort with using the space provided?
8. Does the child or adult try to clean up, or take out pieces and put them back on the shelves? In sandplay therapy, the therapist always puts away the toys at the end of a session. It is hoped that the client can leave the room with the picture or image held in the sand. Photos may be taken, but usually after the client has left, and only for the purpose of following the sandplay process.
9. Can clients leave images or stories in place at the end of the therapeutic hour?
10. Are things seen or buried? Hide and seek is an important ageless task, particularly for those who have had to work very hard to find safety in their lives.
11. Does the child present his or her "hurts," bruises, cuts, or scratches? Are these metaphors for the painful stories being held in the body or psyche?
12. Does the child or adult present somatic complaints, like headaches, stomachaches, and asthma that might be defense mechanisms of resistance or metaphors for the abuse?
13. Is the child or adult a clock-watcher? Overly vigilant behaviors are sometimes lingering parts of the aftermath from abuse.
14. Is the child or adult hypervigilant to noises outside the room?
15. Do children tell you they are hungry as a metaphor for safety and nurturing?

16. Does the child or adult present in a very general way as feeling safe in the therapy room?
17. Does the child or adult test limits in the sandplay process in his or her use of water or fire? This might be done by flooding the trays or by setting fire in the sandtray. Can the therapist tolerate the client's need to push boundaries to test for safe parameters?

All of the previous questions are pertinent to observation and to setting what is referred to as the "temenos" in sandplay therapy. The therapist is asked to consider the previous questions as a way of further understanding what it means to present a "free and protected space" where nonverbal healing may begin to take place.

The following case study affords a deeper understanding of how the process of sandplay therapy can unfold and the potential healing energies that may manifest and be integrated as new potential for the client who particularly needs a nonverbal environment.

Case Study

Nineteen-year-old Michelle, a natural beauty with long dark hair, olive skin, and penetrating brown eyes, stood pensively in the office doorway. With obvious suspicion, she sat down in the nearest chair. She disclosed little information regarding her reason for entering therapy. She answered my questions in a brief, monotonic voice. She was aware of a growing rage at everyone and everything in her life. Her mother, she said, was the cause of her rage, and then she added absently that she had also been sexually molested by her maternal grandfather.

Michelle had never revealed to anyone the sexual abuse by her grandfather until her younger sister, at age 14, disclosed to her mother that she had been molested. At this time, Michelle was 16 and able to verify her sister's allegations. This led to a report to local authorities and broke a generational family system of denial and silence. Michelle, her mother, and sister were immediately ostracized by all local relatives. For the next 3 years, Michelle finished high school and entered college. She was unable to focus and dropped out, aware of a growing sense of rage.

Michelle glanced around the room during her first hour of therapy, noticing the shelves of miniatures and the sandtray. She stated quite emphatically, "You'll never get me to play with that stuff." During the first 2 months of therapy, Michelle never touched the shelves or sand. I respected this. She also never made firm commitments about an appointment schedule. Five years later, in retrospect, Michelle laughed and said she had been waiting and hoping I would give up on her. By this time, she had completed well over 200 h of therapy and had created 22 sandplay scenes.

This case outlines the trauma and injury that sexual abuse induced on the body and psyche. Abuse interrupts the natural unfolding development and individuation of the entire personality. As will be seen, the very early stages of recovery initiate a healing process that can last a lifetime.

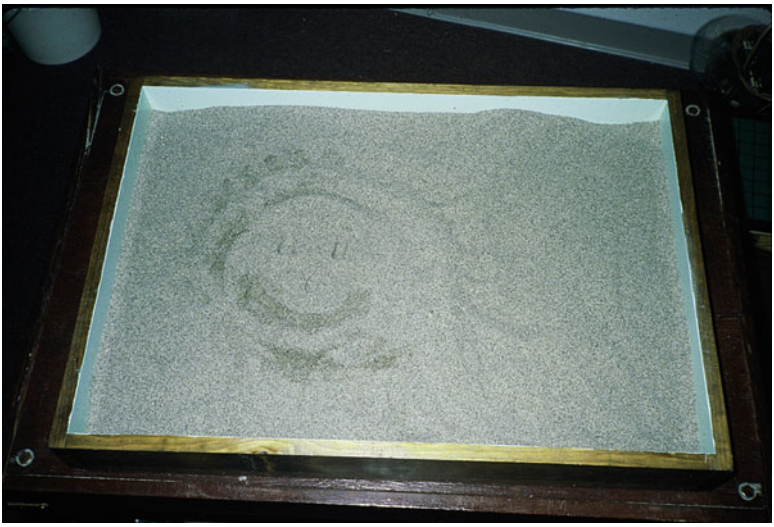

Fig. 8.1

At the end of a session, after 2 months of therapy, Michelle quickly traced a figure in the sandtray as she walked out the door. Radiating finger marks around this face gives the impression of a baby wearing a bonnet (Fig. 8.1).

A very young child appears from her psyche. With undefined presence, a beginning is marked, on many levels. Can Michelle renegotiate these early stages that were so violently intruded upon? The mouth and, in particular, the smile seem plaintive and compliant. It reminded me of other clients with similar histories, survivors, with a telltale sign of having been powerless to others in authority, both physically and psychologically.

Three weeks later, without moving the sand, Michelle tossed in a yellow marble, center. In a haphazard fashion, she added two half clam shells and then, upside down, four kangaroos, two small black gorillas, a giraffe, and wild boar. The arrangement is made quickly and silently. Wounded vulnerable instincts, feminine in nature are apparent in the tray. All appear to be repressed, unavailable, and pushed down into unconsciousness. The heads of all the animals pushed downward into the sand speak to denial, and a psyche thrown asunder, thrown upside down by the affects of sexual abuse and abandonment. Kangaroos, normally a maternal symbol, are unprotective in this position and would literally dump their babies out. Clam shells, also feminine in their ability to contain, are dropped without honor or distinction.

The gorillas, as a dark pair, suggest raw instinctual energy, unpredictable, strong, and not easily tamed. The fact that there are two is important. Kalff noted “pairs are usually a signal from the unconscious of an element coalescing towards consciousness” (Kalff, personal communication, 1984). Finally, the giraffe, often seen reaching upward to sky and spirit, is rendered unavailable. Michelle has little to draw on from instinctual energies within the body.

Fig. 8.2

It is always important to look into the initial tray for some indication of hopeful potential that may manifest or transform during the sandplay process. It is noted here in the placement of the yellow marble. Although much has been repressed, yellow, the color of light, intuition, and wisdom, is in the center of the tray. It symbolizes the possibility of a new consciousness and healing for Michelle. Otherwise, the animals with eyes that look toward unconsciousness could only speak to a repressed story of childhood terror.

In the next scene, a small yellow dwarf leads the way with a large lantern. Standing behind him are two large, destructive animals (Fig. 8.2).

Coming forward are a gorilla, holding a dinosaur in its jaws, and a fearsome *Tyrannosaurus rex* biting a smaller white dinosaur. The dwarf symbolizes a helper from the underworld or unconscious. It works at night, helping to bring energies up from the underground. Here we see the helper bringing up toward consciousness the buried terror of the past, which must be confronted in the healing process. Here is one of the direct ways that nonverbal sandplay therapy supports a confrontation with deeply held trauma. The aggressive prehistoric, perhaps preverbal level, animals with gaping jaws hold Michelle's history of trauma. Again, attention is brought to the mouth, and perhaps what she has had to endure.

This is the first scene in which Michelle has had direct involvement with the symbols. She is no longer haphazard or ambivalent with her intention. She spent a good amount of time making sure she could get the figures to stand in place, balanced, and facing forward. In commentary and in metaphor, she exclaimed, "I can't believe I got them to stay up and stand that way." She looked satisfied as she left the office. Suddenly, with this new energy, dissociated contents from a primordial world appear to bubble up into consciousness.

A menacing gorilla stands just right of center next to a palm tree (Fig. 8.3). Behind the tree, Papa Bear, the good father in the Berenstain Bear books, is head down in the

Fig. 8.3

sand. In the front, a ladder reaches upward. In the lower right, a small green feminine fantasy figure stands next to two clamshells holding Cookie Monster, a child's fantasy figure. Cookie Monster is a hungry little fellow who never seems to get enough food. Just left of Cookie Monster is a small koala bear. Center forward are three Eastern gods. A dinosaur is placed right, with its head down. Looking toward the gorilla is a blue Eastern immortal horse symbol. The hopes and fears of the world seem to be held in this scene. A good father figure is cast downward in unconsciousness. Papa Bear, or the potential for a healthy animus figure, is unavailable.

Menacing instinctual energy returns and threatens Michelle's world. A ladder leads nowhere, offering little relief or passage. A first feminine figure, though it appears in fantasy, arrives clothed in green, the color of life and renewal. This woman in green, also the color of the sensate function, stands next to a birthing. Depicted by the clamshells that now protect and contain, a small hungry character is emerging from the psyche. The gorilla and horse face each other. The horse is a symbol of both the instinctual and spiritual aspects (Kalff, 1983)). Perhaps it can offer mediation between these tremendous tensions and disassociated contents.

Michelle is quite agitated during this session. She paces back and forth and speaks about having difficulty sleeping. Although she refuses to discuss dreams, she relates how restless and disturbed she is throughout the night. As she completed this scene in the sand, she noted, "I guess this will pass." Her fatigue, sandplay, and agitation clearly suggest otherwise. There is no running or hiding, ultimately, from the aftermath of sexual abuse. It is a developmental stage, however, when the game of hide and seek appears. Then it is a joy to be hidden, but a disaster to be found. Michelle has fewer and fewer options available to deny the contents of her unconscious.

Michelle comes to her next session very depressed. Her lack of sleep continues. She is also experiencing ringing in her ears. I ask her to begin coming in twice a week. She musters anger with that suggestion, venting, "I can take care of myself. I don't need anything." In her sandplay, fencing lies asunder. A pitchfork and airplane are tossed in, center forward. Around the end of the tray, outside its boundaries, lies the gorilla, into which Michelle has stuffed Kleenex. Pirate's treasure, a stolen chest of jewels, sits right of the gorilla. A motorcycle lies on its side with a shovel. A shingled Swiss hay house hits on the front edge and next to it a popsicle ice cream stick.

Fencing, in its true function, is a natural way to show boundaries and territory. Michelle's feelings of powerlessness and violation ravage the surface of the sand. She is defenseless. This is a critical turning point in her therapy. She acknowledges the plundering her psyche has endured. The treasure is stolen, tools are lying useless, and the havoc her body is left to clean up is especially apparent with the Kleenex stuffed in the gorilla's mouth. A Swiss hay house with food for the cold winter months is outside the safe and protected boundaries of the sand.

Michelle says she wants to give up on therapy. Her metaphor on giving up, along with the sandplay, is enough for me to immediately make a contract with her regarding suicide. We are at a turning point therapeutically. She must be able to hold the tension of this internal collapse of her defenses, if healing is truly to take place. The ringing she experiences in her ears suggests that she is no longer able to deny either her body or her feelings. Irritation, along with depression, accentuates the consciousness of pain long endured. Her defenses and denial are gone. This is a very difficult and vigilant period. The safety and protection of the therapeutic alliance are of utmost importance now.

In complete silence, throughout the entire session the following week, Michelle carefully rakes the sand, in long strokes, left to right. Her rake is a piece of green fence. At the end of the session, she lightly traces a cross and sets the fence in the sand. Like a Japanese meditation garden, the scene holds an eternal silence, a quiet stillness. The earth (sand) appears "tilled." The single piece of fencing signifies beginning again "from scratch." The lightly traced cross is extremely important. It marks an intersection of opposites and continued movement toward integration rather than disintegration.

> The cross represents all human potentiality, with expansion in every direction, both masculine and feminine as an androgyny. Crossroads have always been held to be of great importance, not only as the meeting and dividing of the ways, the meeting of time and space and the union of opposites, but also as magical and dangerous places where, like the threshold, opposite forces meet. (Cooper, 1982, p. 35)

The depression and suicidal ideation that Michelle has expressed is also held in the cross. It is the symbol of hope, suffering, and surrender.

Michelle has seen a physician who has prescribed an antidepressant. She feels defeated, yet accepting of the help medically. She has reservations about taking medicine for the depression symptoms, but is willing to try it. In this first passage of therapy, Michelle has been able to face without having to discuss directly her fears

Fig. 8.4

of surrendering to the effects of her abuse. Respecting her need to express her imagery without having to explain how or why it serves her is an important aspect of the safe and protected space provided by sandplay therapy.

A year of therapy has now gone by. A new theme of life, death, and rebirth emerges. Michelle's depression has lifted. Center, a small turquoise egg is cracking open. A large green tree is on the left. A piece of its branch is planted lower center. Between the egg and green tree stands a dead brown tree. The sand is again tilled in broad strokes from the palm of Michelle's hand. The sand is moist. A large green tree, the symbol of life, stands in the lower left corner, the place that Kalff referred to as a point in the tray that can sometimes portend what is emerging from the unconscious. New energy is also apparent in the turquoise egg. "The round is the egg, the philosophical World Egg, the nucleus of the beginning, and the germ from which, as humanity teaches everywhere, the world arises" (Neumann, 1955, p. 42). There is hope in this tray. Although it is still empty of instinct and other life forms, the world begins again.

The smaller branch taken from the larger tree speaks of the new beginnings as well. Turquoise, as a color, represents courage, fulfillment, and success (Cooper, 1978). Michelle now holds the part of her personality and defenses that had died, and a new energy is just taking form. The plowed sand stands ready in renewal. In its emptiness, it is also ready for whatever has been missing.

Michelle now comes to therapy looking strong and rested. She is thinking about returning to college this semester. Pushing the sand from deep in the bottom of the tray, Michelle forms a mountain with a cratered top. It looks like a volcano (Fig. 8.4).

Kalff in conversation referred to the volcano as "the mountain that never sleeps." Michelle's energy builds from deep in the unconscious, emerging from the sea, like a volcano.

Fig. 8.5

In her next sandplay, replacing the volcano, the gorilla, used earlier, now stands surrounded by many, many jungle and wild animals. Each corner of the tray is anchored with an animal as well. In the upper left stands a large black bear; in the lower left, a woolly mammoth; in the upper right, a Chinese dragon; and in the lower right corner, the blue immortal horse from the East (Fig. 8.5).

In this scene, we see a healthy reversal of the menacing primitive energy of the gorilla. Now it is surrounded by the returning instincts that had been driven into the unconscious with repression and terror. This scene is a triumphant return of energies that now begin to "boundary up" the gorilla's destructiveness in Michelle's psyche. Repair of the instincts is noted clearly by Clarissa Pinkola-Estes, in her book *Women Who Run with the Wolves*.

> The repair of injured instincts begins with acknowledging a capture has taken place, that a soul·famine has followed, that the usual boundaries of insight and protection have been disturbed. The process that caused a woman's capture and the ensuing famine has to be reversed. (Estes, 1992, pp. 234–245)

The German shepherd, a guardian dog, is left in the gorilla's mouth. Michelle has to continue to develop a healthy inner guardian in order for new boundaries to grow. The bear in the upper left corner is important, as is the panda bear. Fairy tales in Italy, Switzerland, and Japan emphasize the bear, depicted sometimes as a goddess, as an animal that transforms to protect young women from sexual sacrifice. In the Italian folktale, a young woman is safe from incest by her father when she is transformed into a she-bear. She returns to her womanhood only after a safe and kindly prince cares for her, as a bear.

The dragon, appearing in the upper right, is a protector of the maiden and her treasures. Finally, the turquoise horse of the East returns to the lower right. It is known both for its instincts and as a psychopomp, a psychic leader of lost souls

Fig. 8.6

(Kalff, 1980, p. 94). The panda bear, used earlier, now faces outward, eyes opened. "Whenever one understands a dream or some other spontaneous product of the unconscious, one's 'eyes' are opened" (Von Franz, 1980, p. l66).

In her next scene, the face of a young girl emerges from the bottom of the tray (Fig. 8.6).

Prominent red eyes peer outward. A nose is created from a seashell, and the green piece of fencing used earlier now forms a mouth. The shock of Michelle's pain, no longer hidden, is locked in the red eyes. After many years, eyes that cry are reddened and swollen. "Tears are a river that take you somewhere. Weeping creates a river around the boat that carries your soul-life. Tears lift your boat off the rocks, off dry ground, carrying it downriver to someplace new, someplace better" (Estes, 1992, p. 374).

Michelle is now able to tolerate consciously being seen and seeing. The fence now forms her mouth, reminding of the pain endured in the long years of silence. When Michelle finished this image, she was very quiet. As she left, she commented, "It's difficult to look at her."

After facing her pain, Michelle has energy emerging. In the center of the tray stands the green fantasy figure Gumby, one armed raised triumphantly. Placed carefully around him are three fan-like seashells. To the left, a starfish is placed upright in the sand (Fig. 8.7).

In the center, Gumby now stands as a precursor of a healthy ego aspect. Gumby is sheltered and protected by the three feminine shells. The starfish is an animal from the sea that regenerates any appendage that it loses. It has five legs. There are five symbols placed into the tray, and Gumby also holds five in the body. Five is a number representing natural man and a symbol for wholeness. The green figure also suggests the earth and the sensation that is returning to her life. Instincts have been

Fig. 8.7

injured and slowly return, much like the starfish when it regenerates its lost legs. The starfish also has to scavenge the floor of the sea to find food. This has been Michelle's journey to recover food for her soul, for her survival. The fantasy figure Gumby has become a transition object. Michelle has found a key-ring of the Gumby figure. She now "carries the key" to her renewal everywhere she goes.

Three years have passed since Michelle began therapy. She now comes to therapy once a week. Three months have passed since the last tray. Piling up the sand into a long mound and ridge, Michelle works from both sides of the tray. She uses a paintbrush to carefully move all the sand into place. She then places seven conical seashells into the top ridge of sand. At the far left, or bottom, is an elephant. Close to the second seashell is a small silver candelabra. When completed, it looked much like a backbone or spine (Fig. 8.8).

Michelle has been experiencing chronic back pain with no known cause. Her physician has suggested swimming and exercise. I suggest Michelle try massage. I know that she is in some conflict regarding her relationship with her new boyfriend. She genuinely likes him but is frightened of physical touch in the relationship. He is very understanding, yet at this point knows little of Michelle's history. Michelle has never known safe or good touch except throughout her infancy when she formed her first attachment with her mother. Bodywork may offer a healing, safe touch. I accompanied Michelle to her first appointment for a hand and neck massage with a masseuse who worked in the same office building as mine.

This sandtray is indicative of the healing going on deep within her body. It appears as a spine with an elephant at its base. Kalff referred to the elephant as an animal that breaks a path in the forest so that others can follow (Kalff, 1984). It is also know as a divine carrier, sometimes even a Buddha. Clearly, Michelle must begin to live in her body and have it respond in a natural fashion to healing and good

Fig. 8.8

touch. The seven seashells seem to hold symbolism for the seven chakras, the spiritual and psychic centers that can be awakened in the human body. It is significant that the candelabra awaits candles, or to be lit, next to the second seashell chakra. It is the sexual center in the subtle body. Perhaps this new relationship to her body can bring additional healing.

Three more months go by until the next sandtray, although Michelle still has weekly sessions. Five carefully molded pyramids are made in the damp sand (Fig. 8.9).

Around each, dry sand is sprinkled. Lower center, two swans peacefully swim in an oasis. Buddhas sit on four pyramids. Rather than a Buddha, a shepherd strolls next to the pyramid, lower right. Two green trees stand in the upper corners while palm trees grow around the perimeters. A shepherd leads a camel, and a mother lioness sits under the upper right tree. A lion, an elephant, and two prehistoric figures stroll within. This scene has a quieting meditative feel of walking through a peaceful Old Testament land. It is biblical and also holds symbolic energy from the East. Michelle has found a place to rest within. She appears to be in contact with sacred, holy ground. The pyramids are said to be mediators between heaven and earth. They are also burial grounds of times and bodies from the past. The camel, an animal that holds water, the symbol of the unconscious, will endure the hardships of the desert. Michelle clearly has endured. Dora Kalff also stated that when a person penetrates the deeper parts of the unconscious, symbols often show up in the

Fig. 8.9

sandtray from faraway cultures (Kalff, 1984). The two swans hold the masculine and feminine symbolism. The doubling also again suggests newly coalescing consciousness. It is said that the swan maiden sheds her feathers and becomes a beautiful woman.

Michelle now honors her body on a spiritual level. In the next scene sits a beautiful Hawaiian woman. Just in front of her hovers a hummingbird. A marble brown and white egg is set just right of center and circled around to the left are a green upright turtle and a crystal swan. Behind the Hawaiian woman is a piece of driftwood on which sit seven seed pods. In the back of the tray are flowers and two large green trees. Seashells are placed randomly. In the upper right corner, two hippos drink water out of a seashell.

Honor of the feminine and a new sense of integration fill this tray. The bright red flowers speak of the new passion and investment Michelle has in her life. The egg, in dual colors, holds the union of opposites, yin and yang. The turtle, often a symbol of the Great Mother, honors the young woman in the center. It also denotes a figure that now holds both feminine and masculine energies. The hummingbird, a suggestion of spirit freed, assists.

The seven seedpods re-echo the seven seashells of the last tray. New potential continues to unfold. The two hippos, symbols of the Great Mother, have a dangerous unpredictable nature. They are such ferocious animals that they must be tamed by God, alone (Kalff, 1984).

Michelle now appears to own energy and spiritual strength to transform her own history. Michelle continues to deepen the relationship with her boyfriend. It is a committed relationship now, each sharing their lives and history. It is difficult. Michelle continues to test the intent of her boyfriend. So far, he has passed each test with compassion and understanding.

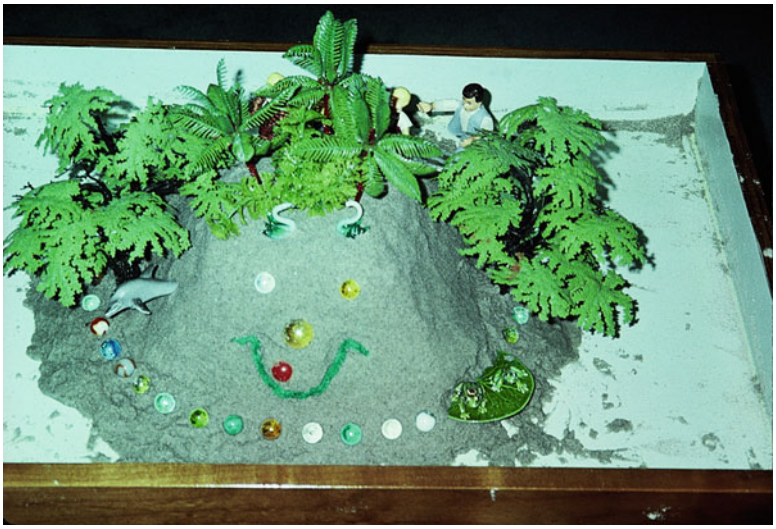

Fig. 8.10

Finally, 6 months later the last tray of this series is created. Mulching the sand for many minutes, adding water as needed, Michelle refers to it as Masa, the corn mix that creates tortillas, flat Mexican pancakes. She builds a mound of earth/sand (Fig. 8.10).

She immediately began to create what she called the Friendly Mountain. Trees and greenery take form as hair. Marbles create eyes, nose, and necklace. A green pipe cleaner is bent to shape a mouth. Swans stand as eyebrows, and a dolphin leaps from where an ear would be. A green lily pad holds two frogs, one of them the frog prince with a gold crown. Moving to the back of the mountain, Michelle placed a family of human figures climbing upward to the top of the mountain, through the green forest. Michelle's exhilaration at completion of this tray is difficult to describe. There are both relief and celebration in her manner. Here stands a creation that Neumann describes as the generative earth: "It arose from the watery primitive ocean. For the primeval ocean … gives birth to the primeval hill, which cosmologically signifies the earth and psychologically is consciousness rising out of the unconscious" (Neumann, 1955, p. 240).

Recovery of the generative, healing energies of her own true nature is present. She is also coming back into the collective, with human figures as a family of mankind, and perhaps noting the new consciousness that she is now able to hold in her body. The large yellow marble used aimlessly almost 4 years ago now becomes the nose, one of the earliest instinctual senses. The dolphin is said to be a messenger of the soul. It is also said to be sacred to the priestesses of earth and mother goddesses. Michelle will now begin to hear, see, taste, smell, and touch her truest nature.

In this scene, she touches the Great Mother, fusing with the earth:

> This mother is the hill itself. She is a mountainous mass of earth whose headdress must seem to graze the heavens from the perspective of the small creature who depends upon her for food and support. She has one vocation; to be fully present to the passage of offspring from life to death and the other way also. (Hall, 1980, p. 42)

Conclusion

This sandplay case presents evidence of the deep, regressive, and regenerating work that is possible in sandplay therapy. The work took place on very primitive and unconscious levels. Many normal developmental stages had been interrupted and traumatized due to the injurious effects of sexual abuse. Slow, careful, verbal, nonverbal, and body work were all part of the process in recovery. Each step, however, was chronicled in the sandplay process. A distortion of body image, as well as living on the instinctual level of body awareness, presented as a major conflict requiring resolution.

Later in her life, Michelle may well choose to continue this process, following further the journey of individuation and healing. For now, she has begun to live. Part of the resolution in recovery from sexual abuse is the acceptance and commitment to an ongoing relationship to one's own personal process. Healing remains to this day a continuing priority in Michelle's life.

References

Cooper, J. C. (1978). *An illustrated encyclopedia of traditional symbols*. London: Thames and Hudson. 1982.
Cooper, J. C. (1982). *Symbolism, the universal language*. Wellingborough: The Aquarian Press.
Estes, C. P. (1992). *Women who run with the wolves*. New York: Ballantine Books.
Fordham, M. (1957). *New developments in analytical psychology*. London: Routledge and Paul Kegan.
Friedman, H., & Mitchell, R. (1994) *Sandplay: Past, present & future*, Routledge, London.
Gil, E. (2006). *Helping abused and traumatized children*. New York: Guilford Press.
Hall, N. (1980). *The moon and the virgin*. New York: Harper and Row.
Harding, M. E. (1965). *The 'I' and the 'Not I': A study in the development of consciousness*. Princeton, NJ: Princeton University Press.
Kalff, D. M. (1980). *Sandplay, a psychotherapeutic approach to the psyche*. Santa Monica, CA: Sigo Press.
Kalff, D. (1983) Statement from Seminar, Kusnacht, Switzerland Personal Communication.
Kalff, D. M. (1984). *Seminar*. Switzerland: Zollikon.
Kalsched, D. (1996). *The inner world of trauma*. London: Routledge.
Neumann, E. (1955). *The great mother*. Princeton, NJ: Princeton University Press.
Siegelman, E. Y. (1990). *Metaphor & meaning in psychotherapy*. New York: Guilford Press.
Von Franz, M. L. (1980). *Projection and re-collection in Jungian psychology, Reflections of the soul*. LaSalle, IL: Open Court Publishers.
Weinrib, E. (1983). *Images of the self*, Sigo Press, Boston, Massachusetts.
Zappacosta, J. (2004). Interior rhythms. *Journal of Sandplay Therapy*, 13(1), 75–88.

Chapter 9
Sandplay as Alchemical Vessel: Healing Sexual Trauma and Drug Addiction

Lydia S. Lennihan

> *We are dealing with life-processes which, on account of their numinous character, have from time immemorial provided the strongest incentive for the formation of symbols. These processes are steeped in mystery; they pose riddles with which the human mind will long wrestle for a solution, and perhaps in vain. For, in the last analysis, it is exceedingly doubtful whether human reason is a suitable instrument for this purpose. Not for nothing did alchemy style itself an "art," feeling–and rightly so–that it was concerned with creative processes that can be truly grasped only by experience, though intellect may give them a name.*
>
> –C.G. Jung, Psychology and Alchemy, §564

Sandplay

Sandplay is a nonverbal expressive therapy that was developed in the 1950s by Dora Kalff, a Jungian psychotherapist. Kalff incorporated the theories of Jungian psychology, Margaret Lowenfeld's World Technique (a nonverbal play therapy), and Eastern philosophy and thought (Kalff, 2003). Kalff observed that the sandtrays that children created often paralleled the individuation process described in Jungian theory (Kalff, 1980). Like Jung, she realized that the "…healthy development of the ego can take place only as a result of the successful manifestation of the Self, whether as a dream symbol or as a depiction in the sandbox" (p. 29). Just as a series of dreams is used in the analytical process, a series of sandtrays "…represents an ongoing practical confrontation with the unconscious…" (Ammann, 1991, p. xv).

L.S. Lennihan, LPCC (✉)
1400 Carlisle Blvd, NE, Suite A, Albuquerque, NM 87110, USA 505.681.0708;
e-mail: lennihan@comcast.net

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3_9,

As an expressive therapy, play is an important part of the sandplay process for both children and adults, and there is "an absence of intentionality inherent to sandplay" that is critical to this modality (Kalff, 2003, p. xi). Stewart (1990) has added that play is actually an "ordering principle in life. It is of ancient, prehuman origin, and as such belongs to the primordial inheritance of the psyche which includes the emotions and the archetypal regulatory functions of the psyche" (p. 27).

Sandplay provides a space for the psyche to heal itself, a function that Estelle Weinrib (1983) believes is "an autonomous tendency, given the proper conditions" (p. 1). The sandtray provides those conditions optimal for healing. The miniatures in the tray act as symbols that are the "healing agents" that provide a "bridge between opposites" required by the alchemical process and by individuation itself (p. 23).

Kalff (1980) understood the danger inherent in dealing with the contents of the unconscious, and she brilliantly used the psychotherapeutic alliance of the transference to create a "…free and sheltered space…" where the child could safely build and stabilize the connection between the self and the ego (p. 29). In her role as therapist, she acted as a guardian, holding the boundaries for her young patients, as well as bearing witness to the transformation of psychic energy in the individuation process.

In order to create a free and protected space, the sandtray itself is built to the exact dimensions determined by Kalff (1980), a size that she felt contained the imagination (and the unconscious) and the visual field, thereby further regulating and protecting the psyche. Kalff knew that sandplay was a powerful therapeutic modality and, in the hands of an untrained therapist, potentially harmful. She therefore cautioned that sandplay be conducted under the supervision of a trained sandplay therapist, and insisted that the therapist experience his or her own therapeutic sandplay journey as well (p. 32).

Each sandplay therapist has his or her own unique collection of hundreds of miniatures that the client uses to create a sandtray. As such, the objects in the collection as well as the sandtrays themselves may become transitional objects, helping to provide a bridge for the client into the world and between the unconscious and the ego, and thus replace "…to some extent, the person of the therapist" in assisting and empowering the individuation process (Weinrib, 1983, p. 51–52). No instructions are given to the client before creating each tray, and in this sense, the therapist is a "silent witness" (Mitchell & Friedman, 1994, p. xix) to a process that uses sand, water, and miniatures to create a "three-dimensional representation of some aspect of [the] psychic situation" (Kalff, 1980, p. 9). Analysis and interpretation are not offered by the therapist, because "we are dealing with a living experience" that cannot be completely described on a "conceptual level" (Weinrib, 1983, p. xi). As Jung (1969) so aptly wrote: "interpretations are only for those who don't understand; it is only the things we don't understand that have any meaning" (§ 65), including symbols, which by their very nature are numinous and ineffable.

Photographs and sketches are made of every tray by the therapist After the sandplay process has had time (up to 10 years) to be integrated, the client and therapist may choose to review the slides of the trays together, at which point analysis and thoughts about the process and the trays may be discussed (Mitchell & Friedman, 1994).

Sandplay may be a helpful therapeutic modality when working with clients who have experienced sexual trauma, as this case study illustrates. Some clients may not be able to communicate or express their sexual trauma and pain in the therapeutic setting and, in some cases, may have split off the experience entirely from consciousness. Sandplay may provide an opportunity for the client to use the symbolic function to express the trauma in the tray with his or her body, creating an image with the hands. Francesco Montecchi (1999, p. 27) writes that hands "can reveal secrets that often cannot be translated into words." The creation of the tray can then free up "the energy necessary for overcoming and healing injuries, both material and psychological…." Paola Manzoni (2011, p. 37) adds that the images in the sandtray are "sometimes capable of overcoming the barrier of the defence mechanism and allows into the scene elements able to awaken the consciousness," thus allowing the experience of sexual trauma to be remembered in a safe, protected, and bounded space.

Alchemy

Alchemists from the medieval period believed that alchemy began with Adam. However, the first written documents pertaining to alchemy are from the first century A.D. (Roberts, 1994). Alchemy is inherently paradoxical and difficult to comprehend. Even the etymology of the term is an enigma: "in the word alchemy we can trace the Arabic transmission to Latin culture of a Greek tradition of an art supposed originally Egyptian" (Roberts, 1994, p. 19).

C.G. Jung theorized that the medieval alchemists were projecting the psychological process of individuation onto the material world, using the symbols of alchemy. "The real nature of matter was unknown to the alchemist…In seeking to explore it he projected the unconscious into the darkness of matter in order to illuminate it. In order to explain the mystery of matter he projected yet another mystery–his own unknown psychic background–into what was to be explained…" (Jung, 1968, §345). He felt that "…the alchemist's hope of conjuring out of matter the philosophical gold, … was only in part an illusion, an effect of projection; for the rest it corresponded to certain psychic facts that are of great importance in the psychology of the unconscious." Jung observed that many of his patient's dream images were similar to archetypal motifs from alchemical texts, and he believed that alchemy "…provides the psychology of the unconscious with a meaningful historical basis" (Jung, 1970, p. xiii). He felt this so strongly that he based his theory of individuation itself on the alchemical process (Jaffé, 1963, p. 200).

The basis of the work, or *opus*, involved the analysis and separation of elements, where the "…opposite tendencies or forces were in conflict…." These elements would then realign in a *coniunctionis*, or union, creating an integrated whole (Jung, 1970, p. xiv). Jung believed that "without the experience of the opposites there is no experience of wholeness and hence no inner approach to the sacred figures" (Jung, 1968, §24). He felt that the conscious ego had to be able to discriminate and be

capable of separating and analyzing elements of the whole situation, dream, complex, or neurosis. He observed that "…the unconscious does not simply act *contrary* to the conscious mind but *modifies* it…," reflecting the ego, and thus expanding consciousness (Jung, 1968 §26).

The adept's path was seldom linear, and instead a winding or spiraling of energy was observed, "…a path whose labyrinthine twists and turns are not lacking in terrors," one where "…we meet with those experiences which are said to be 'inaccessible'" (Jung, 1968, §6). That is, experiences are inaccessible to an ego that does not habitually seek the material hidden in the dark and unconscious part of the psyche, particularly when that material stands in opposition to the conscious and one-sided position of the ego. Psychic contents that have been split off and are unconscious, what Jung called "the shadow," play a decisive role in alchemy, since they lead to the "…union of opposites in the archetypal form of the *hierosgamos* or 'chymical wedding,'" as these contents are incorporated and wed with the ego's consciousness (Jung, 1968, §42). The spiral nature of the work always revolves around the center, what Jung called a "circumambulation of the self" (Jaffé, 1963, p. 196).

The initial state that was sought in alchemy was called the *massa confusa,* or chaos, and is similar to what we see in the therapeutic process when the confrontation with the unconscious arises, including the integration of rejected and forgotten contents of the psyche, or the shadow material. "The *nigredo* or blackness is the initial state…" (Jung, 1968, §334), which held the *prima materia*, or material that was to be acted upon and transformed, such as the lead that was to be transformed into gold. "And just as the beginning of the work was not self-evident, so to an even greater degree was its end" (Jung, 1970, p. xiv). We witness this in therapy as well, when the end of one process signals the beginning stage of another, or a deepening of the same material we thought we had completed, which is often frustrating for client and therapist alike. The spiral then turns back and in upon itself before returning to a "forward" direction again. This is the essence of the alchemical path of the individuation process, one that is often not linear nor logical, but mysterious, dark, and frustrating at times. This aspect of the work was also referred to as the "*rota philosophica* or philosophical wheel," often indicating an ascending or descending movement (Fabricus, 1989, p. 15).

There were four stages of the alchemical work, including the *nigredo*, or blackness; the *albedo*, or whitening; the *xanthosis*, or yellowing; and the *rubedo*, or reddening (Jung, 1967). All phases were necessary for transformation of the *prima materia*, which underwent alchemical processes during each of the phases. They included *sublimatio*, *calcinatio*, *solutio*, *putrefactio*, *mortificatio*, *coagulatio*, *circulatio,* and *separatio*. We will see examples of some of these in the sandtrays. The purpose of these actions was to work on the *prima materia*, which is full of affect and dark emotions such as depression and rage. The burning, drowning, separation, coagulation, repetition, killing, and rotting of the material breaks the object up into its essential elements repeatedly, transforming the affect and shrinking the neurosis or psychological complex.

These processes took place in the "Hermetic vessel," which, although it was an instrument, also "had peculiar connections with the *prima materia.*…" This vessel

was not ordinary, but was "a kind of matrix or uterus from which the *filius philosophorum,* the miraculous stone, is to be born…the vessel is more a mystical idea, a true symbol like all the central ideas of alchemy" (Jung, 1968, §338). The vessel itself could be an oven, a retort, a glass beaker, a bath, or cauldron; any container that held the material. Jung (1968) believed that the work was not merely experiments in chemistry but "something resembling psychic processes expressed in pseudochemical language" (Jung, 1968, §345).

The sandtrays that my clients have made suggest that the tray itself often serves as the alchemical vessel, in which the client, like the alchemist, projects his or her own unconscious and individuation process, through the miniature symbols, onto his or her sandtray creations. This process may then be supported further with dream interpretation and other symbol work, such as active imagination (a form of deep meditation), which serves to deepen the very active and conscious therapeutic work in the tray.

The experience of sexual trauma is often split off and may remain frozen and unconscious, or held in the body and experienced somatically. Clients often describe the feeling that they are stuck in the trauma and are at a loss for how to move forward and heal. In the alchemical model, sexual trauma can be imagined as the *prima materia*, the substance that the alchemical processes break down and reformulate. In this case study, we can see how the client's experience of sexual trauma is held in the safety of the vessel of the tray and, as the *prima materia*, is transformed and made conscious. The alchemical process in sandplay has the potential to give the client an opportunity to heal trauma on both a physical and psychological level, breaking up the frozen aspect of the experience and creating movement.

A Sandplay Case Study

In this case study of a woman whom we shall call "Sarah," we will explore the *nigredo* phase of the alchemical process. The sandtray acted as a "free and protected space" within which Sarah could experience this dark phase, an alchemical process necessary for her to bring unconscious contents pertaining to her sexual trauma and her childhood to consciousness. The *nigredo* phase has to do with becoming conscious of one's own suffering, which often entails an intensification of the experience of suffering itself. It can be extremely painful, and this stage is associated with symbols of death, darkness, and the underworld. Without this difficult work, suffering remains unconscious and often manifests in addiction and other destructive behaviors. Additionally, individuals frequently feel that they are living painful lives without meaning. Existential despair may set in because the suffering they experience has no purpose. It is then unbearable.

Sarah and I started our work together in the spring, when she was in her late twenties, and ended a year later. When we had our first session, Sarah had been clean for 6 weeks from heroin use, from which she had overdosed and clinically died six times in her life. Sarah's body (her *prima materia*) was very involved in her

alchemical process from a very young age. When she first used alcohol in grammar school, her depression disappeared. With her first foray into sexuality, she was never again alone and panic-stricken. When she used drugs, she would stockpile food, re-creating a feeling of bodily safety that she fondly remembered her mother doing. When she could feel nothing, she cut and burned her body in order to feel deeply. Her method of delivering heroin to her system involved piercing the body with needless. The body and the material world (matter), most especially her mother (*mater*) and her internal undeveloped little girl, were the focus of our work together in the alchemical vessel of the tray.

Sarah

Sarah had a quiet, intelligent, shy demeanor and a soft voice. She was dressed in a stylish way, with short hair. She had moved to the mountain West from another area of the country to start fresh, but had not succeeded in her dream of living an idyllic rural mountain life. She seemed determined to find herself and a way out of her journey into the underworld of addiction, unhealthy relationships with men, and the trauma she carried from childhood sexual abuse.

The middle child of three, Sarah was close to her younger brother, but barely spoke to her older sibling. Her parents were educated, upper middle-class, and middle-aged. From the outside, things seemed average by American standards. Sarah stated that she had a "good relationship" with them. She had recently ended a 5-year relationship with a man; she had never been without a sexual relationship since her teenage years and had never lived alone. Her drug of choice was heroin, which she started using at age 17. She said heroin made her life "manageable." She used alcohol for the first time in fifth grade and enjoyed it. In her experience, alcohol was responsible for ending her suicidal depression in grammar school. Indeed, she stated that "using saved my life." Sarah reported that she currently suffered from panic attacks and agoraphobia.

During our first session, Sarah told me that she remembered being sexually abused by a neighbor boy starting at age 3; the abuse ended when her family moved away from the neighborhood when she was 7. She didn't tell her mother because she was scared. When she told her younger brother, he had trouble accepting it, which he expressed by withdrawing from her, which hurt her deeply. Although she was diagnosed repeatedly with cystitis during this time, surprisingly neither her mother nor her pediatrician seemed to realize that something was not right.

Sarah had a history of unhealthy relationships with men. Although she felt she had a good relationship with her parents, they both demonstrated a pattern of neglect and forgetfulness, as if Sarah didn't exist. This was especially true when her younger brother was born, and again when her older sibling was hospitalized for 7 months, when Sarah was 14 years old. Sarah felt that her parents continually tried to make up for their neglect with money, always offering to bail her out of situations without really being present for her emotionally. She noticed that she felt that she "wanted

to be angry" but didn't know why, and felt fearful and had panic attacks about "things never being right" unless there was a man around.

Sarah had been in and out of both individual therapy and inpatient hospital stays since she was 15 years old. At age 21, she completed a 30-day treatment program and, at one point, entered a 2-year residential treatment program, but checked herself out after 5 months. At that time she was diagnosed with bipolar II and prescribed lithium and several antipsychotics. She was not on any prescription medication during our work together.

Tray #1: At the Edge of the Ocean: Beginning the Journey

Sarah's first tray seemed as though she were standing at the edge of our journey together, ready to step into the ocean and the unknown that the great water holds (Photo 9.1A). She said, "It's the beach. I learned to surf in Hawaii last year. It was the most fun thing I've ever done." She stands alone, and for the alchemists, the work required a solitary life, including an inward seeking, as the process of individuation does. "Each worked in the laboratory for himself and suffered from loneliness" (Jung, 1968, §422) (Photo 9.1B).

The multiheaded sea monster in the water is Scylla from Homer's *Odyssey*, and she gives the seemingly idyllic setting an ominous indication of the tribulations Sarah is about to face on her journey. Scylla is a nymph who was turned into a monster by jealous Circe. She attacks ships because she is so enraged at her fate. Like Sarah, Scylla cannot contain her anger.

Edging up to the beach is a sea turtle, and a monkey stands next to a palm tree, to the left of the surfer girl. Could the monkey represent the fact that Sarah was not yet

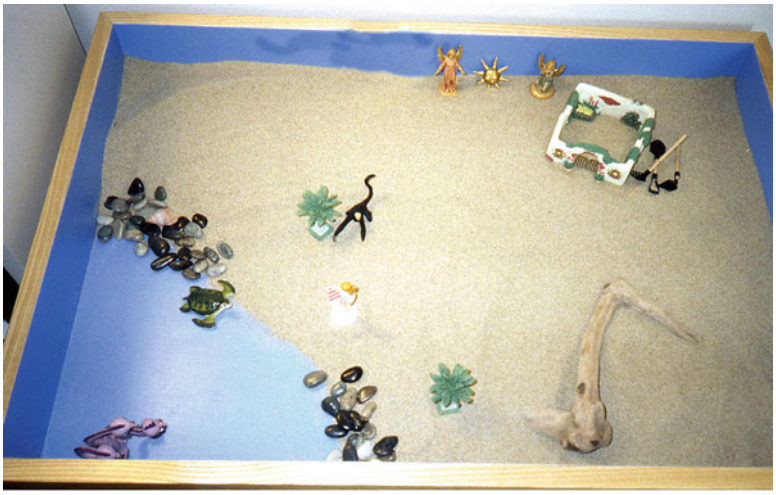

Photo 9.1A At the Edge of the Ocean: Beginning the Journer□

Photo 9.1B Standing at the edge of the ocean

finished with "the monkey" on her back? In different cultures, the monkey has complex symbolism, representing both the "sage and initiate," a "tempter" and a "trickster." As an ancestor of humans, he is capable of great wisdom, intelligence, and indulgences, and helps the sun to rise each day (Chavalier, 1996, pp. 664–67) (Photo 9.1B).

Bradway and McCoard (1997) write about the symbolism of the sea turtle, indicating that they save people who are drowning in the ocean. Turtles "never even see their mothers;" the eggs are buried in the sand, above high tide, and there is "no parental care and no teaching or guarding," similar to what Sarah had experienced with her own parents (Bradway & McCoard, 1997, p. 78).

Did this lone turtle indicate that Sarah would be spared from drowning on her journey into the unconscious? Or was it a symbol for a journey that she had to do alone, without her parents or various boyfriends, who, although physically present continuously, were chronically absent for her in terms of psychological support and nurturing? Her using patterns always revolved around the men in her life. A lone piece of driftwood sits on the beach, molded and eroded by the action of the sea, a castoff of the ocean. Before our first session ended, Sarah informed me that she often had premonitory dreams and felt that she had a "sixth sense" about things.

Behind the surfer girl is a gated and walled enclosure, holding and protecting a treasure chest with gold coins, with gardening tools outside the wall. Against the far wall of the tray is the sun, with two angels flanking him. The sun in many cultures and in alchemy indicates the ego and consciousness. In this tray, two angels stand next to the walled enclosure Jung's (1967) analysis of the vision of Zosimos, an alchemical text, describes "an angel who bears the secret" and is "connected with the meridian of the sun," who brings "illumination, … and expansion of consciousness" (§107). In this, the first tray, we see archetypal alchemical symbolism similar to that which Jung (1970) described seeing in his patient's dreams (§668). The sun may indicate the advent of consciousness and light required to awaken and heal Sarah, and the drying

Photo 9.1C A safe and protected space

aspect required by the waterlogged feminine unconscious in which Sarah was lost. The treasure that for now is protected in the walled space may be the "gold" that Sarah hopes to recover on her transformative alchemical journey (Photo 9.1C).

Tray #2: Walking the Spiral

The second tray was done a week later and consists of a spiral made with the damp sand. The spiral appears to be going in a clockwise direction, as indicated by the direction of the two butterflies. The sun is now in the middle of the tray. A lion cub watches from the right side, where there is a channel of river rocks and a cactus. There are two amber pyramids in the upper left and lower right corners. There is a *horno*, or oven, used by Pueblo Indians in New Mexico to bake bread, in the lower left corner. The oven and the sun hint at the beginning of a *calcinatio* process for Sarah, in which burning and heat will begin to symbolically break apart the *prima materia.* In alchemy, "'heating' is necessary; that is, there must be an intensification of consciousness in order that light may be kindled in the dwelling place of the true self" (Jung, 1967, §29). A flowering rose tree blooms next to the amber pyramid in the upper left corner. The ancient Minoan snake goddess, closely associated with the earth and the feminine body, gazes at the sun (Photo 9.2A).

In Egyptian mythology, the spiral indicates cosmic energy connected to life. The spiral is also associated with cycles of life which, when they near their end, start at the beginning again, much like the workings of alchemy (Cirlot, 1971, p. 305). Spirals move both inward and outward, containing the opposite within. They are associated with feminine symbols such as the moon, the vulva, shells, and helixes (Chevalier & Gheerbrant, 1996, p. 907). In Sarah's case the spiral may indicate the alchemical process of *circulatio,* or repetition, such as drug relapses. Jung (1968) writes that the work "…proceeds from the one and leads back to the one, that it is a

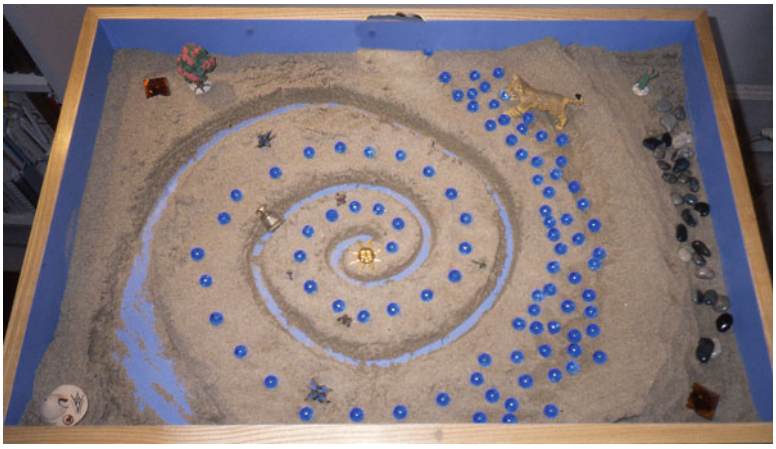

Photo 9.2A Walking the Spiral

sort of circle like a dragon biting its own tail. For this reason the *opus* was often called *circulare* (circular) or else *rota* (wheel)" (§404). For Sarah with her multiple overdoses and failed relationships with men, *circulatio* seemed to be a process with which she was intimately familiar.

The lion is associated with the sun, gold, the king, and consciousness in many cultures, and in alchemy is associated with sulfur, a "fixed" element, and fire (Chevalier & Gheerbrant, 1996, pp. 611–613; Cirlot, 1971, pp. 189–90). Like the eagle, the lion is able to look at the sun without blinking. It can become conscious without getting burned or inflated with too much consciousness, or polarized by one-sided viewpoints. In this case, the lion cub may represent an intensification of the sun's energy and a path to consciousness in the center of the tray that is not yet matured but is just coming into being.

Sarah said as she made this tray that she "wants to be angry, but I don't know why." Perhaps the ship in the bottle represented her bottled-up feelings. She talked about "never feeling safe or secure" and that when her mother is with her, it's a "false security." She was worried that "things will never be right or different" and that "I'll hate myself as much as I do now." Sarah said that these feelings led to panic attacks where she felt that she couldn't breathe. She also stated that she kept seeing "clips from the sexual abuse" perpetrated by her neighbor from childhood and that she was at a loss about "how to get over it." "I have no idea how to deal with this or walk through it." Sarah felt doomed to repeat the feelings of sexual trauma for the rest of her life. The spiral seemed to promise a way out, or down, to consciousness for her, involving both the lunar and solar aspects of consciousness working together, using both matter and spirit in the healing process, utilizing the wisdom of the ancient snake goddess and the eternal solar masculine.

Sarah now seemed to be in the "*nigredo*," or first phase of the alchemical process of individuation. The *nigredo* means black in Latin and is a dark time of confusion and depression, when what we used to know and how we coped in the past do not work anymore. In the *nigredo*, the *prima materia,* or the material being worked on,

undergoes alchemical processes that transform the psyche, so that the individuation process may take place. This is what Jung referred to as "the *opus*," which was necessary for transformation. What is made is destroyed, then re-created anew: a spiral that goes clockwise will unwind into chaos, then build order again. Alchemy is the *opus*, or the work, of life. It is what Jung called a "circumambulation of the Self," another circling or cycle that turns and twists back onto itself and then out into the world again (Jaffé, 1963, p. 196) (von Franz, 1980). The *nigredo* represents unconscious suffering. As the alchemical processes are applied to the *prima materia*, or psyche, that same suffering becomes conscious, and transformation takes place. Individuation and development of the ego are occurring as consciousness begins. The dawning of the sun and the lion cub may represent the possibility of a new attitude and awareness.

Tray #3: The Owl and the Descent

Sarah made this tray 6 weeks later and reported that she had experienced a rough week and "felt catatonic." She had a dream about an eagle she saw when she looked up from an alley. In the dream she was planning on using drugs. "He was huge, with golden light from his wings." Sarah had recently returned from a biking trip in the wilderness, where she had seen many golden eagles. She started this tray by adding water first, "like when we were on the trip." With its dampness and centering, this tray may indicate a dropping down into deeper consciousness, and into a darker, feminine space. Jung (1968) writes that the purpose of descent "…is to show that only in the region of danger (watery abyss, cavern, forest, island, castle, etc.) can one find the 'treasure hard to attain'" (§438) (Photo 9.3A).

Photo 9.3A The Owl and the Descent

Photo 9.3B The owl

Like the lion, the eagle in many cultures represents the sun and the king. It symbolizes the father and, in some cultures, Christ. It is the "king of birds" and, like the lion, is able to stare at the sun and achieve enlightenment without going blind. It is associated with spiritual growth and with angels. In some cultures it represents the sun itself. The eagle is often symbolized as an animal that guides souls into and out of the otherworld. Its feathers are considered powerful healing talismans. The eagle was associated in many cultures with divination (Cirlot, 1971, pp. 323–328).

This tray has a rocky mound in the center of a lake, on which there sits a tiny black owl with piercing gold eyes. Contrary to the eagle, the owl can see in the dark and is a night bird. The owl has significant symbolism for women and can represent the wisdom and divine help of the goddess Athena/Minerva. The owl has mixed meanings for different cultures, including being a harbinger of death, the bringer of wisdom, and being able to see what is coming, or having a sixth sense, as Sarah had described herself at the end of our first meeting (Biedermann, 1994, pp. 249–250).

This tray may indicate a shifting of consciousness for Sarah from the solar consciousness of the masculine eagle and lion to the lunar consciousness of the feminine owl. Like the spiral winding in and out, Sarah's process seemed to be a paradoxical journey that required both masculine and feminine energies (Photo 9.3B).

Tray #4: The Wicked Witch and the Wise Old Man

Sarah was very upset in this session, as she had just been in a car accident. A taxi had hit her car, and this tray was that scene. Her father had purchased the car for her, and it reminded Sarah of the time he had dropped her off at a concert when she was 14 years old, and left her downtown all night, having forgotten about her. Her parents had then developed a pattern of compensating for their neglect with purchases, such as the car they had bought for Sarah that was in this accident. I wondered if the car accident was not part of the descent that Sarah had embarked upon in the past few sandtrays, which seemed to be leading back to her childhood trauma of neglect and sexual abuse.

The tray contains an intersection with a stop sign, a stoplight, and a policeman, none of which can stop the inevitable accident, or confrontation with the unconscious. The wicked witch from *The Wizard of Oz* stands in the lower left quadrant, and the wise old man Obi Wan Kenobi from *Star Wars* stands in the upper right. Wise old men as symbols often portend a change. Both characters are from movies about young individuals who are on dangerous missions of self-exploration and identity. There is an eagle feather near Obi, and an angel stands in front of him, as if protecting him from the witch figure (Photo 9.4A).

The wicked witch is sometimes a symbol for the negative mother complex. Marie-Louise von Franz (1992) tells us that complexes are "…emotionally intensified content clusters that form associations around a nuclear element and tend to draw ever more associative material to themselves. They behave like unconscious fragmentary personalities." When complexes get activated, "physical changes also

Photo 9.4A The Wicked Witch and the Wise Old Man

Photo 9.4B The car accident scene

take place… these complexes affect the whole bodily sphere rather than just the brain" (von Franz, 1992, p. 3). In Sarah's case this is important, as the mother (or *mater*) as well as the body (or unconscious feminine) were problematic for her. Sarah would cut and burn her body when she could not feel. At those times, she internalized the negative mother and harmed herself. Sarah now found herself at a crossroads, in the middle of the negative mother and positive father, between matter (body) and spirit. She has to stop and experience the tension between the two without moving. Her car is totaled, so to speak.

The water added to the road is applied only to the horizontal part of the intersection, not the vertical. The tray is split in two as a result, and we can see the use of water and its *solutio* process working together with the alchemical process of *separatio*, or separation, to help Sarah make a distinction between herself and the negative mother. Sarah is often not capable of self-care and is her own negative mother, when she engages in destructive behavior. The Wicked Witch of the West cannot survive the *solutio* process and is killed when Dorothy throws a bucket of water on her, melting the negative mother complex (Photo 9.4B).

In *The Wizard of Oz*, the wicked witch wants Dorothy dead so that she can have Dorothy's power. In Sarah's life, her mother didn't protect her, and Sarah felt horribly betrayed and abandoned by her. Dorothy has no parents and is fostered by her aunt and uncle. Similarly, her alchemical transformation involves her body and her courage, and she is assisted mainly by the masculine in her ordeal. The witch is killed by water, or the feeling function, a function with which Sarah has trouble. In fact, Sarah's addiction issues and self-destructive behaviors center around her feeling function.

Tray #5: Confrontation of Opposites

Sarah showed up for her session with a look of worry on her face. She had killed a cat with her car. Cats are ambivalent symbols, representing both healing and harm. Bastet, the cat goddess in Egypt, is female, but associated with her father, Ra, the god of life. She represents lunar consciousness, as well as the "solar heroes of all mythology who fight with the devil in various forms" (von Franz, 1999, p. 55). In the medieval era, the cat was associated with the devil, and black cats were sacrificed in various religious rites. A white cat, however, is represented at the foot of Christ's cross, and is associated with healing, and the necessary sacrifice that leads to the renewal of life. Like Sarah's six clinical deaths, cats are said to have nine lives and can survive falls that would kill other animals. The cat is also associated with the individual independence of the feminine (von Franz, 1999). What was this cat's death about? Was this a sacrifice made literal by Sarah's unconscious processes? Jung (1970) found that "in psychotherapy, it often happens that, long before they reach consciousness, certain unconscious tendencies betray their presence by symbols, occurring mostly in dreams but also in waking fantasies and symbolic actions" (Jung, 1970, §668). The accidental death of this cat was a symbolic action writ large for Sarah.

During each of our last four sessions, Sarah had experienced some traumatic event that involved her car, including going to jail for an unpaid parking ticket. Was her vehicle, the one her father had bought for her to make up for past neglect, not able to carry her anymore? Perhaps Sarah would have to abandon her car and make the rest of her journey on foot. In the *nigredo* phase, what worked before no longer does, thus intensifying the suffering in order to make it conscious. Without consciousness, we can't change.

Sarah told me that she "set up situations to have feelings," so that she "would have a reason to have feelings." If there were not situations to be upset about, she would often end up institutionalized. It seemed as if Sarah could not hold the emotions and feelings, or the tension that they produced in her body. She told me that she self-mutilated to feel deeply. She said that she was "screaming inside," but that she grew up with parents who wanted her to look normal on the outside, yet didn't care what she did privately. It was as if Sarah believed that she was not allowed to feel unless she was in crisis or mutilating herself (Photo 9.5A).

In this tray we see another character from the *Star Wars* saga: the Jedi knight in a battle with a dark character. The battle is contained within a white picket fence, perhaps a symbol for the normalcy that Sarah's parents so badly wanted to display. Two dolphins watch the fight. Dolphins, like sea turtles, are said to rescue humans who are drowning in the ocean. There are blue and green beads in the tray, perhaps representing a continuation of the *solutio* process we saw in the previous tray. In the lower right corner, there is a lush grove of trees and plants that contains an eagle, a butterfly, and a dragonfly. A small lamb rests there also, witness to the battle raging within the picket fence (Photo 9.5B).

Jung felt that psychic energy, or libido, was created by the conflict of opposites. He theorized that the entire individuation process consisted of a series of oppositions

Photo 9.5A Confrontation of Opposites

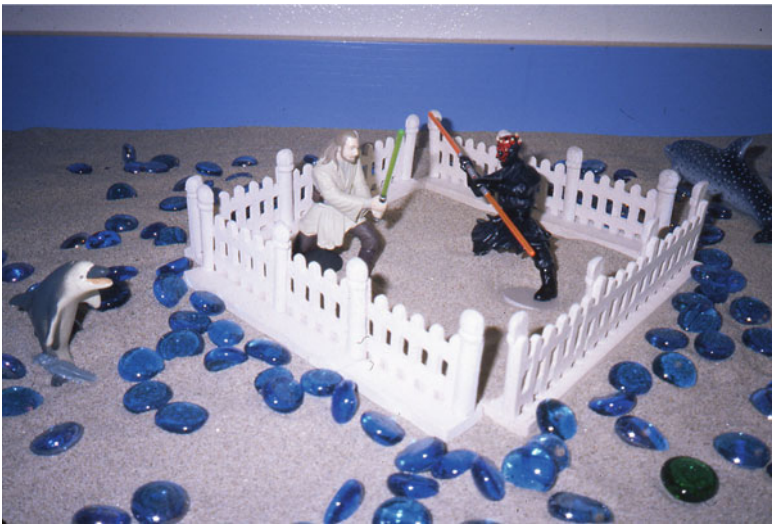

Photo 9.5B The tension between the opposites

that then had to be brought into union, or integration with one another. He called this the coniunctio, or conjunction of opposites (Jung, 1968, §24), and the transcendent function (Jung, 1970). "This continual process of getting to know the counterposition in the unconscious I have called the 'transcendent function,' because the confrontation of conscious (rational) data with those that are unconscious (irrational) necessarily results in a modification of standpoint" (Jung, 1970, §257). The opposition in the *nigredo* phase is between consciousness and the unconscious, particularly regarding the process of suffering. In this tray, the opposites are in a pitched battle,

as the masculine and the feminine were in the preceding tray. The cat, as a symbol, holds both masculine and feminine, healing and illness, within itself. As we will see in the next tray, so does the symbol of the lamb.

Tray #6: Excalibur and the Lamb

Sarah began a series of dreams about a baby girl at this time. In the first dream, the baby was desperately in need of care, and was kept in a shoebox inside a filing cabinet and had wet diapers on. It was not clear what would happen to the baby, since no one knew where or who the mother was, reminiscent of Sarah's missing caregivers. When Sarah did this tray, she had decided to end her unhealthy relationship and live alone for the first time in her life. She described breaking up like "getting off drugs." Perhaps being on drugs was, for Sarah, like being nurtured by her mother or lover, and provided for her a sense of safety and calm that eluded her when she was not high and remembering her sexual trauma and the ensuing panic and anxiety.

In this tray we see a tiny lamb lying next to Excalibur, the sword of King Arthur. Both sit in the middle of a relatively undeveloped mandala made up of river pebbles and blue and white glass beads. Excalibur is released only to King Arthur and, in the end, to the Lady of the Lake, or the lunar feminine. It contains the opposites within itself, in that it "serves to heal the wound it has inflicted" (Jung & von Franz, 1986 p. 86) (Photo 9.6A).

Perhaps the movement away from the boyfriend represents the alchemical process of *separatio*, in which discernment is acted upon the material, leading to a strengthening of the self-ego axis, symbolized by the lamb and Excalibur in the

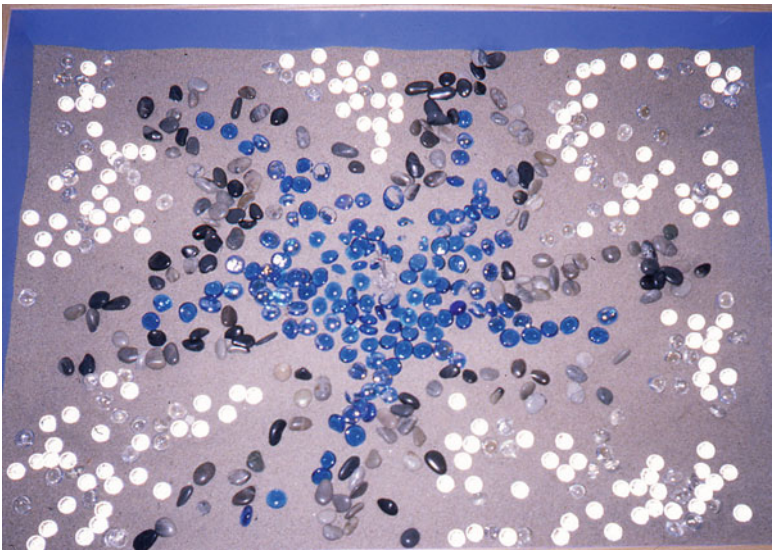

Photo 9.6A Excalibur and the Lamb

Photo 9.6B The sword and the lamb

center of this tray. Swords represent mental acumen in the tarot. Edinger (1985) observes that,

> every newly encountered area of the unconscious requires a cosmogonic act of *separatio.* Each new increment of *prima materia* calls forth a sharp-edged action by Philo's "Logos-Cutter." The creation of consciousness requires that new contents be carved out of the unconscious (Edinger, 1985, pp. 189–91)

In alchemy, the sword is a tool of discrimination, giving structure to undifferentiated conditions (Kobler & Murr, 2010, p. 492).

The lamb is associated with spring, rebirth, and hope. In many cultures, it is sacrificed to ensure its own salvation, as Christ was sacrificed (Chevalier & Gheerbrant, 1996, pp. 585–586). The sword is associated with the sacrifice of the lamb in the Catholic Mass (Jung, 1968, §417). The Latin word for lamb, *agnus,* is related to the Greek word *agnos* or the unknown, as well as *agni*, or fire; as such, the lamb is "a sacrificial symbol of the periodic renovation of the world" (Cirlot, 1971, p. 176). In alchemy, chaos, like the lamb, is sacrificed to establish order again, which then gives way to disorder. The alchemists realized that life is a spiral movement that moves in on itself and out again, symbolized by the snake biting its own tail, or *ouroboros*. The lamb is similar in its symbolism of beginning and end being contained in the same symbol. This is the second time the lamb appeared in Sarah's trays (Photo 9.6B).

Tray #7: The Archetypal Mother

Sarah was now living in an apartment by herself for the first time in her life. She announced while she was making this tray that she had stopped drinking coffee and

Photo 9.7A The Archetypal Mother

sugar. She also planned to quit smoking soon. She said, "I've never been able to do any of this before, now it just seems like the next step."

The storyteller grandmother sits at the top of the tray, holding multiple children, passing on wisdom and cultural knowledge to them. The sun sits in front of her, and both are inside of a circle made of river stones with three radiating lines on two sides that seems to repeat the sun motif. Below, at the top of a triangle that points toward the grandmother, is a small bowl of food (Photo 9.7A). Eastwood (2002) writes that,

> when we find triangle designs in sandplay, we can assume that energy is moving. Libido is the result of the tension of opposites. With the number three, we see a movement of energy toward synthesis and psychological self-sufficiency. (Eastwood, 2002, p. 67)

Perhaps as Sarah's relationship to food changed and she started mothering herself in a positive, life-affirming way, her relationship with the mother was changing as well. The last female figure that appeared in the sandtray was the wicked witch, but in this tray, the storyteller figure as a symbol for the positive, nurturing mother is holding many children, and food and care are available. This seems to indicate a transformation of the inner mother in Sarah's psyche, one who can allow her to create a new paradigm for self-care.

The sun is in almost the exact location as the last tray, perhaps indicating that the ego is being acted upon and in the process of undergoing transformation as well. The river stones are smooth and feel grounding here and remind one of the Native American medicine wheels made of stones that were found in the western United States. The stones seem to duplicate the sun's rays and the pyramids' shape from previous trays. Sarah did not do another tray for six sessions.

Tray #8: Reversing the Spiral

The feminine appears in this tray as a sensuous Asian woman who is enjoying her beautiful body in the center and beginning of a spiral. The spiral in the tray that Sarah had done in the beginning of her work seemed to go clockwise, yet this one was in reverse, and began the journey in the opposite direction, originating with the sensuous feminine. This tray, like the previous spiral tray, may represent the process of coagulation, whereby "coagulation is promoted by action (diving, churning, whirling motion)" (Edinger, 1985, p. 85).

The familiar masculine sun seems to be moving along the path as well, not far from the woman. Two soldiers carry a wounded man on a gurney. Is this wounded soldier a symbol for the traumatized part of Sarah's psyche being carried to consciousness? Two camels walk the spiral, following eight white horses. Camels are a symbol for sobriety, as they are capable of crossing the desert with nothing to drink, traveling across inhospitable and dangerous terrain. Three Chinese dragons sit next to the adult tiger, in the same spot where previously the baby lion sat in the first spiral tray (Photo 9.8A).

Tigers in China are the opposite of dragons and represent the active, dry, consciousness principle versus the damp, moist, and unconscious. "Five Tigers" guard the four cardinal points and bring order to chaos by holding the center of the world. They are symbols of strength and faith in Buddhism, and they are associated with shamans, who ride them (Chevalier & Gheerbrant, 1996, p. 1007). They often represent the North, the winter solstice, and protect humans from demons. The tiger rests at the end of the spiral in this tray, and as such may represent the transformation of the feminine in the beginning to the masculine at the end of the spiral. Many permutations develop along the way.

Photo 9.8A Reversing the Spiral

The eight horses have a prominent place in the tray and command our attention. The number eight is a symbol of wholeness (Jung, 1978, §351), doubling the number four. The circular spiral itself may represent a pattern of order that is beginning to emerge in Sarah's psyche. Eight is also related to the phases of the moon's cycle, and baptismal fonts often have eight sides (Eastwood, 2002, p. 163). The developmental task associated with the double quaternity of eight (two fours) is the transcendence of the "duality of male/female consciousness" to find equilibrium. "The symbol of the number Eight's integration is the caduceus, where two snakes–the material and the spiritual–are entwined around a staff" (Eastwood, 2002, p. 157). The integration of matter, or the body, and the spiritual seems to be a recurring theme in Sarah's trays. It may be that this is a path to healing the sexual trauma that she experienced, an attempt to connect body and spirit, masculine and feminine, and perhaps right and left sides of the brain, in terms of giving words and meaning to the unconscious and the unspeakable trauma lodged in Sarah's brain.

Horses are powerful archetypal symbols, and humans have had a profound and very complex relationship with them for thousands of years. Like many of the symbols in Sarah's other trays, they are deeply ambivalent symbols and may represent both dark and light energies; they are both life-giving and destructive forces. As a symbol representing heaven, earth, the body, and the instinctual, the horse often represents the self (Jung, 1978, §356). The horse is a symbol that arises out of the earth, the sky, and the ocean and represents life and death, fire and water. The horse is a "major lunar figure," associated with the moon, sexuality, divination, and the renewal of the seasons (Chevalier & Gheerbrant, 1996, p. 516). The "white, celestial horse" is associated with the sun, control and mastery, sublimation of instincts (Chevalier & Gheerbrant, 1996, p. 516), and with the triumphant Christ (Biedermann, 1984, p. 178). The horse travels between the two poles of moon and sun. The fact that there are eight horses in the tray may represent an attempt to integrate these paradoxical aspects of the horse energy in Sarah's life. Horses are also psychopomps in the world of shamanism and carry their riders into the otherworld. Additionally, horses carry people into the underworld of death, and horse is a common moniker for heroin (Chevalier & Gheerbrant, 1996, pp. 518–519).

During the 2 months after this previous tray, Sarah had celebrated her birthday without a man or her parents, as well as 5 months of abstinence from drugs. She had traveled home to visit her family and was feeling strong and positive. She was practicing self-nurturing skills that, she said, "were all new behavior to me." She was working on repairing her relationship with her older brother, the "high achiever." She noted that she always compared herself to her brothers and "was never good enough."

Before her trip to see her family, she had a second dream about the baby girl. In this dream, the baby is in a trashcan, "filthy dirty." Sarah is thinking about using and is furious that the baby is in this state. She notices that "other babies are not in the trash."

Sarah says, "I feel like I've grown, but I hate all this stuff about me; I'm more aware of it. I'm doing loving things while hating myself. I've gained 10 pounds. I'm using food as a defense, and I eat when I'm not hungry." She said that she had gone

to the grocery store for the first time in months and was cooking healthy meals for herself. She remembered that when she was using heroin, she would always buy groceries to feel "safe and nurtured, that there would be enough to eat." Like the positive and negative mother symbols, food seemed to take on an ambivalent role now, as Sarah was both overeating and gaining weight while cooking nourishing foods that represented health. It seemed that a transformation was taking place, where Sarah had one foot in both worlds and was in the liminal space of betwixt and between. Her behavior was changing for the positive, as she was becoming conscious of previously unconscious material and feelings that had a negative tinge to them. It was becoming clear that the baby girl in the trashcan was emerging and demanding to be dealt with; she was refusing to stay split off and separated any longer.

An important new development had also occurred. Sarah had met a man at a 12-step meeting. He was married and a newly recovering heroin addict; Sarah now decided to become involved with him romantically.

Tray #9: St. Michael and the Golden Lion

Sarah had not done a tray in 2 months and had started using heroin again with the man with whom she became involved with in the 12-step program. The circular process of alchemy and addiction was at work again, as the spiral began another round. Sarah's drug use always involved men with whom she was romantically involved.

She had had a third dream about the baby girl, who was now 3 or 4 years old, and a little boy who was 6 or 7 years old (approximately the same ages of Sarah during her sexual abuse). They walked together through the woods to a railroad trestle bridge, 30 ft above the ground. The tracks were painted baby blue and pink, and they were walking on the pink track. A train was coming on one track, and Sarah and the boy jumped onto a platform to avoid the train. The girl was too scared to walk, and Sarah went back to get her and carry her to the platform. She was relieved that the girl was safe. The girl then impetuously and without Sarah's consent started quickly climbing down the platform, and fell face down to the ground 30 ft below, when Sarah heard her head crack. The girl then looked up; she was not dead, but Sarah thought she must be badly hurt at this point. Sarah was very upset by this dream, but not surprised that the little girl showed up when she was using drugs. The little girl seemed to be taking on a life of her own, acting out in very destructive ways. The little boy was a new addition; perhaps a result of the integration of the solar, masculine conscious that had begun in the previous trays. It was notable that he was older than the girl, and did not hurt himself.

After this dream, Sarah began using drugs again when she was alone and started having panic attacks whenever she was without her boyfriend. She realized that the drugs were not working for her as they had before. They were no longer comforting. Something big had changed for Sarah. I wondered if the presence of the young masculine in the dream indicated a quickening of consciousness that was possibly

serving to temper the total immersion into the feeling function of the body that drugs afforded Sarah. There was perhaps a solar "drying out" going on now.

One day when she went to buy drugs, Sarah saw a baby rattlesnake lying in her path, which I felt was an unconscious and literal manifestation of the dangerous path she was on now. She went back to her old habit of buying groceries to feel grounded, comforted, and safe. She talked about the little girl who had now taken over, the one who had fallen off the trestle. Sarah then had another dream about the girl, who was now 4 or 5 years old in the dream. She was standing in the hallway of a house her family lived in before they moved away from the molesting neighbor, in a corner in the dark. Sarah felt scared of her and sorry for her at the same time. She woke up and imagined holding the girl in her arms, afraid that the girl would bite her, perhaps like the baby rattlesnake. The little girl was growing up and transforming now and was no longer able to contain the contents of Sarah's unconscious suffering and trauma. She was now angry and instinctual, and represented a threat to Sarah. Although she was only 5 years old, she seemed to be in control of Sarah's life.

Sarah and I started doing sessions on the phone at times because she could not leave her apartment due to her severe panic attacks. She remembered her first drink, and how the world changed for her then. She went from feeling suicidal every day to feeling wonderful. She described how betrayed she felt by her parents that they failed to protect her from the boy who had sexually abused her. She said her mother "had suspicions" about the boy. "It broke my heart that she knew and did nothing." She said she "felt guilty for feeling betrayed" by her parents. Sarah was now painfully conscious of her suffering and deeply conflicted feelings. Sarah's younger brother was born after they moved away from the perpetrator. As soon as he was born, she was sent away to live with an aunt, for "it seemed like forever."

The day that she made the next tray, Sarah recounted a dream she had about the world flooding, a dream in which people were gathering equipment that would be needed to live under the water, similar to the film *Waterworld*. They were getting ready to live in "disaster mode." They had large rafts, and she was a leader of one of the groups of people. Perhaps Sarah was getting prepared to make another descent into the unconscious, and I was relieved that there were equipment and rafts available for her survival. In alchemy, *solutio* is a process that transforms the *prima materia* at hand. *Solutio* involves water and the dissolution of the material in the water. Edinger (1985) states that "*solutio* often meant the return of undifferentiated matter to its original undifferentiated state – that is, to *prima materia.*" He goes on to say that "water was thought of as the womb and *solutio* as a return to the womb for rebirth." The symbols associated with this alchemical process include drowning, melting, intoxication, the ocean, tears, the moon, and flooding (Edinger, 1985, p. 47). Swimming itself "returns us to our primordial origins in water." In the water, "the ego's defenses are softened so that it can surrender itself to more flexible motility" (Kobler & Murr, 2010, p. 438).

Sarah had also dreamt of being in a house under construction, where a man was trying to murder his wife in the attic. In the construction of the self-ego axis, perhaps the thinking/ego/masculine side was trying to kill the emerging feminine/lunar/body side in Sarah's "head" or attic. In the wheel of life that Sarah was experiencing, a

battle was raging within her as, once again, the opposites confronted one another. Sarah remained in the nigredo stage of the *massa confusa*, or chaotic state, of her alchemical journey. I was reminded of the alchemist, who experienced the "opposite tendencies or forces in conflict" and who then had the onerous and challenging task of answering "the great question of a procedure which would be capable of bringing the hostile elements and qualities, once they were separated, back to unity again" (Jung, 1970, p. xiv). Sarah and I sat in the tension of this dilemma together, as she made her next tray.

This tray contained an apple tree in the upper center, surrounded by red glass beads and gray river stones. St. Michael is to the left of the tree, standing in the middle of four mirrors. It seems as though he is trying to hold the center in the quaternity of the four reflecting pools. The number four seasons; wholeness and completion; it is the square within the mandala's circle, and the cross. It is the four cardinal directions, the four winds, the four seasons; the basis of the year (Chavalier & Gheerbrant, 1996, p. 402). On one mirror sits the gold lion, quiet and small. Mirrors are reflecting tools and tell us about ourselves from a different perspective. They allow us to see ourselves as others do, yet also to gaze back at ourselves. They are made by painting glass with silver on one side, and hence are associated with the feminine and the lunar. Was it possible for Sarah to see the truth about herself? (Photo 9.9A).

This tray is intriguing in that Sarah had split the space diagonally and had used only the upper portion, indicating another *separatio* process. It seemed as if all of the energy was being marshaled into one half of the space. The color red is predominant in this tray: the autumn tree holds a few red apples, there are red beads, which Sarah had never used before, and St. Michael's cape is red. Red is associated with

Photo 9.9A St. Michael and the Golden Lion

Photo 9.9B Battle in the garden

the *rubedo* phase of alchemy, wherein the lifeblood is returned to the whitened material, but I knew that Sarah was not at that stage yet. She was, however, injecting herself and had been diagnosed with cellulitis, which is a skin infection caused by needles that results in a reddening and inflammation of the skin. St. Michael stabs the devil with his sword, but was the sword also a needle stabbing Sarah's skin? Was he aggravating her wound so that she could become conscious of the wound and her suffering? St. Michael is an archangel and is associated with justice and war. He is most often depicted with a foot standing on Satan with his sword drawn.

The apple tree is associated with knowledge and the otherworld. The knowledge may be from the tree of life or the tree of the knowledge of good and evil. Eating an apple may grant immortality, or in the case of Snow White, a deadly sleep, akin to a heroin overdose. The golden apple, like the lion, is associated with alchemical sulfur and the fiery process of *calcinatio*. In Celtic myth, it is a miraculous fruit that prevents old age and encourages renewal (Chavalier & Gheerbrant, 1996, pp. 35–36). I had many trees in my collection, yet Sarah had chosen a tree that represented deeply ambivalent and ancient symbolism, indicating choices about consciousness and life and death (Photo 9.9B).

Tray #10: Kuan Yin: The Good Mother

Sarah tried to detox through a methadone clinic and told me she was clean, but she was still using. It was almost Christmas, and she was planning to spend the holidays with her family. She felt positive about her relationship with the man she continued to see and use with.

In this tray, we see a lighted gateway with Kuan Yin standing in front of it. The white picket fence has reappeared and creates a starlike pattern emanating from the centered Kuan Yin. Perhaps the white picket fence is Sarah's hope for the future, or her parents' idealized and unrealistic vision that did not allow for the unpleasantness

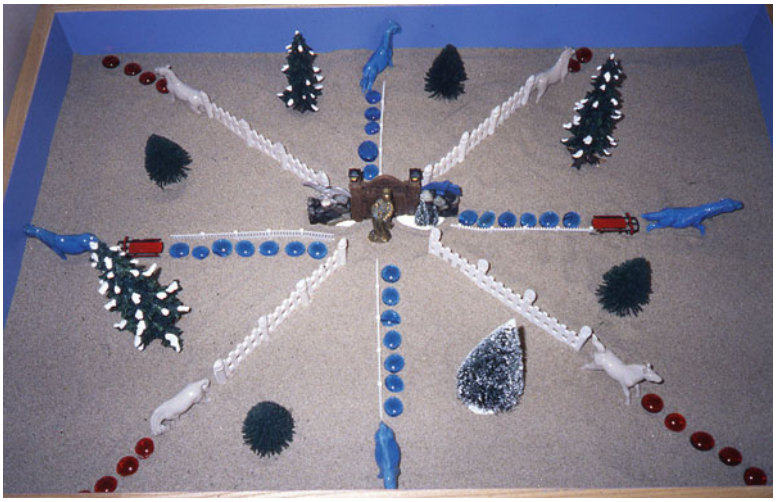

Photo 9.10A Kuan Yin: The Good Mother

of reality, and life's pain. The blue beads form a cross in the tray, anchored by four blue horses. Four white horses with red glass beads anchor the other four fences. There are eight evergreen trees, one in each of eight sections of the evenly divided tray. The number eight in the sandtray, according to Prahtibha Eastwood (2002), is a "harbinger of a reorganizing of personal reality into a new way of being, the creation of a core constellated in relationship with the Self." (p. 167). Eight is also "spirit returning and emancipating matter" (p. 164) (Photo 9.10A).

The tray seemed centered and still, like a mandala. The eagles that had helped Sarah in her dreams were now perched on either side of Kuan Yin: silver and blue, as if accompanying or protecting her. Kuan Yin holds a baby. Is it perhaps a baby girl? Sarah was feeling tired now, but she was also sure that she "wanted to live, that I like feeling, living life." She realized that she had lived most of her life not feeling. She stated, "I *am* just like a baby." Without her mother to comfort her when she was molested, or when her brother was born, or when she was a teenager and her older brother was hospitalized, Sarah had found a womb-like comfort in drugs and alcohol, which, as she said, had "saved her life." Although that had seemed so counter-intuitive to me when she said it, I was now beginning to understand what Sarah's relationship to drugs meant to her. They *had* saved her life, they had mothered and comforted her in a strange way, and led her on a labyrinthine path to this very tray of centeredness, in the midst of her suffering, her addiction, the chaos, and her trauma. The drugs, in a way, had created the *prima materia* that the alchemists had to find before they could begin the work.

I was amazed and humbled by this tray, which seemed to be a symbol of the transcendent function and the self, created by an actively using heroin addict. It seemed paradoxical, to say the least. But I remembered that in the alchemical process, the entire *opus* is paradoxical. The transcendent function is one that unites

Photo 9.10B Kuan Yin, goddess of compassion

"…pairs of opposites, which, as alchemy shows, are arranged in a quaternio when they represent a totality. The totality appears in quaternary form only when it is not just an unconscious fact but a conscious and differentiated totality; for instance, when the horizon is thought of not simply as a circle that can be divided into any number of parts but as consisting of four clearly defined points" (Jung, 1970, §261) (Photo 9.10B).

Kuan Yin is an Asian goddess of compassion and protects mothers and children. Could she protect and heal the instinctual and terrifying/terrified little girl that Sarah was so frightened of? The feminine had now progressed from Sarah herself as a helpless and traumatized baby, to the wicked witch, to the storyteller grandmother, to the compassionate bodhisattva, the one "who hears the cries of the world." Finally, here was a mother who could take in Sarah's unbearable pain and hold it, and Sarah herself. In the context of alchemy and the conjunction of opposites, it is interesting that until the late eighth century A.D. in China, Kuan Yin was a male bodhisattva named Avalokitesvara (Palmer, Ramsay, & Kwok, 1995, pp. 7–8). The masculine becomes the feminine; the opposites embrace, fold over, turn inside out, and start over again.

Tray #11: The Crossroad

Sarah created this tray while she was "maintenance using" heroin. She said as she made this tray that "something unattainable is possible now." She noticed that the tray was "pretty full with a lot of good things, but there are still some scary things." The negatives, she noted, were "mainly on the left side." The left side of the tray was notable for the disembodied doll's hands reaching out from the sand, surrounded by red demons. I felt that Sarah's work was about to go deeper.

The individual tiles were separate and distinct, indicating that the *separatio* process was happening again, hopefully providing some discernment about the various aspects of Sarah's psyche, including which parts were the negative complexes and which parts were the "good things." If we cannot distinguish what the parts are, we have trouble transforming what is destructive or nurturing what is beneficial for us (Photo 9.11A).

The individual marble squares seemed to form a transept, or cross in this tray, with the familiar sun in the center square, surrounded by a small gold feather that was used in previous trays, a black and white feather, a Chinese sage, and a ladybug. The transept form may indicate a physical sacrifice that Sarah is making with her body, as Christ did, in order to transform her sexual trauma and subsequent addiction cycle. The eagles had appeared again; there were also a shell, the monkey from the first tray along with the chest of gold, two gateways, two Chinese sages, a crystal ball, several rabbits, a rat, a lizard, a crane, a spaceman, an angel, a frog prince, a house, a seed pot, and some trees. At the very top was a tiny nativity scene, and at the bottom were a *Star Wars* character and a line of red demons, flanking the spaceman and the disembodied hands that seem to be desperately reaching out. There was also a fairy child on the right with her hand to her brow, as if something was terribly amiss. When I saw the marble tiles without the figures, it looked like a cross with blue beads at the foot in the shape of an inverted moonlike crescent, reminding me of the crescent moon at the foot of the Virgin Mary (Photo 9.11B).

Sarah continued to pretend that she was clean, and perhaps that is why there were elements contained within each tile, as if she were trying to compartmentalize and keep the chaos at bay while she tried to act as if she were not using, and create order in her tray. But the darkness was beginning to grow again after the last tray, which is common in sandplay. We often see trays involving reemergence of chaos, or a descent into the unconscious, after a centering "self tray." This example was another

Photo 9.11A The Crossroad

Photo 9.11B The transept

reminder to me that the sandtray itself is an alchemical vessel that provides the space needed to contain the ebb and flow of the work, as well as the creation of opposites, their painful confrontation, and reintegration.

Tray #12: The Final Tray

It was the new year now, and Sarah had returned from a reportedly good trip seeing her family for the holidays. She continued to use daily, and had finally told me. She was starting to have panic attacks again and had also started sleepwalking and eating food in the kitchen while she was asleep. Her unconscious was trying to find nourishment for her that was symbolically made up of empty calories. When she made this tray, Sarah noticed the food she had placed in the tray, and said, "I never noticed all that food before, and it's all my favorite foods." Sarah was not only eating food in her sleep, she was providing it in her tray, perhaps so that she could withstand the journey that lay just ahead. Similar to her flooding dream, maybe Sarah was now preparing for disaster. Sarah seemed to be desperately trying to find what she needed in the abundant food sources, but the destructive masculine that had tried to kill his wife in Sarah's dream from weeks ago had returned in the form of the hunter. He was gunning her down now (Photo 9.12A).

Sarah told me she had dreamed again about the troubled little girl. This time she was spanking her and couldn't "spank her hard enough." I wondered what the child

Photo 9.12A Gunning for an angel

had done to be so severely punished. Sarah asked for the first time if she could place an object on the edge of the tray. She put a tiny glass cat on the edge of the back of the tray on the right side. The cat as a symbol for the feminine was relegated to the edge of the space and was no longer allowed to be inside the vessel.

In this tray there are two humans: the distressed fairy child from the previous tray and a hunter who appears to be aiming directly at it. The eagle stands with its wings spread behind the fairy as if to attempting to protect it. There is a pail of spilt milk next to the eagle and a red heart, and the abundant food that Sarah will need to nourish herself (Photo 9.12B).

A month after she made this tray, Sarah was admitted to the hospital for possible heart valve replacement, among other physical issues associated with her drug use. She was very frightened. She detoxed while she was in the hospital and, in the end, didn't have to have heart surgery. She was released into her mother's care, with whom she returned to her home state to stabilize. Our last visit was at the hospital, where we said our final goodbyes. I looked down at the floor and spotted a blue glass bead like the ones Sarah had used in many of her trays. I reached down and picked it up and handed it to her. We were both amazed at the synchronicity of finding a sandtray symbol on the hospital floor. It seemed as though the lone blue bead was a ray of hope for her healing and future.

In the year that I worked with her, Sarah was in the *nigredo* phase of alchemy. She has since progressed in her journey, is in a long-term relationship, and has completed her education. She is currently active in her community and has several years of her own recovery. She now helps others in their path out of addiction and realizing their individuation process. She continues to believe that sandplay was a critical part of her recovery, as she had made many attempts in the past.

This case is an example of the alchemical process in the vessel of the sandtray, where Sarah had the opportunity to explore her painful wound of sexual trauma and

Photo 9.12B The Final Tray

neglect. She was able to experience a deepening of her own suffering in order to bring it to consciousness and transform its contents, and no longer has to act out the suffering repeatedly and unconsciously, as she had in the past. She no longer needed to repeatedly die. We as therapists occasionally have the opportunity to hold the tension between the opposites and sit in the alchemical process with our clients, waiting, sometimes interminably, to see transformation. Sarah's process taught me that in alchemy, transformations are always taking place, even if we cannot see them in the moments they are happening. It taught me to trust Sarah's process, and life, and the wisdom of the psyche that will always attempt to heal the individual who is suffering. I learned that I am only a witness to my client's journeys, in the vessel with them, sometimes in profound fear with them, for what will come next, perhaps even death.

I am very grateful for Sarah's generosity of spirit that allowed me to share her profound journey with others. She and all of my clients have given me an opportunity to witness their lives and journeys that require such bravery, heart, and perseverance. I am humbled and honored each day to be able to provide them with an alchemical vessel in which to transform, and to be able to accompany them on their journeys in the sand.

I would be remiss if I did not repeat the caveat that social workers who do not have training in sandplay therapy should be cautioned to not use this modality without (1) first doing their own process in the sand with a trained sandplay therapist and (2) obtaining the proper training themselves as practitioners of sandplay. Using sandplay as a modality without training and experience is unethical at best, and can be extremely dangerous to the client, at worst. The Sandplay Therapists of America website (sandplay.org) is a good place to start.

References

Ammann, R. (1991). *Healing and transformation in sandplay: Creative processes become visible*. Peru, IL: Open Court Publishing.

Bradway, K., & McCoard, B. (1997). *Silent workshop of the psyche*. New York: Routledge.

Biedermann, H. (1994). *Dictionary of symbolism: Cultural icons and the meanings behind them* (J. Hulbert, Trans.). New York: Penguin.

Cirlot, J. E. (1971). *A dictionary of symbols* (2nd ed.) (J. Sage, Trans.). New York: Philosophical Library.

Chevalier, J., & Gheerbrant, A. (1996). *The penguin dictionary of symbols* (2nd ed.) (J. Buchanan-Brown, Trans.). London: Penguin.

Eastwood, P. S. (2002). *Nine windows to wholeness: Exploring numbers in sandplay*. Honolulu, HI: Sanity Press.

Edinger, E. (1985). *Anatomy of the psyche: Alchemical symbolism in psychotherapy*. La Salle, IL: Open Court.

Fabricus, J. (1989). *Alchemy: The medieval alchemists and their royal art*. London: Diamond Books, rev. ed.

Jaffé, A. (Ed.). (1963). *Memories, dreams, reflections* (R. & C. Winston, Trans.). New York: Vintage Books.

Jung, C. G. (1967). The collected works. In H. Read, M. Fordham, & G. Adler (Eds.), *Alchemical studies* (2nd ed., Vol. 13) (R. F. C. Hull, Trans.). Princeton, NJ: Princeton University Press.

Jung, C. G. (1968). The collected works. In H. Read, M. Fordham, & G. Adler (Eds.), *Psychology and alchemy* (2nd ed., Vol. 12) (R. F. C. Hull, Trans.). Princeton, NJ: Princeton University Press.

Jung, C. G. (1969). The collected works. In H. Read, M. Fordham, & G. Adler (Eds.), *The archetypes and the collective unconscious* (2nd ed., Vol. 9i) (R. F. C. Hull, Trans.). Princeton, NJ: Princeton University Press.

Jung, C. G. (1970). The collected works. In H. Read, M. Fordham, & G. Adler (Eds.), *Mysterium coniunctionis* (2nd ed., Vol. 14) (R. F. C. Hull, Trans.). Princeton, NJ: Princeton University Press, 1989.

Jung, C. G. (1978). The collected works. In H. Read, M. Fordham, & G. Adler (Eds.), *Aion: Researches into the phenomenology of the self* (2nd ed., Vol. 9ii) (R. F. C. Hull, Trans.). Princeton, NJ: Princeton University Press.

Jung, E., & von Franz, M.-L. (1986). *The grail legend* (2nd ed.) (A. Dykes, Trans.). Boston, MA: Sigo Press.

Kalff, D. M. (1980). *Sandplay: A psychotherapeutic approach to the psyche*. Boston: Sigo Press.

Kalff, M. (2003). Foreward. In D. M. Kalff (Ed.), *Sandplay: A psychotherapeutic approach to the psyche* (pp. v–xv). Cloverdale, CA: Temenos Press.

Kobler, F., & Murr, K., (Eds.). (2010). *The book of symbols: Reflections on archetypal images*. Cologne, Germany: Taschen Press.

Manzoni, P. (2011). The body and the wound: Analysis with sandplay process. *Journal of Sandplay Therapy, 20*(1), 35–54.

Mitchell, R. R., & Friedman, H. S. (1994). *Sandplay: Past, present & future*. London: Routledge.

Montecchi, F. (1999). Hands that talk and analytic listening. *Journal of Sandplay Therapy, 8*(1), 25–67.

Palmer, M., Ramsay, J., & Kwok, M.-H. (1995). *Kuan Yin: Myths and prophecies of the Chinese goddess of compassion*. London: Thorson.

Roberts, G. (1994). *The mirror of alchemy: Alchemical ideas and images in manuscripts and books*. Toronto, Canada: University of Toronto Books.

Stewart, L. H. (1990). Play and sandplay. In K. Bradway, K. S. Signell, G. H. Spare, C. T. Stewart, L. H. Stewart, & C. Thompson (Eds.), *Sandplay studies: Origins, theory & practice* (pp. 21–37). Boston: Sigo Press (1981).

von Franz, M.-L. (1980). *Alchemy: An introduction to the symbolism and the psychology*. Toronto, Canada: Inner City Books.
von Franz, M.-L. (1992). *Psyche & matter*. Boston/London: Shambhala.
von Franz, M.-L. (1999). *The cat: A tale of feminine redemption*. Toronto, Canada: Inner City Books.
Weinrib, E. L. (1983). *Images of the self: The sandplay therapy process*. Boston: Sigo Press.

Index

S. Loue (ed.), *Expressive Therapies for Sexual Issues: A Social Work Perspective*,
DOI 10.1007/978-1-4614-3981-3, © Springer Science+Business Media New York 2013