

**Attachment Re‘story’ation through Playback Theatre:  
Construction of a Program Guide for Mothers with Insecure Attachment Narratives**

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## **Abstract**

### **Attachment Re‘story’ation through Playback Theatre: Construction of a Program Guide for Mothers with Insecure Attachment Narratives**

**Kimberly Jewers-Dailley**

This program guide is constructed based on a review of attachment theory, the reflective function, adult attachment narratives, and Playback theatre. Integrating Playback theatre, drama therapeutic exercises, and relevant theory related to attachment work, this original program guide serves to benefit mothers who have been indicated as having insecure attachment narratives by the Adult Attachment Interview (AAI). The 20-week, five-stage program intends to promote the reconstruction of attachment narratives, increase empathy and the reflective function, and facilitate insight into attachment experiences. Reflective functioning, a concept that has been shown to be fundamental in the attachment process, and empathy are promoted in the program by integrating the mothers in the Playback theatre process as actors. The group therapy structure also serves to promote secure attachment relationships and change the perceptions and expectations of personal relationships. Playback theatre is an effective modality for mothers with insecure attachment narratives as it facilitates an exploration of personal stories. Playback theatre offers a non-judgmental and respectful forum where stories are given a chance to be told, witnessed, and transformed in an aesthetic and powerful way. From member referrals to program evaluation, the program guide outlines necessary elements and steps needed to implement the program in a variety of settings.

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To my mother, for her strength...

To my garden, for always showing me the growth that can come from patience, passion, and love...

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## **Chapter 1**

### **Introduction**

The attachment between a mother and child is important and crucial to the social, emotional, and psychological development of the child (Bowlby, 1988). The style of attachment formed between the mother and child is dependent on many factors, including the mother's own past attachment experiences (Fonagy et al., 1991). These past experiences of the mother influence the ways she interacts with, responds to, and reflects the internal states of her child (Fonagy et al., 1991). Assessed by the Adult Attachment Interview (AAI) mothers with insecure attachment histories are unable to convey coherent, consistent, and complete narratives of their past. Furthermore, the mother's reflective functioning, the ability to reflect the internal states of the child, will also be compromised if the mother's past attachment experience was inconsistent or troubled (Fonagy, Steele, & Steele, 1991). Playback theatre techniques, which incorporate the telling, retelling, enactment and reflecting of stories, could help enhance the reflective functioning in mothers with poor attachment histories and would enable them to transform their life stories and gain new perspectives of life as it is expressed, reframed, and highlighted through art. Playback theatre as a Drama Therapy technique could promote healing and connection in mothers with poor attachment histories, which could thus be transmitted into the formation of a secure attachment bond with her child.

#### **Statement of purpose**

Through the use of Playback theatre in a therapeutic Drama Therapy framework, mothers with a history of past attachment problems would be encouraged to share their attachment narratives and become involved in the reflection of other group members'

experiences. The aim of this research is to explore how Playback theatre can help mothers increase coherency and integration of their attachment narratives, and improve the reflective function. Mothers with incoherent, or inconsistent, or incomplete attachment narratives and poor reflective functioning (both assessed in the AAI) are at risk for developing insecure attachment bonds with their children. The insecurely attached child is at risk for developing emotional deregulation, maladaptive behavior patterns, and in some cases psychopathologies. Therefore, this research is important as it explores the possible intervention of Playback theatre as a means of preventing the transmission of poor attachment bonds from mother to child.



## Chapter 2

### Review of Literature on Attachment

#### *Attachment theory*

Developed by John Bowlby (1969), Attachment theory suggests that there is a biological connection between a child and his/her caregiver that secures the safety and survival of the child. This connection involves the interaction of the child's expression of emotion with the response of the caregiver. Attachment Theory asserts that cognitive strategies, known as internal working models, are developed early in life. These internal models act as frameworks in controlling how interpersonal objects are addressed and understood, the kind of emotions that are triggered in the experience, and the memories that are recovered. Described by Bowlby as mental schemata, the models store information about the expected behavior of others towards the self, based on a complex, interwoven representation of past experience. For example, the child whose caregiver consistently responds to his/her needs will develop an internal working model that involves the child seeing him/herself as deserving nurturance and care; a belief based on their past experiences with the caregiver.

Children develop different styles of attachment based on experiences and interactions with their primary caregivers (Ainsworth, Blehar, Waters, & Wall, 1978). Bowlby (1969) suggested that the early attachment experience is vital for the child's understanding of the expectations of the self and others, adjustment to situations, and the shaping of the future. Ainsworth et al. (1978) identified four different attachment styles in the well-referenced Strange Situation experiment where behavioral strategies of toddlers were witnessed in the event of separation from their caregivers. She

distinguished four patterns: secure, anxious-ambivalent, anxious-avoidant, and disorganized infant attachment patterns in the infants. The securely attached infants were distressed by separation, then sought proximity with the caregiver upon their return and quickly returned to explore and play. The secure child is able to self-regulate their emotions, and easily recovers from distressing situations. The anxious-ambivalent infants were resistant and showed considerable distress at separation. When reunited with their caregivers, these infants were clingy, angry, and exhibited tense behavior. Less anxious about separation, the anxious-avoidant infants showed no preference for the caregiver over a stranger, and were unaffected by their caregiver's return. The fourth group of infants displayed disorganized patterns of attachment, where their behavior had no strategy or coherent structure in dealing with their caregiver's separation.

It is important to refer to the attachment styles as found by Ainsworth et al. (1978), for they indicate the role of the child's caregiver as a provider of a secure base. The secure base, and thus a secure attachment relationship, is formed by the parent's ability to balance the needs to protect and be available to the child, for the development of their independent exploration of their surrounding world. The insecure attachment relationship, whether avoidant or ambivalent, forms when the parent is unable to balance the protection and exploration encouragement needs of the child, or if one of these factors is not present at all (Mercer, 2006). When the mother is unable to form a secure attachment with her child, she is putting her child at risk for emotional deregulation, maladaptive behavior, distorted self and other representations, and possible psychopathologies later in life (Fonagy & Target, 1997; Mercer, 2006).

Another area of attachment theory concerns the transmission of attachment patterns from generation to generation. In the work of Main et al. (1985), as cited by Slade et al. (2005), it was initially expected that the events of parents' lives would be linked to their capacity to respond sensitively to their infants and would thus predict infant attachment. However, it was the degree to which the parents had integrated and made sense of their own early childhood experiences that determined their child's security (Main et al., 1985). Integration of early childhood experiences were reflected in the quality and organization of narratives using the Adult Attachment Interview (AAI; George, Caplan, and Main, 1984), an interview that asks adults to describe their early attachment experiences. Slade et al. (2005), reflecting on Main et al.'s (1985) work, states: "mother and fathers who were able to tell a coherent, fresh, believable, undistorted, and integrated story of their early relationships (regardless of the degree of hardship they had experienced in these relationships) were those whose children were more likely to be secure in relation to attachment at 1 year of age" (p.285). Thus, these parents were seen to have a "secure" internal working model of attachment. Such internal models, whether secure, insecure, or unresolved, were then seen to be conveyed from mother to child through behaviour. It was later found that reflective functioning, which will be discussed later, was also related to the transmission of attachment patterns between generations and is able to account for the "transmission gaps" in the research. Therefore, interventions with mothers who have experienced poor attachment experiences are very important as they can perhaps assist in discontinuing the transmission of such experiences to the mothers' children. The importance of mothers establishing secure attachments with their children will be discussed next.

### ***Attachment and the formation of the self***

Fonagy et al. (1996) suggest that security in infancy facilitates the development of an autonomous and coherent self. Secure children are more likely to have confidence in their abilities, to modulate their emotions, to communicate effectively in relationships, and to trust others (Fonagy & Target, 1997; Stroufe, Egeland, & Kreutzer, 1990). Ownership of one's inner experience is facilitated by the ability to effectively and confidently regulate affect. The *self*, in this context, comes to be seen as being a competent affect regulating assistant and also a vehicle to understanding the mental states of both the inner experience and the experience of others.

Security, in the form of maternal attunement, responsiveness, and attachment, can allow a child to put his/her feelings into words, deal with conflict or distress, and achieve a sense of fulfillment and meaning in their lives (Bowlby, 1988). Reflecting the work of Ainsworth, Mercer (2006) comments on the importance a mother's behavior has on the shaping of her child's internal working model of social relationship, including the self in relation to the world and others. An internal working model is a set of memories, emotions, and thoughts that determines a person's expectations and attitudes about the world and of others, and consequently shapes behavior. From the mother's behavior, the child develops particular expectations of others in relation to the self and learns to behave in specific attachment-related ways. Conversely, environmental failures such as parental unresponsiveness and mis-attunement may contribute to childhood pathology and feelings of emptiness and meaninglessness (Bowlby, 1988). Winnicott (1965) agrees with Bowlby in seeing the precursors of pathology and thus a disintegrated sense of self, as the failures of an infant's holding environment. Significant separations from the

mother or a lack of empathic responses from her, create an unstable holding environment for the child's sense of self to develop. The secure base, as indicated by Ainsworth et al. (1978), and likewise a secure attachment with the mother is thereby unable to form and support the child's psychological and self development.

The insecurely attached child lacks a secure base and is caught in a vicious cycle of anger, fear of retaliation or abandonment, and an increased sense of insecurity (Bowlby, 1988). The child expects to have their needs unmet, and fear emotional expressions, implicating severe effects on self-esteem, interpersonal relationships, and the development of the self (Bowlby, 1988). Therefore, the formation of a secure attachment between a mother and child is crucial for the development of the child's sense of self and his/her functioning within the world. Interventions to promote a secure attachment bond between mother and child are thus valuable and critical to healthy child development.

#### ***The mother as mirror: Reflective function and attachment***

Winnicott (1967) formulated that the mother's face is the *mirror* in which the infant first begins to recognize itself. To be seen is to have one's true self noticed, admired and mirrored by the near-perfect adaptation of the mother who promotes the illusion of omnipotence in her baby. Cited by Holmes (2001), Gergely and Watson (1996) found that the mother engages with her infant in one of two mirroring ways: the first is "marking", where the mother exaggerates normal facial and vocal expressions and thereby separates them from her own everyday expressions; and by "contingency", where the mother conscientiously puts herself aside so that she only follows and reflects her infant, and does not bring in any of her own feelings to the interaction. The child's sense

of self is thus reflected back to the child during this interaction. The infant is able to find his real self reflected in the caregiver's expressions and actions.

The reflective function (RF) is understood as “the capacity to understand one’s own and others’ behavior in terms of underlying mental states and intentions...a crucial human capacity that is intrinsic to affect regulation and productive social relationships” (Fonagy et al., 1991, p.269). In the mother-child relationship, reflective functioning is understood as the mother’s ability to hold in her mind a representation of her child as having feelings and desires, and reflect of these states back to the child unaffected by her own mental or emotional engagement (Slade, 2005). It refers to the mother’s capacity to hold, regulate, and experience emotion, where an entire willingness to engage emotionally with her child, to make meaning of internal states and feelings without becoming overwhelmed or disengaged. At the heart of sensitive caregiving, the reflective function promotes a child’s own ability to mentalize and process the actions of others (Fonagy & Target, 1997).

Fonagy, Target, Steele, and Steele (1998) have found that it is the parent’s capacity to reflect upon their child’s internal experience as being crucial to the development of a secure attachment. It is the parent or caregiver's ability to consistently make sense of and reflect the infant's early intentions and internal feeling states that gradually confers psychological status on the baby in the form of attachment (Fonagy, 1995). This gradual internalization of a sense of psychological self, of the self as an 'intentional being', motivated by beliefs, desires and other mental states, and, by extension, our ability to see others in the same way, is developed by and within a close attachment relationship where we have been seen in the same way. Where maternal

mirroring is characterized by over-accurate and therefore overwhelming reflection of the infant's feelings, or where it is non-existent, so that the infant's experience remains unacknowledged, the infant fails to find a representation of his/her self-experience in the mind of the other. Over time, and with the accumulation of such experiences, the development of a secure sense of self may be compromised.

This inability to reflect accurately has been found to be influenced by the mother's own attachment experience (Grienenberger, Kelly, & Slade, 2005). In the case where the mother was not reflected accurately as a child and where an insecure attachment was formed, she is more likely to be unable to reflect the states of her children and develop secure attachments. It is therefore crucial to help mothers with poor attachment experiences learn how to reflect the states of others so that they may learn to reflect the states of their children and thus develop secure attachment bonds.

#### ***Attachment and Parent Narratives***

*A narrative is composed of a unique sequence of events, mental states, happenings involving human beings as characters or actors...their meaning is given by their place in the overall configuration of the sequence as a whole...its plot.*

*(Bruner, 1990, p.44)*

One of the strongest predictors of infant attachment found is the caregiver's state of mind regarding attachment (Van IJzendoorn, 1995). Attachment state of mind refers to the way in which adults process thoughts and feelings regarding their own attachment experiences, and is assessed through the use of the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1996). The AAI uses open-ended questions about childhood experiences to reveal the adult's internal working model (Mercer, 2006). Certainly, stories of families cooperating happily reveal very different working models than do tales of abandonment or abuse. The AAI is analyzed for not only content, but also how

organized, coherent, and clear the stories are. Do separate stories form a consistent pattern of experience? Does the adult only remember particular experiences, or remember none? From the AAI analysis, four primary adult attachment classifications are generated: autonomous-secure, dismissing, preoccupied, or unresolved. An autonomous state of mind is shown by a coherent and plausible story regarding one's relationships with his or her parents, and the value of attachment. A dismissing state of mind is indicated by the deemphasizing of the importance of attachment relationships, and idealization of parental relations and an evident lack of recollection for attachment experiences. A preoccupied state of mind is assumed by current enmeshment in the relationship with parents, shown in the expression of anger toward the parents or by a passive and confusing narrative style. Finally, an unresolved state of mind is characterized by gaps in reasoning or discourse when recounting a loss or a trauma. The adult responses on the AAI have been found to be reliable, and do not seem to be related to other memory or intelligence factors (Mercer, 2006).

The autobiographical, narrative account of an adult's childhood and attachment history, as indicated by the AAI, can be linked to their behavior as parents, and with the attachment security of their children. Clear, coherent stories, as indicated by the autonomous adult classification, correlate with securely attached children (George et al., 1996). Dismissing adults tend to have children with avoidant patterns of attachment, while preoccupied adults have children with resistant patterns. Adults with unresolved attachment have children with disorganized patterns of attachment (Van IJzendoorn, 1995). Ultimately, the inability to tell any sort of story, or the telling of one that is entangled, confusing, or incoherent, reflects narrative incompetence and is linked with



insecure attachment. Similarly, coherency of a mother's attachment narrative is closely related to her child's behavior patterns and attachment status in the 'strange situation' experimental procedure. Connected to these findings, young children who are securely attached have been found to be more likely to understand affective states in others than those who are insecurely attached (Fonagy et al., 1996). This capacity, in turn, has been clearly linked to coherent parental narratives of past attachment. For example, those mothers and fathers who show a high level of 'reflective-self function' in their attachment narratives before the birth of their baby are 3-4 times more likely to have a securely attached baby at one year than those whose reflective capacity is low (Fonagy et al., 1991).

Thus, narratives concerning a parent's own childhood experiences and attachment views are connected to their own children's attachment patterns. The transmission of attachment patterns from parent to child can thus be predicted by the parental attachment states of mind as classified by the AAI. The parent's past experience of attachment as recounted by their narratives are suggested to impact the ways in which they behave in and approach their attachment bonds with their children. Therefore, interventions or treatments that will help mothers to reform, gain awareness, and heal their attachment narratives will help the formation of secure attachment bond between mother and child. The use of Playback theatre as a means of enhancing mother reflective functioning, and healing attachment narratives will be discussed in the next chapter.

## Chapter 3

### Review of Literature on Playback Theatre

#### *Playback Theatre*

*It's often only when we tell the story of what happened that some order can emerge from the abundant jumble of details and impressions. When we weave our experience into stories, we find meaning in what we have undergone. Telling our stories to others helps us to integrate the story's meaning for us personally.*

(Salas, 1996, p.18)

Developed by Jonathan Fox in 1975, Playback theatre began with a vision of a theatre where ordinary people would act out the stories of their community (Salas, 2000). Committed to the growth and expression of the human spirit through theatre, Fox combined aspects of ritual tribal life, where lives are interconnected and brought together to heal through ceremonial and artistic proceedings, and storytelling, an oral tradition where stories embedded with truth and wisdom are shared aloud. Also, Fox was inspired by Jacob Moreno's psychodrama approach, where strength is derived from the body and soul involvement of both the individual, or protagonist, and the group. Ultimately, Playback is theatre with the power and intention to heal and transform the storied lives of individuals, groups, or communities (Salas, 1996).

#### *Process and Production*

The process and production of Playback theatre involves the formation of space, roles, and ritual. Salas (2000) describes Playback's process in detail. Two chairs are set up at the side of a cleared, empty space. The chair closest to the audience is for the director or emcee, known as the conductor in Playback. Four or five chairs or boxes are set up along the back of the area for the actors to sit on. Opposite the conductor, a musician accompanied by instruments is situated, and a collection of large fabric pieces is

placed upstage. The conductor invites someone from the audience to sit beside them and come and tell a story, this individual is called the teller. The teller is asked detailed questions by the conductor to find out what happened, who was there, and how the story ended. The teller is then instructed to choose actors to play the key roles in his/her story, beginning with his/her self. The chosen actors stand to increase their attention and internalization of the teller's story. With the command, "Let's watch!" the actors act out the story and the emotional essence it contains as accurately and creatively as possible. Once finished, the conductor invites the teller to comment on the scene. If the enactment was not true enough to the essence of the story and does not satisfy the teller, the actors will be asked to redo some or all of it, taking the tellers comments into effect. If, in the case where the story has been enacted properly but has left the teller troubled, the conductor may ask the teller to imagine a new outcome, for which the actors will enact. This is called a "transformation" in Playback. This process continues, as new tellers are brought into the Playback space to tell their stories. In general, this process is reflective of Playback in a performance context.

"Workshop-model" Playback is more reflective of a therapeutic process (Salas, 2000). In this model, the group and its leader(s) play the Playback roles: conductor, teller, actors, and musician. Individuals take turns acting for one another and telling stories. This frame of Playback would be most therapeutic for mothers with insecure attachment experiences, as they would learn how to take on the actor, and thus reflective role, for other members in a group. In her work with children, Salas (2000) used the workshop frame of Playback. A significant growth in empathy, surfaced from allowing the children to enact and reflect their fellow members' stories, as they were able to safely

step into the feelings of another. Taking the roles in other's stories and witnessing and reflecting one another's experiences "engendered a compassionate fellow feeling" that was absent in their normal interaction with each other (Salas, 2000, p.295). The healing potentials of Playback will be discussed next.

### ***Playback and Healing***

While Playback theatre was primarily developed as a versatile theatrical form, it has been recognized by drama therapists and health professionals as a therapeutic approach. Emunah (1994) incorporates Playback theatre in her Five Phase Model approach to Drama Therapy. Recommended as a series or session closure exercise, Playback theatre enables collective creation and promotes connection and empathy. One person tells a real life story, which selected members in the group enact. The members do not necessarily enact a literal translation of the story, but rather attempt to capture and communicate the emotional essence. The members are therefore encouraged to connect with the teller of the story in a highly empathic, sensitive, and reflective way. This ability to effectively reflect the story, and its emotional essence, is promoted by the group dynamic and creative connection as emphasized in Drama Therapy and Playback theatre.

Similarly, in his description of the nine core processes of Drama Therapy, Jones (1996) indicates the healing potential of interactive audience and witnessing, the life-drama connection, and transformation in Drama Therapy. Playback theatre, in therapy and as performance, enables these therapeutic elements to express themselves and heal the participants. The first element, interactive audience and witnessing, refers to the act of being a witness and audience to others or to oneself. This element is inherent and crucial to theatre work, as without audience, theatre does not exist (Brook, 1998). A

crucial core to theatre is the emphasis it places upon the audience/performer encounter. The function of the audience or witnessing in Drama Therapy, like that of Playback theatre, acts as a way for clients to feel acknowledged and supported; a feeling that many adults who experienced poor attachment bonds in childhood did not experience (Ainsworth et al., 1978; Jones, 1996). Furthermore, clients can develop the 'audience' and reflective aspects of themselves towards their own and other's experiences (Jones, 1996). This experience enhances the capability to engage differently within themselves and life events, and contributes to active, sensitive, and empathic witnessing of others. In this way, individuals participating in Playback theatre engage in the witness and audience roles, and are thus more likely to enhance their ability to reflect the states of others and gain perspective and insight into their own personal and intrapersonal interactions. The second therapeutic element, the life-drama connection, indicated in Jones (1996) core Drama Therapy processes, exists in Playback theatre through the telling and enactment of life stories. This connection is intentional and essential to the process of change in both Drama Therapy and Playback theatre. Playback theatre acknowledges the therapeutic potentials of bringing life and drama in contact with one another. Life and drama are connected in Playback, whether intentional or not, through the telling and enactment of one's own or another's story. For example, a client may tell a story that, out of the drama or enactment, seems to have no meaning or relevance to his or her life. However, connection may be made during or after the enactment has been performed and witnessed. Similarly, one may not connect their life with another's story until an enactment takes place. The experience may then change the way they or the teller responds to a situation or the way they feel about the story or issue embedded within the

story. Ultimately, Playback theatre promotes the life-drama connection, and thus facilitates the opportunity to gain insight and awareness of life events from one's own or another's telling of stories. For mothers indicated as having insecure attachment narratives, Playback theatre provides the opportunity to not only enhance the ability to be an active witness and reflect the mental states and feelings of others, but encourages a life-drama connection where insight and life-awareness is gained. Lastly, transformation occurs in Playback theatre through reforming life events into enacted scenes and creating new outcomes to troubling life stories or circumstances (Jones, 1996). Through reorganizing and rearranging life material, whether through enactment or new outcomes, one is able to reflect, interpret, and understand their experiences in a new way. For some, the experience of bearing witness to a new perspective on troubling or enduring life stories provides the opportunity for healing and change. The troubled, incoherent, inconsistent attachment narratives of mothers would have the opportunity to be transformed in Playback theatre. The transformative potential of Playback can provide these mothers with the ability to form new associations and feelings related to their past attachment experiences and encourage reflection, insight, and more coherent understandings.

According to Salas (1996), Playback's healing efficacy comes from a number of elements. The first of which, is that people have an inherent and imperative human need to tell stories. It is through the telling of stories that culture, identity, history, and a self-positioning in the world is formed and maintained. Similarly, people tell stories as a way of making sense of their worlds (Gersie & King, 1999). In the act of storytelling, both the storyteller and the listener engage in a relationship, which connects them to each

other, to their families, to their culture and nation, through the past, present, and the future. Storytelling, as a reflection of life, gives meaning to existence.

Playback also offers a non-judgmental forum for the sharing of personal stories (Salas, 1996). No one is exploited or demeaned, but rather nurtured and cared for in Playback. The “safe place” established in Playback is healing enough for therapeutic change, resembling a therapeutic environment of unconditional positive regard. This provides even the most shy or disturbed individuals the chance to share their stories. Another healing benefit of Playback is the inherent aesthetic form it brings to life stories (Salas, 1996). When one encounters, or bears witness to something that reflects their own experience in an aesthetic form they are reassured, validated, and even inspired. This aesthetic component of Playback is healing in the way that it reveals the beauty within the stories told and presents life in a new and reformed way. This element of Playback would provide mothers with troubled attachment experiences the opportunity to witness their attachment stories in a way that is renewed, inspiring, and beautiful.

In the case where patients or clients are in the role of the actors, they experience an ultimate healing experience (Salas, 1996). Within this role, participants realize that they can help another. They gain an understanding and awareness of other group member’s feelings, internal states, and perceptions. Furthermore, one person’s story in Playback may embody themes of importance for others or for the group (Salas, 1996). The related meaning of stories holds perhaps the greatest healing power for Playback as it promotes group understanding, relatedness, and transformation. Personal memories are elicited in bearing witness to others’ stories. For the actors responding to narratives it becomes imperative to acknowledge the impact of the surfaced memories, but also to

remain empathetic and present in the moment of the other's story. In order for true and therapeutic responses, one must remain attuned and empathetic to the teller's emotions, and feelings. However, the imposition of personal memories can become a way for the actors to heal their own self-narratives as they engage in a dance between their own and other's stories (Salas, 1996). This interaction brings awareness to the stories, while also creating a new tale to be explored. Ultimately, Playback with mothers who have incoherent, inconsistent, or incomplete attachment narratives would promote reflective functioning through the enactment of others' stories, and encourage insight, transformation, and healing through the re-presented stories of their lives. The mothers would be able to see and present past experiences of attachment in a new, artistic, safe, and healing way.



## Chapter 4

### Narrative Considerations

#### *Narrative Approaches*

Specific narrative approaches would assist with reflection, resolution, and containment in a Playback program. A technique in narrative therapy called *externalizing the problem* allows one to objectify and, at times, personify his/her oppressive problems or key issues (White & Epston, 1990). This technique would provide the mothers with the opportunity to separate their insecure attachment issues from themselves and render them less restricted, better able to confront their issues, and able to describe themselves from a new, nonproblem-saturated perspective. It would also enable the development of an alternative story to attachment, a re-authoring of a troubled past, and options for dialogue about resolutions. It is recommended that this narrative approach be considered and implemented throughout the course of the program.

Also, incorporating what Tom Andersen (1987) names “The Reflecting Team” in the beginning and final stages of the program would promote the mothers exploration of their attachment experience, while facilitating the collection of significant past experiences for the team. The reflecting team format would also assist the mothers in developing an alternative story and bringing new insights to old problems related to attachment. Allowing the program’s team to express how they were captured, and personally affected by the mothers’ stories would create a “culture of acknowledgement” from the very beginning, and resonate through the remaining stages of the program. This reflective frame would provide the mothers with a sense of validation and contribution, and hopefully create a more reflective group.

## Chapter 5

### Integration

#### *Re[story]ing Attachment*

*There is evidence that just one relationship with a caregiver...who is capable of autobiographical reflection, in other words, a caregiver who possesses a high reflective self-function, can enhance the resilience of an individual. Through just one relationship with an understanding other, trauma can be transformed and its effects neutralized or counteracted.*

(Fosha, 2003, p.223)

The idea of attachment as being identified through narrative has been discussed. The ways in which attachment experiences are developed into internal working models relates to the ways in which the attachment narratives are constructed. The constructed models can be seen as scripts in which repeat experiences facilitate a generalized perception or “story” of attachment (Dallos, 2006). Dallos (2006), cites Goffman’s (1959) ideas of human interaction as being “analogous to drama, with the idea of different scripts that we can play, people as actors and authorship of scripts” (p.72). Byng-Hall (1995) connects this idea of scripts and story and describes attachment narratives as the stories we come to know about, and which come to form, our experiences. It is suggested that people’s ability to form a coherent story is related to mental health, even for people who have experienced some very difficult events (Baerger and McAdams, 1999). When these stories are not coherent and integrated, an individual’s experience can then be thought of as being unformed, confusing, and unhealthy.

In this way, one can begin to think about attachment narratives as stories in which the protagonist is the individual who has lived the experience. As they have lived the experience, they are also the authors of their story, which is being continuously ‘re-

written' by new experiences. What this then implies, is that the attachment narrative is not fixed, or permanent. According to Dallos (2006), a number of studies have indicated that even when people have experienced extremely difficult childhood experiences they can still be successful in overcoming these if they are able to form coherent accounts of their experiences. Furthermore, attachment theory suggests that the presence of one or more supportive attachment figures, and the process of therapy, can assist in the development of abilities, especially reflective functioning, so that one can become able to integrate difficult experiences. This relates to the discussion on the importance of the secure base between a therapist and client, as providing a repairing attachment experience and modeling reflective and coherent strategies.

Integrating Playback theatre with the understanding of attachment as a narrative self-story, influenced by reflective functioning, the proposed program facilitates the exploration and re'story'ing of the mothers' attachment narratives. The program is developed to help the mothers integrate and establish coherency in their attachment narratives while developing reflective functioning skills, both of which promote secure attachment experiences. Playback theatre, combined with Drama Therapy and psychodrama exercises, promotes the telling of personal stories and allows the teller to become a director in their lives. Witnessing the enactment and re-enactments of their stories, the mothers will be encouraged to reflect on the events in their lives and become aware of the inconsistencies, gaps, or unresolved issues in the stories. Playback theatre, and the promotion of spontaneity and play in the program exercises, will encourage the mothers to develop their stories into more truthful, integrated, and strength-focused self-narratives. This will then facilitate the creation of more secure attachment experiences

with the mothers' children or partners, and influence the mothers' psychological well-being.

The construction of the program follows.

## Chapter 6

### **Construction of Program: A practical guide to attachment re‘story’ation using Playback Theatre**

#### *Overview*

This program integrates Playback theatre with maternal attachment narratives in a group therapy process. It is a 20-week brief therapeutic intervention that works with mothers who are indicated as having insecure attachment, as shown by their attachment narratives on the Adult Attachment Interview (AAI). The ritual and therapeutic frame of Playback theatre provides an open, accepting space where personal attachment stories can be explored, transformed, and integrated. The integration of Drama Therapy and narrative approaches will also provide further exploration into the meaning and relevance of attachment narratives on the lives and relationships of the mothers.

#### *Program Referrals and Group Formulation*

Mothers will join the program based on recommendations by qualified psychologists, therapists, or other mental health professionals. Ideally, the mothers will have taken the Adult Attachment Interview (AAI), administered by a trained professional, and thus recommended for the program based on their interview classifications. Mothers with dismissing and preoccupied narratives are most indicated for the program. The mothers should ultimately have the choice to participate in the program and attend strictly on a willing and voluntary basis. However, once the mothers have joined the group, it is expected that they will attend the sessions and commit to the group and therapeutic process.

According to Yalom (2005), “good group therapy begins with good client selection” (p.231). The group dynamic in this program is of great importance to both the

success and maintenance of the therapy. It should be expected that the group format will stimulate feelings and behaviors from past or present relationships, especially those from family or close relationships. The people who enter groups usually have a history of “highly unsatisfactory experience in their first and most important group: the primary family” (Yalom, p.13). Yalom suggests, that group therapy resembles a family in many respects, including the presence of an authority/parental figure(s), peer siblings, intimacy, strong emotions, and hostile or competitive feelings. It can be expected that mothers displaying the insecure-preoccupied attachment pattern will show group behavior that is quite different than mothers presenting an insecure-dismissing attachment pattern. For instance, it would not be unrealistic to expect that mothers who present preoccupied attachment will have the tendency to become dependent on the therapist and instill a great amount of power and knowledge onto them. Idealizing the therapist and preoccupation with the therapist’s interests or needs can also be expected by these mothers. On the other hand, mothers who present a dismissing attachment pattern can be expected to treat the therapist as if they do not matter and that they are useless or unnecessary. They may be skeptical of the therapist’s abilities to help and will likely have trouble trusting the therapist as a safe and reliable source. It is thus important for the group therapist to not only allow the mothers to relive these familial conflicts and desires while in the group, but to have them be relived in the correct way. As such, growth-inhibiting relationships must not be permitted to freeze into the rigid impenetrable system that characterizes many family structures (Yalom, 2005). Instead, fixed roles must be constantly explored and challenged, and ground rules for investigating relationships and testing new behavior must be constantly encouraged” (Yalom, 2005, p.14).

In formulating the group, it is important to have an equal, or close to, number of preoccupied to dismissive mothers so as to both balance the group dynamics, and also allow the mothers equal opportunities for learning from the “opposite” side of their attachment pattern. In having the two attachment patterns co-exist in a group will allow for the fixed roles and behavior tendencies of the patterns to be challenged and explored, thus encouraging insight and change. It is recommended that mothers presenting a disorganized or unresolved attachment pattern be excluded from this program’s group formulation as the frame and scope of this program is not intensive enough for the work needed to be done with mothers of that attachment pattern.

Keen effort should be made in establishing a group that is willing and ready to explore their attachment relationships – past and present. It should be made clear from the beginning that the program is intended to help mothers manifesting insecure attachment patterns explore and understand their attachment narratives, and will not provide parenting advice or training. The mothers should be encouraged to see their attachment narratives as meaningful and relevant to their current or future relationships with their child/ren. Mothers who are disruptive and are unable to engage in the fundamental principles and norms underlying the program should be referred for more intensive help and not be included in the group.

If feasible, the mothers should have access to on-site childcare. It is encouraged that the children have an opportunity to engage in reflective play with trained play therapists or drama therapists. This work would then compliment the work being done with the mothers and would prepare the children to have reflective, attuned experiences

with others, as the internal working models of both mother and child are being reconstructed.

### *Space*

An adaptable dramatic form, Playback theatre has been performed in jails, hospitals, community centers, and shelters (Salas, 1996). Rowe (2007) says, “it is unusual for playback to take place in venues solely designated for theatre” (p.49). In deciding the space for the program, it is important to acknowledge and understand how the space will affect the mothers and the company. It can be expected that the personal nature of the stories will be influenced by the environment that lies both inside and outside of the space. For instance, if the space is located in the gymnasium of an elementary school, the mothers may bring up stories about their schooldays or feel overwhelmed and vulnerable in the expanse of the physical space to share personal stories. Also, it is important to think about what the mothers may have to do or encounter in order to get to the space. Will they have to search a congested parking lot in order to park their cars? Or, travel a difficult bus route? Will they have to climb six flights of stairs or make their way down a long and dark corridor before they reach the room? Will they have to pass by a baby nursery in a busy hospital? Ultimately, be aware of how the environment that surrounds and precedes the space of the program will trigger certain responses and memories in the mothers. The environment inside and outside the therapy space will undoubtedly influence the nature and tone of the personal stories told. This being said, there will always be triggers to memories that may not be accounted for in planning the space for the program. And, triggers are not necessarily “bad”, in fact they may help the mothers unconsciously “prepare” for the sessions. The point being is that a



genuine and conscious care and consideration is taken in choosing the space for the program. Above all, the space must be intimate, comfortable, and private to facilitate trust, connection, and most importantly, confidentiality for the mothers.

According to Salas (1996), the first task of a company is to transform a space to meet the needs of a Playback environment. Simply, the space must be accessible and large enough for the company to move and for audience members to witness. However, the space must be intimate to support the personal nature of the stories. The space should also have acoustics that are bright enough to support the speech of all members but not so bright that clarity is lost (Salas, 1996). The transformation of the space is important as it not only prepares the process, but also the atmosphere and tone of the work. Whether there is access to an actual stage or not, care and consideration should still be taken in creating a space where stories can be shared intimately and have the opportunity to come to life. Colors and textures can be added to the space through the careful selection and placement of the props and fabrics. See, "*Process and Production*" section of this paper for the specific Playback set-up.

Emunah (1994) recommends that group participants move the furniture themselves. In Emunah's opinion, "the rearranging of the room is symbolic as well as practical" (p.80). Allowing participants to move the furniture themselves allows them to have a sense of control and provides them, both practically and symbolically, with the opportunity to change their environment. Most importantly, in rearranging the room, "the stage is being set for new possibilities" (p.80).

### ***Role of the Facilitator***

The facilitator of the program is responsible for creating a safe, open, and playful environment where personal stories can be expressed and explored. The facilitator would take on the role of the conductor during the Playback time and would also be the group therapist to provide further processing and integration of the work.

### **Facilitator as Therapist**

Bowlby (1988) outlines the therapist's role, with five tasks, when applying attachment theory to work with clients. While he specifies this focus towards analytic, individual psychotherapy the tasks still remain relevant to the facilitator's role of a group focused on attachment work. The tasks outlined could thus be used further in the individual therapy sessions involved in the program. The word "clients" will be used here in place of Bowlby's word "patient" to help focus and clarify the suggestions so that they may act as guidelines for the work in this program.

The first task suggested by Bowlby (1988) involves the therapist providing clients with a secure base so that they may have the support and sympathy to explore the variety of unhappy or painful aspects of their life, whether past or present. This idea of the secure base is especially related to the relationship between the therapist and client. It is through the established relationship that the client begins to feel safe enough to explore their personal material. The therapist, in being attentive, sympathetic, reliable, trusting, and genuine, enables the client to feel secure in the therapeutic relationship and more willing to let go of defenses and resistance. However, because the mothers in this program have experienced insecure relationships, the secure base and the therapist can be thought of as being unsafe, and not truthful. On the other hand, some of the mothers may believe that the sympathetic therapist will save them from their past and be an ever-

lasting source of care and affection. It is thus necessary for the therapist/facilitator in this program to have a keen awareness of the many shapes each relationship with the mothers could take. Bowlby (1988) states that, “a therapist needs to have the widest possible knowledge of the many forms [the] misconstructions can take and also of the many types of earlier experience from which they are likely to have sprung” (p.141). The information gathered during the team interview in Stage One of the program is thus imperative to this task.

It is also important for the therapist to have a clear awareness of their own contributions to the client relationships, and expect that it will in some way reflect what he or she experienced during his or her own childhood (Bowlby, 1988). The counter-transference, a topic that will not be expanded on in this paper, and the complicated transference and misconstructions of the clients must be continually acknowledged and worked through in the here and now interactions with the client. As such, the relationship between the therapist and the client act as an opportunity for client to explore their attachment patterns and images, while being held within the safe container of the secure base and the therapeutic relationship. The secure base, and the role of the therapist in its establishment, will be further considered in this paper when outlining Stage Two of the program.

Continuing with Bowlby’s (1988) tasks for the therapist in attachment work, the second task is for the therapist to assist the clients in their exploration by encouraging them to consider how they interact with significant individuals in their current lives, to explore their expectations of emotions or behaviours in their relationships, and to consider the unconscious biases that exist in their selection of persons with whom they

hope to have intimate relationships. This task would manifest in the program by allowing the mothers to tell the stories of their relationships within the Playback Theatre form. Through Playback, and with the guidance of the therapist/conductor, the mothers will have the opportunity to consider, explore, and witness their relationships. The form would allow for a multi-sensory experience of the relationships, providing the opportunity for awareness, insight, and change.

The third task Bowlby (1988) outlines is the exploration into the relationship between the therapist and the client, which is highly encouraged. Into the relationship with the therapist, the clients “will import all those perceptions, constructions, and expectations of how an attachment figure is likely to feel and behave towards him that his working models of parents and self dictate” (1988, p.138). Simply, the clients are expected to bring their own attachment relationship experiences and expectations to the relationship with the therapist. Beginning the program, it can be expected that the mothers will be anxious and fearful. With these emotions present, the facilitator must expect then that attachment systems will be triggered to some extent. The mothers will actively search to find someone, in most cases the facilitator, to take on the role of attachment figure by any means necessary (Brisch, 2002). It thus becomes necessary for this experience and its many expectations to be explored. Again, the Playback form is recommended here, but the mothers may feel more comfortable exploring this area within the individual therapy sessions prescribed and recommended in this program.

The fourth task is for the therapist to encourage clients to consider how their current perceptions, expectations, feelings, and actions may be the product of their childhood or adolescence encounters or experiences, especially those with their parents,

or what their parents may have repeatedly told them (Bowlby, 1988). This process is seen to be difficult and frightening for some clients, as it encourages the exploration of ideas and feelings that were perhaps once regarded as impossible or unimaginable. The idea here is that clients may then turn to action, along with feelings of fear and anger, either towards their parents or the therapist. The establishment of a secure base, as outlined in the first task, thus becomes even more important during this fourth task.

Lastly, Bowlby (1988) suggests that the therapist's fifth task is to enable their client to realize that the images of him or herself and of others may or may not be suitable to their present or future. This allows the client to question and reflect on the accuracy of the images and how they may be affecting their ideas and behaviours within significant relationships, including their relationship with the therapist. The client is then able to see the images for what they truly are and not as the products of past experiences. For the therapist, this fifth task focuses on enabling their client to free themselves from their past, unconscious stereotypes and adopt new, and more truthful, ways of feeling, thinking, and behaving (Bowlby, 1988). This connects to the narrative approach of finding alternative stories, and is recommended to be encouraged during the Playback process.

In relation to Bowlby's five tasks, Brisch (2002) recommends that the therapist working with adults who have experienced attachment problems, take specific points into consideration. For the purposes of the program, the following selected considerations are encouraged:

- In his caregiving behaviour, the therapist must allow the help-seeking patient to speak to him via his activated attachment system, and make

himself emotionally available for the patient. This includes budgeting sufficient time and space.

- Taking the various attachment patterns into consideration, the therapist must be flexible in the way he handles closeness and distance with the patient, both in their interactions and in the establishment of the therapeutic setting.
- In his careful dissolution of the therapeutic bond, the therapist serves as a model for dealing with separation...a forced separation initiated by the therapist could be experienced as rejection. The patient should be encouraged to verbalize his separation anxieties and his questions about being on his own with the therapist – perhaps even to do some experimenting...(p.77) (*For the complete list, see Brisch (2002)*).

Like Bowlby (1988), Brisch (2002) encourages the therapist to become a secure base for their clients. Requiring a great deal of empathy and sensitivity, the therapist must adjust to and navigate through the attachment-driven behaviours and needs that arise in the therapy, in order to establish the security needed for successful treatment (Brisch, 2002). Holmes (1993), citing Bowlby's work, explains that individuals who have experienced insecure attachment experiences need specific needs in their relationship with a therapist. Relevant to the program outlined in this paper, Holmes (1993) cites Bowlby's work in saying that the ambivalently insecure individuals "need a combination of absolute reliability and firm limit setting to help with secure attachment, combined with a push towards exploration" (p.154). While individuals who have an avoidant attachment pattern, "associate close contact with pain and rejection...and so

benefit from a more flexible and friendly therapeutic relationship” (Holmes, 1993, p.154). The therapist facilitating this program must therefore understand the attachment needs of the individual mothers, and the group, and establish appropriate therapeutic relationships based on these needs.

Adding to Brisch’s last point concerning separation, it is imperative that the mothers be informed of the program’s timeline, especially the date of the last session. They should also be periodically reminded of the date of the last session throughout the duration of the program. The program has been designed to accommodate this separation process over a four-week period, as outlined in Stage Five.

While Bowlby (1988) and Brisch (2002) both focus on individual psychotherapy techniques, their suggestions can and should be applied to the group within the program. While all of their suggestions may not be put into action with each individual member at all times, they should be taken into account when considering the general position of the therapist working with individuals who have experienced attachment difficulties.

#### **Facilitator as Conductor**

According to Fox (1986), the conductor in Playback is the channel through which the words, feelings, and energies of the teller flows through. A good conductor, “an intermediary between actors and audience, has strong presence, connects the audience with feelings as well as thoughts, makes bold interventions and takes risks in the name of truth” (Fox, p.127). In being the conductor, s/he would be required to balance between playing a number of different roles. As a conductor, one “will probably need to be, at different moments, a master of ceremonies, a director, a therapist, a performer, a showman, a clown, a diplomat” (Salas, 1996). Most commonly, the conductor acts

between a director and an actor (Fox, 1986). As a director, the conductor needs to be aware of the time and agenda of each performance. They need to be able to keep the basic ingredients of the performance within the timeframe prescribed, while remaining spontaneous and open to change. Also, the openings and closings of each session and each story are in the hands of the conductor. Whether during a crisis or a revelation, the conductor must be able to bring each story to a close and allow the teller, audience, and performers to have their own space. It should be expected that boundaries will be challenged in this respect, especially when the group becomes more cohesive, intimate, and trusting. Most evident, the conductor is a director in the way that they attend to and shape the story of the teller. The story's essence provides him/her with the core around which to direct and shape the enactments, and serves as a guide for organization (Salas, 1996). Like a director, the conductor needs to have a firm grasp on the essence of the story so that the aesthetics may take form. It may be that the story is enough on its own to guide the actors into action, or it may need the conductor's guidance and attention to particular aspects of the story in order for meaning to emerge. It is through the care and consideration for meaning and aesthetic that the conductor as director takes true form.

Residing within the performance space, the conductor also takes on the role of an actor. Fox (1986) brings his attention to the shamanistic "act" of the conductor in saying, "The conductor is a kind of perpetual pioneer, leading a band of hearty souls into the Wild, Wild West of experience. In the Playback context, the conductor/shaman magically invokes a soul-shaking scene. The conductor stops the teller just at a moment when truth is touched and run away from."



The conductor suddenly alters the order of the program in order to seize inspiration. (p.134)

As an actor, the conductor in this program must ensure authentic and genuine presence with the teller and audience. They should not be “performing” in the sense of theatrical role-playing, but rather siding with an artistic and spiritual sense of holding and storytelling. Their ultimate attention is not on their own “act”, but is fully invested in the story and life of the teller. (For more on the “Conductor”, see Salas (1996) and Fox (1986).

Lastly, the program requires for the conductor to be a teacher of ‘skills’. The mothers will require the conductor’s guidance and experience to help them author their attachment narratives into coherent stories. The research of Baerger and McAdams (1999), cited by Dallos (2006), indicates that the ability to author one’s life into a coherent story is a highly complex skill. To attain coherency in narratives, the conductor must pay attention to the mothers’ stories and then focus on particular components that will encourage this process. According to Dallos, these components include, “setting the story in context, causal connections between events, and evaluation of events and a sense of purpose or a point to their lives” (p.75). The conductor should also encourage awareness and reference to shared cultural ideas of normal development, transitional markers, and expectations. Assisting the mothers to connect the events of their attachment experiences, the conductor will encourage the mothers to think about other people’s intentions and internal states, and thereby promote the reflective function. The conductor and the Playback form will also encourage the mothers to stand outside of their

stories and reflect on the inconsistencies, gaps, and details, leading to a more coherent and truthful narrative of attachment.

### ***The Company Actors and Team***

In this program, the Playback company will be group supporters and the members of the reflecting team, along side their roles as Playback actors. Whether the company has worked together or not, it is highly recommended that the company rehearses together before the initiation of the program. Rehearsal stories should include those from the company actors' childhood and involve tales from past and present relationships. In playing each other's personal stories, they will not only gain the teamwork and openness that is key to a Playback ensemble, but also gain the sensitivity and empathy necessary to play the mothers' stories (Rowe, 2007). It is important for the actors to be prepared for the types of stories and themes they will be encountering and asked to portray during the course of the program. In the sharing of each others' stories, the actors will begin to sensitize themselves to the impact of dramatizing personal stories and provide them with the opportunity to take risks and acknowledge their personal limitations. Planning and preparation, combined with frequent rehearsing and personal story sharing, will ultimately offer the actors psychic safety and provide protection for the tellers and their stories (Rowe, 2007).

Simply stated by Salas (1996), "playback actors have to be prepared for anything" (p.45). This program requires that the company actors have the emotional flexibility and openness to play many, expectantly painful, stories in a professional yet engaging way. Self-awareness, including knowing one's personal limitations and boundaries, is essential for the entire company. Salas (1996) emphasizes this importance in saying,

Playback actors need a great deal of emotional and expressive flexibility, grounded in self-awareness. No one is ever free from the features of their personality or from life problems, but actors who know themselves well can find resources to fulfill any role. They can go deeply into a character, summoning all the intensity called for by the story, and then step out of it when the scene is over. They develop strength and agility like a gymnast, using emotion and expressiveness rather than muscles. (p.47)

The company actors will also function as part of the reflecting team in Stage One and Stage Five of the program. Andersen's (1987) article entitled "The Reflecting Team: Dialogue and Meta-Dialogue in Clinical Work" outlines the roles and expectation of the team, and so will not be addressed in this paper. Andersen (1987) should be used as an essential guide for this process.

### ***Resistance***

Resistance in psychotherapy is a fairly common occurrence amongst most clients at some point in the therapeutic process (Emunah, 1996). Emunah, citing Laplanche and Pontalis (1973), describes resistance in psychotherapy as "the client's organized attempt at opposing the processes of becoming aware and of the emergence of unconscious forces" (p.84). Individuals who have encountered insecure attachment experiences can be expected to be especially resistant in the therapeutic process, as it requires them to be in a significant relationship with an "other" i.e. the therapist, or group. As previously stated, the intimate relationship with a therapist or group can trigger memories of past relationships and evoke feelings of fear, confusion, and anger (Brisch, 2002). Also, the

idea of “drama” or “theatre” as therapy raises anxiety and fears concerning performance, “standing out” or “being seen”, and appearing silly or childish (Emunah, 1996).

In addressing this expected resistance in regards to psychodrama, Leveton (2001), considers the idea of reducing the “staginess” and “performance” aspects of the process. Removing these qualities, the process integrates more psychotherapeutic work that can be found in more familiar therapy groups. For example, when using Playback theatre in the program, the stage can be anywhere. It does not have to be on a pre-established stage or in the center of the room, but can be where the group members feel most comfortable establishing it. Getting involved in the stage “construction”, the group members will also gain a sense of control and ownership over the process.

Emunah (1996) suggests that client resistance be played out in the dramatic activities. The activation of the resistance, as opposed to its suppression, allows for the resistant energy to be expressed and released. For example, the mothers in the program may be encouraged to play out a scene related to their fears of closeness, or fears of abandonment. Line repetitions, object transformations, and other drama therapeutic activities may be focused on bringing the mothers’ resistance into active expressions. Appropriate warm-up exercises are especially recommended to facilitate the playful acknowledgement of resistances and prepare for the session activities.

Lastly, the attitude of the facilitator is a crucial element in the dealing of resistance. In addition to the empathic, caring, and respectful presence, “it is important that the therapist’s own boundaries be clearly maintained and that she not be personally threatened by the clients’ manifestations of resistance” (Emunah, 1996, p.88). In dealing with the mothers’ resistance, the facilitator and team must remain open and caring, yet

firm, in order to transform the resistance into a playful exploration of the fears and anxieties that are likely to reflect the attachment patterns and behaviours of the mothers.

## **The Program**

### ***Program Structure***

The 20-week program is designed to accommodate from 8-10 mothers. The program is sectioned into five stages:

Stage 1: Assessment and Formulation (*Two weeks*)

Stage 2: Establishing a Secure Base (*Four weeks*)

Stage 3: Playback Theatre and Attachment Narratives (*Eight weeks*)

Stage 4: Making Meaning, Integration, and Saying Goodbye (*Four weeks*)

Stage 5: Re-assessment and Evaluation (*Two weeks*)

The stages are intended to flow into each other, overlap, and follow a developmental progression. Similar to Emunah's (1994) Five Phases in Drama Therapy, this program's stages are best seen as not structured, inflexible levels but rather a process of unfolding layers, revealing therapeutic growth and group process. It can be expected that elements from Stage Two will be present throughout all stages of the program, especially in regards to the established security and trust. It may also be that elements from three or four stages become involved in a single session. Most important, the stages are not intended to serve as a prescription for this kind of work, but rather provide guidelines. This program and its stages should be used to assist the facilitator(s) in group progression and pace, identifying group needs, and choosing techniques and interventions.

While the stages are accompanied by recommended week durations, this author recognizes that there is not a set or “perfect” time through which a group may progress through the stages of this program. The weekly indicators should be taken as guidelines and not as a prescribed standards of progression through the stages of the program. If, for instance, more than four weeks in needed for Stage One processes and goals to be achieved, then extra time should be taken and the program schedule adjusted appropriately. Ultimately, program duration and group progression should be guided by treatment goals, group needs, and facility or funding rules and expectations.

### *Sessions*

Each session will be 120 minutes (2 hours). The sessions should be held at a convenient time of day and in an easy accessible space. It is recommended that individual therapy sessions are made available to those participants who request more time and space to process their attachment experiences.

As this paper serves as a guide for the implementation of a program, general session procedures will be provided. However, session guidelines will be provided as framed within the five stages of the program and should not be taken as final or all-inclusive. The program, while designed with particular goals and objectives, may be shaped differently than specified within this paper. The use of this paper should be used as a guide, not as a practical how-to manual.

Stage outlines are divided into the following areas:

- 1) Overview
- 2) Stage objectives
- 3) Therapeutic goals

- 4) Recommended exercises
- 5) Role of the facilitator and team
- 6) Other considerations

It is recommended that the mothers keep personal journals to facilitate further reflection inside and outside of the group space. Journal keeping may also facilitate memory work and allow the mothers to unearth once-forgotten memories or feelings.

### ***Session Structure***

The sessions will always begin with a warm-up, which should include games and activities that encourage and promote reflectiveness, trust, empathy, spontaneity, group cohesion, openness, flexibility, playfulness, and safety. The warm-up will be followed by the Playback and narrative exercises to facilitate attachment narrative sharing, exploration, and transformation. Finally, the sessions will always end with a closing ritual that will promote the therapeutic container while acknowledging and validating the themes, stories, and tellers of that day. Recommended Drama Therapy exercises and Playback theatre methods will be provided, but not elaborated upon. For elaborations and further reference please see Boal (2002), Emunah (1994), Fox (1986), Jones (1996), Leveton (2001), Salas (1996), Spolin (1999), and Sternberg & Garcia (2000).

### ***Stage Outlines***

#### **Stage 1: Assessment and Formulation (Two weeks)**

##### ***Overview:***

Before being recruited to the program, the mothers should be assessed by the Adult Attachment Interview (AAI). Having done this, the mothers will then enter the program and take part in this initial assessment stage. In this stage, the selected mothers

and their families will take part in a team reflection interview process. As outlined by Andersen (1987), the interview will provide the therapists and the family access to important familial information while allowing new ideas and alternative stories to emerge. The interview will act as the first opportunity in the program for the mothers to explore and reflect upon their attachment experiences. It will also act as the groundwork for the emergence of alternative stories and more integrative attachment perspectives. Having the team members witness and reflect upon the mothers' stories, will establish a foundation from which change may arise.

The focus of the interview should be on the mothers' experience within their current and childhood family, i.e. how she relates/ed with the other family members. The interview should not alienate the mother nor make her feel as if she is the "problem". The interview should rather be used as a way to know how the mother experiences her family and how the family experiences her. The interview should include all family members as sources of information. It is most important for the therapists to get a good sense of what the family perceives as problematic, and how the mother's attachment experiences are constructed and played out within the family.

What is most important in this process is that the mothers, and their families, are given the opportunity to think differently about their relationships. Through the reflecting team's speculations about the family, the mothers will have the opportunity to become more familiar with and perhaps question the patterns and stories that exist within themselves and their family system. Acting as observers to the family, the reflecting team provides alternatives and offers new perspectives on old problems. Andersen (1987) expands on the reflecting team's role by saying,



The reflecting team tries to imply the notion of *both-and* and *neither-nor* by having members of the reflecting team take this stance, and by members of the team underlining that what they say is based only on the version of the problem that each perceives. In this way, they convey the idea that the problem has many aspects and is multifaceted. We believe that the family, or whoever is watching the reflecting team, can discover the richness embedded in the sharing of various points of view on the same issue (p.11).

With this experience, it is hoped that the mothers will then enter the program with more insight and a greater willingness to explore their attachment narratives.

*Stage objectives (in no particular order):*

- Introduce the mothers to the team and the program.
- Create a safe and comfortable space for the mothers and their families.
- Include the mothers' family members in the assessment to gain a complete and inclusive record of the family system and functioning.
- Gain clear understandings of the mothers' family functioning and her attachments within and outside of the family.
- Collect information about the mothers' attachment history, including significant relationships with relatives, friends, and past partners.
- Assess mothers' connections with their families and the team through body language and verbal observations.

- ‘Collect information about the mothers’ family systems, including the quality of relationships, and the historical, societal, and/or psychological factors affecting their families.
- Prepare the mothers for the exploration of their attachment narratives.
- Begin the process of seeing new and “other” ways of experiencing and understanding attachment experiences.

*Therapeutic goals (in no particular order):*

- Establish a therapeutic space based on safety, trust, and openness.
- Connect with the mothers through empathic listening and genuine interest.
- Model a reflective stance towards feelings and expressed emotions.
- Create an environment where the sharing of personal material is not judged, scored, or given specific value.
- Reassure the mothers and their families of the intention to help.

*Recommended exercises:*

The team reflection process is the only exercise recommended for this stage.

*Role of the facilitator and team:*

The therapist(s) and team should follow the guidelines as set out in Andersen’s (1987) paper on the reflecting team for this initial stage of assessment. Their role is to facilitate the telling, exploration, and reflection of the attachment and family stories unearthed within the process of the interview. They should not be directive, but rather supportive of the telling of family stories. The team should be reflective and model a genuine interest in the mothers’ stories. The team’s reflective behaviour is an important process for the mothers to witness and be a part of, as it becomes an important skill for

them to acquire during the course of the program. Importantly, another task of the team is to provide the mothers and their families with new and alternative ways of thinking about their problems and attachment histories. According to Andersen (1987)

The reflecting team has to bear in mind that its task is to create ideas even though some of those ideas may not be found interesting by the family, or may even be rejected. What is important is to realize that the family will select those ideas that fit. Some may be found useful and be used; the hope is that they will trigger a small change in the family's picture or in its understanding of the picture. The reflections may even trigger a change in the understanding of this understanding (p.5).

For the mothers, the team's role in this stage is to begin the process of reflection and change. By suggesting new ideas and perspectives on attachment narratives and family problems, the team encourages the mothers' curiosity and hope for new possibilities. What the mothers experience during this first stage, will become the vehicle from which exploration and transformation occurs. The ideas and thoughts that emerge during this initial stage will likely be the focus of the mothers' explorations in the program. Therefore, by the end of this stage, the team should have a strong understanding of each of the mothers' attachment experiences and family relations, and be able to use the team interviews as a basis for group formulation and the development of treatment goals and session objectives.

*Other considerations:*

This initial stage will be the first time that the mothers meet the team. It can be expected that nervousness and anxiety will be present in both the mothers and the team

members. For both parties, the initial meeting can be an exciting, yet scary time. It is a time when hopes and expectations are made and yet feared to be unmet or broken. Questions of personal worth and likeability also come into thought. Individuals who have experienced insecure attachments can be especially wary of new relationships. New relationships for these individuals can trigger a number of complex feelings, including rejection, hostility, distrust, and anger. Clients, in general, will re-create their relational patterns within a group (Yalom, 2005). It can be expected then that the mothers, who have experienced attachment difficulties, will likely re-create relational patterns that reflect their attachment style, within the group.

This will also be the first time that the mothers' are witnessed within a group setting. Their behaviour during this initial assessment stage can be indicative of their behaviour within the group. According to Yalom (2005), the more similar the test group procedures are to the actual therapy group procedures, the more accurate the prediction of the client behaviour. Therefore, the assessment should model how the team and facilitator will work within the program in order to get the best sense of how the mothers will behave within the group.

## **Stage 2: Establishing a Secure Base (Four weeks)**

### *Overview:*

Stage Two is the most important and crucial stage to the success of the program. As noted previously, one of the most important roles of the therapist in attachment work is to provide a secure base for the client. Without a secure base, "therapy cannot even begin" (Bowlby, 1988, p.140). Bowlby (1988) relates this role of the therapist as being similar to what Winnicott describes as "holding" and what Bion calls "containing". In

therapy, the secure base can be thought of as providing clients with a psychic space and therapeutic relationship that is supportive, encouraging, and safe. The therapist needs to provide their client with a strong sense of safety and a place where they can be open, honest, and vulnerable. Bowlby (1988) explains that the role of providing a secure base is one of availability, readiness, and if needed, intervention. The therapist, as a provider of a secure base must be available to the needs of their client and be ready to respond when encouragement or assistance is needed. Active intervening, may only take place when the need is clearly necessary. The secure base is especially important for clients who have experienced insecure attachment experiences, as they will generally have more difficulty forming strong, secure, and trusting relationships with the therapist, the team, and the group as a whole (Bowlby, 1988). Research on psychotherapeutic technique has shown that among a variety of variables that influence the results in therapy, the therapeutic bond between a therapist and client is one of the strongest factors influencing success (Orlinsky, Grawe, & Parks, 1994). The quality of the relationship between a therapist and their client has been consistently found to be related to the success of the therapy (Joyce, Piper, Ogrodniczuk, 2007). The therapeutic relationship affects the ability of the client to open up, and be willing to let go of their defenses and resistance. According to Brisch (2002), “without a secure base - in other words, without a secure therapeutic attachment - it is difficult to work through affectively laden conflicts” (p.76), which include attachment relationships, losses, and separation. The client looks for a secure attachment figure in the therapist, so that they may use the attachment to endure the exploration and processing of their emotional content. The establishment of a secure base within the therapeutic bond and amongst the program members will be essential for

the successful treatment of the mothers in the program. Hence, the primary goal of this second stage is to establish a secure base within the group, between its members, and between the facilitator(s) and the members.

While the secure base is the most important aspect of Stage Two, there are also other aspects to be considered. Stage Two is the first time that the mothers will be meeting together with the facilitator and team. It will be their first time in the group and in the space. The pace of this stage must be slow and careful to ensure the safety and comfort of the mothers. The exercises used in this stage must be carefully planned and focused on the group as a whole, rather than on individual needs or demands. This attention directed towards the group, as opposed to individuals, will begin to strengthen the bonds between members as it encourages belonging, universality, and group cohesion. Holding the members within a unitary energy, the group work will assist in the establishment of the secure base, trust, interpersonal relations, and safety, while improving the chances of attendance and the success of the program. Specifically, mirroring exercises should be used in this stage to encourage the mothers to initiate the important process of attending to and reflecting the states of the 'other'.

*Stage Objectives:*

- Welcome the mothers and introduce them to the space, to the facilitators, to each other, and to the program.
- Communicate the roles of the therapist/facilitator and ensemble.
- Communicate program goals, objectives, and expectations.
- Begin to build an atmosphere of hope, trust, and safety through drama and improvisation exercises.

- Establish a secure base.
- Create a group contract that incorporates the needs of all members.
- Promote group universality, instill hope, and work on group cohesion.
- Have the group become familiar with the group rituals. For example, it is suggested that the sessions always begin and end with the whole group in a circle, to establish a sense of togetherness, unity, and strength. Another ritual may be to move the furniture together before the actual sessions begins, although this ritual may not be necessary for some spaces.
- Have the facilitator be very active during these initial sessions in Stage Two to energize the group, connect the members, and initiate the process (Emanah, 1994).
- Over the four weeks, gradually work towards having the mothers play roles, tell stories, and participate in the enactment of stories or scenes in the sessions.

*Therapeutic goals:*

- Establish a secure base.
- Encourage emotional expression, trust, spontaneity, play, physicality, group interaction, and sharing.
- Create a culture of openness and acceptance.
- Establish group rituals to foster a sense of belonging, ownership, and collective creation. For example, the Magic Box exercise may be used at the beginning and end of sessions to ‘open’ and ‘close’ the group process.

- Establish the boundaries/rules of the program and group, to ensure safety for both the mothers and the facilitators.
- Communicate the program goals and expectation as they are intended to facilitate a safe and holding environment for the mothers.
- Develop the groundwork for a trusting, playful, and spontaneous environment where mothers can gain access to past material and begin to feel safe expressing themselves.

*Recommended Exercises:*

Following Emunah's (1994) suggestions for drama therapeutic work, the exercises at the beginning of a program should encourage the group to work together and interact. The focus of these exercises should be on emotional expression, trust, observation and concentration, group interaction, and physical activation (Emunah, 1994). Spontaneity and play are also encouraged during this stage to foster more openness and flexibility to changes, challenges, and the "unknown". The exercises should be planned to flow into each other and used to set up themes and topics for the day. Considerable time should be given in this second stage of the program to allow for the mothers to get to know one another and the team. The exercises chosen during this stage of the program should be "simple, engaging, failure-proof, and age-appropriate" (p.36) to avoid client resistance, early drop-out, or indecisive commitments (Emunah, 1996). It is especially important for the exercises to be age-appropriate and not childish or demeaning. As trust is one of the main goals of this stage, the exercises should not instill fear, anxiety, or embarrassment, which can often accompany the act of being childish or child-like. Moving on, this stage represents a time in the program for the



mothers to begin to think about the stories they will tell during the Playback stage of the program. Thus, nearing the end of this stage, and if the group is ready to begin their transition into Stage Three of the program, the exercises should begin to focus on storytelling, scene and role-playing, and the mothers' own individual stories.

The following exercises, in no particular order, are recommended for this second stage of the program:

Beginning of the stage and sessions:

- Magic box
- Name game (including sounds, movement)
- Categorical groupings
- Nurturing falls
- Blind walks
- Pushing against each other
- Joe egg (aka trust circle)
- Rag doll
- The line up
- Hopes, fears, and expectations
- Changing places
- Complaint department
- Nasty/nice
- Group Sculpture
- Questions
- Feedback

**Middle of the stage and sessions:**

- Mirroring exercises
- Emotional statues
- Line repetitions (group and partner)
- Storytelling and narrating a scene
- Script dialogues
- The week in review

**Closing the stage and sessions:**

- Magic Box
- Fortunately/Unfortunately
- Circle ball throws
- Space substance
- Object transformation
- Handsqueeze

***Role of the facilitator and team:***

Before the session (and every session following) begins, it is recommended for the leader of the group to make contact with each individual group member. The ensemble may also decide to make contact. According to Emunah (1994), “during this contact, even if it is just for a brief moment, the therapist gains a sense of the client’s state and, equally important, the client picks up the attitude of the therapist” (p.80), which should be an attitude of care, genuineness, and acceptance. As the group is ongoing, this contact will reestablish connection with each of the participants and bring them from their outside world and into the therapeutic space.

The facilitator and team are ultimately responsible for creating, planning, and facilitating sessions that are for the purpose of establishing a secure base, and promoting emotional expression, spontaneity, and group cohesion. They need to be directive and intentional during this stage in order to establish the group structure and program foundation. Also, the more structure the sessions have at this beginning stage, the more it helps to ease the anxiety and resistance that can be expected of the group members in this beginning process (Emunah, 1996). While being structured is important, it is also necessary for the facilitators to allow the group to guide them and shape the sessions to suit their needs. This will allow the group members to feel a sense of ownership over their process and of their group, and provide with a sense of belonging and of being helpful. Lastly, the facilitator and team should always keep in mind the themes, stories, and images that surface during this beginning stage as it will help to plan and focus the later sessions. The pattern behaviour and relational dynamics existent in the group and individual group members should also be noted to inform later work and treatment goals.

*Other considerations:*

Stage Two provides the foundation and framework for the program. Its goals and objectives should not be taken as optional, but rather as necessary steps required to continue into the next stage of the program.

**Stage 3: Playback Theatre and Attachment Narratives (Eight weeks)**

*Overview:*

Stage Three is the heart and soul of the program. It is within this stage that the most work and change is expected. Stages One and Two can be thought of as the pathway and the door leading to change. It is in Stage Three however, that we find the

key, are able to enter the house, and truly explore and live within the walls of lived memories and life. As such, Stage Three is the longest (eight weeks), and the most intensive stage in the program. It is the stage where the attachment narratives come to life through the Playback form.

Playback theatre techniques and processes are the focus of Stage Three with the intention of unearthing, exploring, and transforming attachment narratives. The narrative focus in Playback theatre provides the opportunity for attachment experiences to be re-storied and given meaning. Through the telling, witnessing, and enactment of the narratives, symbols are given new meaning, events are transformed, and distorted or false stories are given the space for truth to be found. As previously discussed, the narrative capacity that is compromised in mothers who have experienced insecure attachments, affects their behaviour as parents and the security of their children. Insecure attachments create a “broken line” in the construction of a coherent narrative (Holmes, 1993). The use of the Playback form in this stage, accompanied by drama therapeutic techniques, will provide the opportunity for the mothers to make meaning out of their “broken” or “unstoried” lives. The mothers will enhance their narrative capacities through the telling, re-telling, and witnessing of stories and have the opportunity to develop reflective functioning skills as they enact, reflect, and ‘live’ the stories of others. With a secure base, the group therapy process, and narrative work, “the ‘broken line’ of insecure attachment is replaced by a sense of continuity, an inner story which enables new experience to be explored, with the confidence that it can be coped with and assimilated” (Holmes, 1993, p.158).

*Stage objectives:*

- Facilitate the sharing of personal attachment stories, using Playback, Drama Therapy techniques, and psychodrama exercises.
- Continue providing a secure base and establishing a trusting, safe, and open group.
- Continue to work on group cohesion, spontaneity, and emotional expression.
- Teach the mothers how to reflect on the stories of others and how to be an empathic, reflective actor in Playback.
- Promote reflective functioning skills through the integration of the mothers as actors in the Playback method.
- Reflect on and discuss the impact and meaning of the stories told in the group and enacted in Playback.

*Therapeutic goals:*

- Maintain and strengthen the secure base.
- Maintain and strengthen the trust, safety, and cohesion in the group.
- Increase the mothers' emotional expression and openness.
- Promote the establishment of meaningful, secure relationships with/in the group and the team.
- Unearth, share, and reflect on personal attachment stories.
- Develop and transform the mothers' narratives.
- Create a "culture of acknowledgement" (White, 2000).
- Enhance the mothers' reflective functioning skills.

- Promote and facilitate the construction of more coherent, connected, and truthful attachment narratives.

*Recommended Exercises:*

The exercises in Stage Three are focused on the exploration of childhood memories related to experiences and relationships, and on present relationships. Psychodrama techniques are used more in this stage, to facilitate personal stories and childhood conflicts. The exercises are also intended to facilitate memory recollection and focus on individual, as opposed to group, processes.

The exercises listed are to complement and initiate the Playback theatre method, which is to be the main exercise and focus of Stage Three sessions. The following exercises are recommended:

Beginning of the stage and sessions:

- Feedback
- Childhood play
- Time travel
- Next step
- Treasure trunk
- Family fantasy
- Writing with the unaccustomed hand
- Family sculptures
- Doubling exercises
- Photo album
- The social atom

**Middle of the stage and sessions:**

- Family roles
- Family therapy
- Person in your life
- Therapist-client
- Hidden conflict
- Transformations
- Ideal planet
- Yourself at different ages
- Building a home for the group
- Sociograms
- Exploration of past and current roles, and role relationships
- The self-presentation
- The body knows
- The family in action
- Role-reversal exercises

**Closing the stage and sessions:**

- De-roling exercises
- Sharing and reflections
- Non-verbal gift-giving
- Handsqueeze
- One-word-at-a-time
- Group poem

- Magic box

*Role of the facilitator and team:*

The facilitator in this stage takes on the dual role of the conductor and the therapist for the group. It is important for the facilitator to balance between these two roles and to fulfill the requirements of each (see the *Role of the Facilitator* section in this paper). The facilitator should also be aware of their transition from group leader and therapist to individual listener and director. This transition from a global leader to a more individually-focused leader can be expected to impact the mothers' security and trigger their attachment patterns. Feelings of hostility, fear, and anger may be expressed, as the mothers experience the facilitator connecting and directing their focus on the individual tellers' stories and needs. This experience can trigger memories of sibling rivalry or parental favoritism and should be a topic open for discussion and reflection within the group as it relates significantly to the attachment-focus of the program.

Listening to and guiding the telling of the mothers' stories, the facilitator as conductor needs to assist the mothers in finding consistency and coherency in their narratives. While this coherency may be reflected by the Playback actors in their representation of the stories, the conductor needs to act as a model and teacher for the mothers in their narrative tellings and re-tellings. The conductor must work with the mothers to help them find resolution, consistency, meaning, order, and a capacity for narrative expression within their stories, as this will encourage a more integrated experience of attachment and relationships. In the telling of stories, meaning and order somehow emerges from muddled details and chaotic impressions (Salas, 1996). As experiences are made into stories, and witnessed by others, a sense of belonging and



understanding emerges as a personal, integrated meaning is produced. The intrinsic structure that exists within stories, and within Playback theatre, will assist the mothers in bringing the chaotic or confusing experiences of their attachment relationships into a meaningful form. The conductor must therefore encourage and assist during this process of integration and meaning making, to facilitate exploration, understanding, and transformation.

Like the facilitator, the team also takes on dual roles and becomes the Playback actors along side their roles as group therapists and supporters. As actors, the team must be intuitive, genuine, expressive, flexible, and most importantly, self-aware (see *The Company Actors and Team* section of this paper). The team is also responsible for modeling the reflective stance of the Playback actor for the mothers. If the mothers are ready and well-prepared by the team, it is encouraged that they become the Playback actors for their group. With the assistance of the team, the mothers will learn to empathize, become intuitive, and accurately reflect back the states of the fellow tellers. As their attention focuses to the expressed, and also internal, states of the “others” it is expected that they will increase their ability to be reflective mothers and form secure attachments with their children. The team should be always available to the mothers during their transition from witness/teller to actor and be ready to model and teach the necessary skills required for this role. Also, the mothers should always have the right to stop acting at any time and should only perform if they are willing and ready, as agreed upon by the team and facilitator.

Finally, the facilitator and the team can expect that the attachment narratives will contain traumatic and/or disturbing memories of attachment experiences. The team’s role

as holders and safe-keepers of the group thus become even more important and crucial to the safety of the group and their own experience. Adequate time should always be set and planned for after the telling of the stories for the group and the team to reflect and share on their experience as witnesses, actors, and tellers. Ultimately, the safety of the group should never be compromised and so becomes the teams' most important role in the program.

*Other considerations:*

The sessions in this stage should follow a structured plan that allows for all of the mothers to have a chance to share at least once by the end of the eight weeks. The Playback theatre method should always be the focus of the sessions and be preceded by an appropriate warm-up that prepares the group for the themes and stories of that day. Also, the choice and implementation of the closing exercises and rituals are crucial to the psychological well-being of the mothers and the team. The mothers, and the team, should not leave the sessions without having a chance to share their feelings and experiences of the session. Time should always be taken for the mothers and team to distance themselves from the material of the session, whether through de-roling or sharing at the end of the sessions. Also, individual therapy sessions are highly recommended during this stage of the program and should be encouraged by the team.

**Stage 4: Making Meaning, Integration, and Saying Goodbye (Four weeks)**

*Overview:*

Stage Four brings together the work accomplished in the previous three stages, and facilitates the integration of the material and processes that surfaced during this time. Stage Four is also focused on effectively closing the group process. Through the sharing

of group memories and reflecting on the individual and group journeys that occurred within the program, the process becomes integrated and meaning is made from the experience. This stage should be handled with care and not rushed through. For individuals who have experienced insecure attachment experiences, premature separation or termination can feel as if they are being abandoned or rejected (Brisch, 2002). These feelings can then reinforce their past attachment experiences and prevent them from moving beyond their distortions of relationships and intimacy as being rejecting, intrusive, confusing, or dangerous.

*Stage objectives:*

- Help the mothers integrate and make meaning out of the group process and program experience.
- Reflect on the group's journey and transformations.
- Revisit and reflect on the stories shared in the program.
- Revisit significant moments in the program (i.e. where a member made a meaningful change, or where the group overcame a tough obstacle).
- Facilitate sharing and discussions about saying good-bye to the group.
- Facilitate the processing and meaning of loss and separation for the group and individual group members.
- Assist the mothers in their transition out of the group and into the world.
- Review, develop, and create symbols of strength for each of the mothers to take with them into the world outside of the group (i.e. create masks, mandalas, or other symbolic art pieces).

- Celebrate the accomplishments of each individual and the group as a whole.

*Therapeutic goals:*

- To have the mothers acknowledge and address their separation anxieties or fears of loss in leaving the group.
- To reflect on and integrate the impact of the group process and the themes of the program.
- Validate the mothers' journey through the program.
- To enhance the mothers' self-awareness.
- To promote sharing, and intergroup perceptions.
- To promote collective creativity.
- To promote the mothers' trust in interrelationships and the "other".
- Promote a sense of accomplishment, and hope and excitement for the future.

*Recommended Exercises:*

To promote a more collective and organic closing process for the group, the exercises in Stage Four are not indicated as being recommended for the beginning, middle, or closing section of the fourth stage. Specific exercises may be used for an entire session or take up a few, while others may be used collectively and developed upon over the course of the four weeks. The most important recommendation for the choice of exercises is that the exercise allows the mothers to process and integrate their experience within the group and the program. The following exercises are recommended:

- Discussion/sharing

- Rites of passage
- Affirmation circle
- Three snapshots
- Letting go
- The perfect group
- Magic box
- Group statue
- Group poem
- Guess that scene
- Toasts
- Reunion
- Group photo

*Role of the facilitator and team:*

In this stage, the therapist and team are responsible for bringing the group back together to share and reflect on their experiences within the group. The group should once again be unified, and focus should be placed on the strength of the group and its individual members. The team should also facilitate the revisiting of significant moments within the program and share how they have been impacted by the group and its members. The facilitator and team are also responsible for preparing the mothers for their exit out of the group and into the world. As mentioned previously, this is not expected to be an easy task. This process should be carefully planned by the team and approached with genuine care and concern. Transferential dynamics can be expected from both the

mothers and the therapists during this transition, and should be immediately addressed and worked through within the group or in individual therapy sessions.

*Other considerations:*

This stage may reflect many of the same feelings that were present in the beginning stages. Anxiety, fear, and resistance are all expected at times of transition and should be addressed in the here-and-now process of the group.

**Stage 5: Re-assessment and Evaluation (Two weeks)**

*Overview:*

The fifth, and final stage of the program is used to measure and evaluate the possible change and transformations that the mothers experience. The mothers will be re-assessed using the team reflection process as described in the first stage of the program and are encouraged to be re-assessed using the Adult Attachment Interview (AAI). This stage also provides an opportunity for the program and its facilitators to be evaluated by the mothers so that the program may be modified in order to strengthen its success. A sample questionnaire for the mothers to complete is provided (*see Appendix A*).

*Stage objectives:*

- Re-assess the mothers' attachment narratives and their perceptions of attachment and relationships; team reflection, AAI.
- Assist to re-integrate the mothers into their own families.
- To review the mothers' progress and process.
- Evaluate the program and its facilitators.

*Therapeutic goals:*

- Establish a safe, open space for sharing and feedback.

- To have the mothers feel supported and validated for their work in the program.
- Have the mothers gain a sense of ownership and success in the program.
- To distance the mothers from the therapeutic process and the program as a whole.
- To re-integrate the mothers into their families and have them feel supported and proud of their progress.
- To instill hope for the future.
- Provide resources if help is further needed.

*Recommended exercises:*

The team reflection process is the only exercise recommended for this stage of the program.

*Role of the facilitator and team:*

The facilitator and team are recommended to act as advocates for the mothers as they transition from the group “family” into their own families. As it often occurs, the mothers’ families may be skeptical of the work being done in the program and may be fearful of the changes the mother has made. In the team assessment, the facilitator and team should acclimatize the family to the mother’s changes and ensure that the changes are intended to benefit the family and their relationships. The facilitator and team should also establish balanced relationships with the mothers that is distant enough for the mothers to safely detach and individualize, but not so distant that the mothers feel rejected, abandoned, or taken advantage of.

*Other considerations:*

The questionnaire may be distributed again for the mothers to complete after 3-6 months after completing the program. It can be expected that the mothers may be overly optimistic and hopeful for the future when leaving the program. Or, they may feel rejected by the facilitator and angry with the team for leaving them. These factors, and more, will all influence the mothers' evaluations of the program. As such, after a period of 3-6 months it is recommended that the mothers have the opportunity to re-evaluate the program.

As a last consideration, assessment of the mothers' reflective function may also be encouraged at the beginning and end of the program. It is recommended that the reflective functioning manual, developed by Fonagy, Target, Steele, and Steele (1998) for application to the AAI, be used for this purpose.

### ***Limitations of Research***

The theoretical construction of this program is based on research relating to the topics of attachment, reflective functioning, Playback theatre, and Drama Therapy. It is intended to serve as a guide for mental health professionals, especially Drama Therapists, in the implementation of the program and is open to the needs and styles of their practice. The program offers the therapist creative freedom to adjust or modify elements to best suit the needs of the given population.

Limitations to this research include the performance-based nature of Playback theatre, which may not be suitable for all mothers. The research is also limited by indirectly proposing Playback theatre as a preventative technique for insecure attachments. Being unable to implement the proposed program due to time constraints and population unavailability, also limits the research being demonstrated as practical,



beneficial, and most importantly, generalizable. The study is also limited by the possibility that the mothers may experience re-traumatizing feelings when sharing their attachment narratives. More research and practical applications of this program are needed in order to study the program's effectiveness.

## Chapter 7

### Conclusion

Attachment theory, developed by John Bowlby (Bowlby, 1969/1982; Bowlby 1988), suggests that humans have a universal need to form close affectional bonds. As infants, the attachment bonds formed through reciprocal care with caregivers provides protection and security, while also being sources of emotional regulation. These experiences with the caregiver are collected into representational systems, which are termed by Bowlby (1973) as 'internal working models'. These representations are then found to influence attachment behaviour as indicated in the well-known 'Strange Situation' experiment (Ainsworth et al., 1978). The internal working models of the self and other, and the related attachment behaviours were proposed by Bowlby (1969/1982) as providing the prototypes for later relationships. It has been found that children who experience secure attachments are more resilient, self-reliant, empathic to distress, and establish and maintain deeper relationships in later life (Sroufe, 1983; Sroufe, Egeland, & Kreutzer, 1990). Attachment relationship patterns have also been found to be transmitted transgenerationally. Van IJzendoorn (1995) found that secure adults are 3 to 4 times more likely to have children who are securely attached. To account for this transmission of attachment patterns, Fonagy et al. (1991) found that the reflection function, the capacity to understand one's own and others' behavior in terms of underlying mental states and intentions, was a determining factor. Furthermore, parents with high reflective capacity are more likely to promote secure attachment in the child, particularly if their own children experiences were adverse (Fonagy et al., 1995). Therefore, reflective

functioning serves as a key component in the transmission of secure attachment relationships from caregiver to child.

The Adult Attachment Interview (AAI), a structured clinical instrument, elicits narrative histories of childhood attachment relationships (George, Kaplan, & Main, 1996). Based on the structural qualities of the narratives, individuals are classified into secure/autonomous, insecure/dismissing, insecure/preoccupied, or unresolved categories. Those classified as possessing insecure attachment narratives exhibit incoherency, avoided memories, and confusion in their recollection of childhood experiences. These individuals are unable to integrate their childhood experiences and are at risk for transmitting their insecure attachment experiences to their children without intervention or developing reflective functioning skills (Fonagy et al., 1995). It is suggested that people's ability to form a coherent story is related to mental health even for people who have experienced some very difficult events (Baerger and McAdams, 1999). The ways in which attachment experiences are developed into internal working models relates to the ways in which the attachment narratives are constructed. The constructed models can be seen as scripts in which repeat experiences facilitate a generalized perception or "story" of attachment (Dallos, 2006).

This research paper was used to construct a program for mothers with insecure attachment narratives using Playback theatre and drama therapeutic interventions. Playback theatre, which brings together personal experience through the telling and enacting of stories, is suggested to promote the exploration and integration of attachment narratives. Mothers with insecure attachment 'stories' would be able to witness their experience from an outside perspective, enabling them less-restricted and able to reflect

on and change the events of their past. Playback theatre allows individuals to witness their lives from a distanced perspective and create an aesthetic, integrated, and more truthful experience of their self-story (Salas, 1996). In collaboration with the conductor, the mothers as tellers would be encouraged to reflect on their past experiences, make connections between events, and consider inconsistencies or incomplete aspects of their narratives. As such, the conductor facilitates and increases the capacity for coherency in the mothers' narratives, allowing them to be more integrated and meaningful. Also, witnessing the stories of others promotes a shared experience, and can encourage the exploration of new perspectives and the development of alternative stories. Taking into account the reflective function's role in the transmission and establishment of secure attachment relationships, the proposed program encourages the mothers to be integrated into the Playback theatre as the actors, as opposed to just being the tellers or witnesses. As a Playback actor, the mothers would learn to attune and empathize with the storytellers and reflect the essence of the stories. Mirroring, and taking on the 'lives' of others, the mothers will enhance their ability to understand and reflect internal states, and promote a reflective capacity that can be transferred to their relationship(s) with their child/ren.

The program outlined in this research paper is encouraged to be implemented in real practice. It was developed with the intention of assisting mothers with insecure attachment experience to explore their attachment narratives in a theatrical, drama therapeutic way that encourages self-expression, sharing, and reflection. This author hopes that the program facilitates the establishment of secure attachment experiences

**between mothers and their children, and fosters meaningful relationships, resiliency, and self-esteem in more children in the world.**

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Appendix A – Program Evaluation Questionnaire

Thank you for participating in the “Attachment Re‘story’ation” program. Please complete the following questionnaire to assist in the development and success of future programming. All questionnaires will be confidential and anonymous.

1. What, if any, were your expectations and/or goals upon joining the program?

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2. Do you feel that the program met your expectations and/or goals? If so, how?

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3. Do you feel that the program helped you to understand and/or find meaning in your attachment experiences? If so, how?

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4. Have your feelings about your attachment experiences changed since beginning the program until now? If so, how?

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5. Do you feel that the program has helped your ability to empathize with others in your life? If so, how?

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6. Do you feel that the program has helped you to reflect the feelings of others in your life? If so, how?

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7. Has your understanding and/or experience of the personal relationships in your life changed? If so, how?

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8. What, if anything, did you find challenging in the program?

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9. What, if anything, did you find rewarding in the program?

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10. On scale of 1 to 10 (1 = not effective, 10 = very effective), how effective were the facilitators of the program?

*Please, circle your choice:*

1      2      3      4      5      6      7      8      9      10

*Please explain your choice:*

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11. Would you participate in a program like this again? If so, why?

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12. How could the program be improved for future groups?

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Thank you for completing the questionnaire. Your answers will remain confidential and anonymous. Your participation is greatly appreciated.