

SOCIAL ISOLATION, SCHIZOPHRENIA, AND THE GROUP EXPERIENCE:
A THEORETICAL EXPLORATION IN DRAMA THERAPY

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ABSTRACT

SOCIAL ISOLATION, SCHIZOPHRENIA, AND THE GROUP EXPERIENCE: A THEORETICAL EXPLORATION IN DRAMA THERAPY

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This theoretical inquiry explores the potential implications of group drama therapy on social isolation experienced by adults with schizophrenia. A brief history of the conceptualization of schizophrenia is provided, followed by a deeper examination of the current paradigm. An in-depth examination of a range of factors which contribute to social isolation in the lives of individuals living with schizophrenia is presented, as well as an extensive literature review, examining previous research and writing relating to group drama therapy used in the treatment of schizophrenia. Relevant findings in the literature review are then correlated to the causes of social isolation, demonstrating how group drama therapy might be implemented to address those causes, and ultimately help individuals with schizophrenia lead richer social lives. The purpose of this project is to provide a resource for mental health professionals, especially drama therapists, as well as to serve as a platform for future intervention research and development.

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Chapter 1: Introduction

In the final year of my Master's degree I completed an internship in a rehabilitative inpatient unit treating individuals with complex, treatment-resistant psychotic disorders. Here, the profound power of drama therapy to access the inaccessible, to engage the withdrawn, to excite the apathetic, to unite the isolated—to treat symptoms that medication often cannot, became an undeniable certainty in my mind. I had the honour of experiencing my clients as lively, resilient, supportive, empathetic individuals who had much to say and to share but who at times, needed a bridge to access these aspects of themselves. From my experience, I believe that drama therapy possesses the tools needed to help construct this bridge.

I conducted this research because I believe that drama therapy has a vital place in the treatment and rehabilitation of individuals with severe mental illness, such as schizophrenia. I believe that in order to stake this place, it is imperative that the pioneering field of drama therapy have access to resources which deconstruct and demonstrate this process. In addition, as Casson (2004) explains, we as therapists need “guidelines for good practice to provide a foundation for the work” (p.239). Although the field of drama therapy offers an impressive variety of resources, few of these specifically address my area of interest: drama therapy, schizophrenia, and the phenomenon of social isolation.

Casson (2004) also states that “we need to be aware of our beliefs and the effects they have on the way we construct people's suffering and how we, as therapists, respond” (p.39). This document begins with a contextual foundation in understanding schizophrenia, including how the illness has been conceptualized, how it is currently understood, the challenges faced by those with this illness, and how these challenges pose barriers to active participation in the social world. This is followed by an extensive review of related work, highlighting where drama therapy has been or could be used to help address these obstacles to social integration. This review is then summarized with the hope that it will provide a useful resource for drama therapy practitioners, other mental health professionals, researchers, as well as serve as a platform for social integration intervention planning for individuals with schizophrenia, or other psychotic disorders.

Chapter 2: Methodology

Purpose

This theoretical research sought to answer the primary research question: “How might the group drama therapy process be used to address social isolation in adult clients living with schizophrenia?” This project is important in extending the current knowledge and in developing an understanding of how and why drama therapy might be utilized with the population in question.

Findings from this research may be used to

- develop specific framework(s)/intervention(s) which would specifically address social isolation in clients with schizophrenia;
- educate new students entering the field of drama therapy; and
- provide basis for continued research.

Method

This research project has used an exploratory, theoretical method. As such, data has been collected mainly through published works exploring theory and findings of previous studies, as opposed to through implementing research participants (Junge & Linesch, 1993). Research has been collected through secondary sources (primarily published books and academic journal articles) to understand and present: (a) a historical context of schizophrenia; (b) the most current, widely understood paradigm of schizophrenia; (c) factors which contribute to social isolation in adults living with schizophrenia; and (d) related drama therapy work which may be applied to the research question. Relevant information from section (d) has been correlated to and synthesized with data obtained in section (c), to inform a discussion in an attempt to answer the primary research question. Detailed descriptions of the data collection and data analysis procedures are located beneath the subheadings under the same names, respectively.

Data Collection

Data collection has relied on an extensive library literature search involving the collection of books, peer-reviewed articles, and university research papers, relating to the primary research question. A systematic exploration of available related data has been conducted, primarily from the following databases: PsychInfo, EBSCOHost, ERIC, PubMed (Medline), and Google Scholar. In collecting data looking at social isolation and schizophrenia, the following search terms have been used in combination: “schizophrenia,” “psychosis,” “mental illness,” “social isolation,” “social withdrawal,” “social factors,” “negative symptoms,” and “positive symptoms.” In collecting related drama therapy data, the terms: “drama therapy,” “dramatherapy,” “group drama therapy,” “adult drama therapy,” “schizophrenia,” “psychosis,” “mental illness,” “social isolation,” and “social skills” have been used. Sources have been eliminated from the data set if content appeared irrelevant to the research question or if it was presented in a language other than English.

Data Analysis

A thematic network method has been used in order to guide the process of data analysis (Attride-Stirling, 2001). The following steps have been undertaken:

1. Extracted and coded drama therapy material based on relevant subject matter, as it pertained to theoretical interests guiding the primary research question, as well as salient issues which arose from sources (Attride-Stirling, 2001). This included, but was not limited to drama therapy method, drama therapy intervention, drama therapy core process, drama therapy phase, and data source.
2. Sorted data in terms of themes abstracted through step 1, in order to identify patterns/commonalities appearing throughout the literature. Through interpretation, themes have been refined in order to represent data in a more manageable, concise set of pertinent themes (Attride-Stirling, 2001).
3. Organized data based on thematic groupings. This has been achieved through a process of arranging themes which arose in the drama therapy literature, and looking for links between those themes and themes which arose through initial research relating to social isolation and schizophrenia. Global themes were then deduced (i.e., principal or core ideas) and arranged. Thematic groupings were verified by going back through the data and making sure that text segments reflected and supported the extracted themes. Adjustments were made where necessary (Attride-Stirling, 2001).
4. Explored and described data through thematic networks. Original text has been revisited using the thematic networks as a tool for identifying underlying contradictions and patterns between selected sources (Attride-Stirling, 2001). Sources presented in the literature review have been critiqued, synthesized, and discussed, with an emphasis on the interactions of themes between texts and how they relate to the research question (Elsbach & Kramer, 2015).

Ethical Considerations

Ethical issues may arise from personal bias. In efforts to counter negative effects of personal bias on the research process and the results, reflexivity has been practiced. Reflexivity refers to the concept of continually seeking to be aware of and challenge (where necessary) personal stances, perspectives, and views, in order to be mindful of and make transparent how they are affecting the collection and interpretation of data (Savin-Baden & Wimpenny, 2014).

Some of the salient, pertinent biases are the assumption that social isolation has a negative effect on a person's well-being, and existing ideas relating to the efficacy of certain methods and interventions, which have developed through practicum experience. Such biases risk influencing the interpretation of data, prejudicing which points are seen as salient, as well as impacting which sources are selected. It has

been important to keep these biases in mind, consciously including sources that run counter to beliefs, as well as employing member checking. Member checking has been conducted through peer evaluation, having an expert in the field (research supervisor) review and examine the findings, interpretations, and method of presenting findings (Savin-Baden & Wimpenny, 2014). This review has helped identify gaps, inconsistencies, contradictions, assumptions, or biases that needed to be addressed (Savin-Baden & Wimpenny, 2014).

An additional ethical concern in theoretical research is that writing may differ greatly from practice. As such, unanticipated results may be elicited. This connects to another ethical consideration—the potential harm that may result from readers attempting ideas/suggestions brought forth in the research paper. These are limitations of this method—in order to address them, attempts have been made to understand and present vulnerabilities of this particular population, as well as potential risks associated with specific drama therapy interventions.

Finally, there lies the ethical concern of representation: how the population is depicted in the final research paper. This has been addressed through data source triangulation, using multiple data sources so as to find corroboration, in order to achieve the most accurate description possible (Rouse & Harrison, 2016). Member checking has also been important here, to address the issue of representation.

Chapter 3: Schizophrenia

Brief Historical Context and Alternative Views

The illness now widely known as *schizophrenia* appears to have existed for centuries: The earliest evidence—written documentation of schizophrenia-like symptoms—has been discovered by archaeologists, dating back to the days of ancient Egypt (Veague, 2007). Early understandings of schizophrenia, however, were often described as separate conditions, for example: *hebephrenia* (a person with extremely disorganized thoughts); *catatonia* (a person who displayed little to no movement, often holding unusual positions); and *paranoia* (a person obsessed by fear of being harmed) (Abramovitz, 2002). Additionally, although schizophrenia-related symptoms have been observed for centuries, the way in which symptoms have been viewed has differed vastly from culture to culture. In some cultures, episodes involving psychosis were seen as spiritual experiences, possessing religious connotation, or as part of a normal human experience—similar cultural differences in understanding remain today (Abramovitz, 2002; Kurtz, 2016; Larøi et al., 2014).

Beginning in the nineteenth century, a number of European psychiatrists including Bénédict Augustin Morel (1809-1873), Thomas Smith Clouston (1840-1915), and Karl Ludwig Kahlbaum (1828-1899) attempted to define the illness, focusing on specific psychosis related symptoms, which they believed began mainly in adolescence, and followed a degenerative path (Jablensky, 2010). The conceptualization of schizophrenia as an illness being comprised of various symptoms began with the German psychiatrist Emil Krapelin (1850–1929) in the late nineteenth century. Krapelin believed that the condition indicated irreversible deterioration of the brain (Veague, 2007; Abramovitz, 2002) similar to that seen in dementia, only beginning much earlier (childhood to early adulthood)—he called the condition *dementia praecox* (i.e., premature dementia) (Veague, 2007). This popular theory fueled the belief that treatment for the illness was futile, leading to permanent institutionalization of individuals over attempts at rehabilitation (Veague, 2007).

In the early twentieth century, Swiss psychiatrist Eugen Bleuler (1857-1939) conceptualized the same condition as *schizophrenia* (1908), comprised of the Greek words *schizo* (i.e., split) and *phrenia* (i.e., mind) (Veague, 2007; Maatz, Hoff, & Angst, 2015). Bleuler's theories, particularly his emphasis on psychogenetic influence, were greatly informed by the works of Sigmund Freud (1856–1939) (Bruijnzeel & Tandon, 2011). Bleuler believed the essential feature of schizophrenia to be a “splitting of psychic functioning” which often manifested as an inability to distinguish fantasy from reality (Yeragani, Ashok, & Baugh, 2012, p.95; Ross, 2008). This concept, which Bleuler used to explain a “split from function or an incongruence between mood or affect and words” (Ross, 2008, p.55) led to a common

misunderstanding that the illness of schizophrenia indicated multiple or a split personality (Abramovitz, 2002; Ross, 2008).

One of Bleuler's significant influences on today's understanding of schizophrenia comes from what he called *the four A's* of schizophrenia: lack of or incongruent *affect*; irrational or disorganized *associations* apparent in thought and speech; *ambivalence* in attitudes, feelings, and actions; and *autism*, withdrawing from reality into an internal world (Veague, 2007; Abramovitz, 2002; Jablensky, 2010). Unlike Krapelin, Bleuler believed that schizophrenia was not an indication of irreversible brain decay, but rather a treatable psychosocial disturbance (Veague, 2007; Abramovitz, 2002).

Sigmund Freud (1856-1939) believed that schizophrenia was a manifestation of traumatic unconscious childhood memories (Abramovitz, 2002). Together, Freud and Bleuler's theories led to the belief that schizophrenia was a result of psychological trauma during childhood, trauma caused by a mother's parenting (Abramovitz, 2002). This theory was known as the *schizophrenogenic mother* (Veague, 2007).

In the 1960's a movement spearheaded by Hungarian-American psychiatrist Thomas Stephen Szasz and Scottish psychiatrist Ronald David Laing rejected the idea of mental illness, and schizophrenia, —the *antipsychiatry movement* (Ross, 2008). This movement challenged common psychiatric diagnosis and treatment paradigms felt to oppress rather than to heal individuals with serious mental health issues, such as individuals experiencing schizophrenia-like symptoms (Ross, 2008; Szasz, 1988). This movement attested that psychiatric treatment attempted to force individuals to fit within society's norms, instead of seeking to uncover the nature and origin of their struggles (Ross, 2008; Szasz, 1988). This movement, and other views which challenge the modern psychiatric paradigms of schizophrenia, continue to evolve today.

One such modern alternative view is presented by Dr. Benjamin Gray (2009), a mental health researcher diagnosed with schizophrenia. Gray believes that modern psychiatry—perhaps unintentionally—silences individuals with atypical experiences (such as hearing voices or experiencing delusional thoughts). In his view, this is due primarily to the influence of the biomedical/scientific standpoint, which ignores the content of delusional material, viewing effective treatment as an irradiation of these positive symptoms through medication in the name of “normalization and keeping a stable social and medical order” (p. 662). Gray too describes common medical treatment as a form of social control and oppression which “crushes people's subjectivity, choices, human rights, and free will,” tranquilizing people's personal beliefs, subjectivity, diversity, thoughts, and emotions (p.662). He believes that treatment should emphasize the thoughts and feelings of individuals with schizophrenia-like mental health issues and seek to develop a deeper understanding of and insight into the content of these thoughts and

feelings. He explains that in this way, the individual may experience healing without medical treatment which risks extinguishing an individual's personhood.

Current Paradigm

Schizophrenia, as it is currently widely understood, is a severe mental illness, the onset of which is linked to both brain chemistry and structure, environmental factors (Schizophrenia Society of Canada, 2018), and genetic predisposition, affecting roughly 1% of the world's population (McCance & Huether, 2014). Presently, schizophrenia is diagnosed by observable symptoms: There are currently no administrable laboratory or brain imaging tests to diagnose, although such tests may be used to rule out any other conditions which may be responsible for a person's schizophrenia-like symptoms (Schizophrenia Society of Canada, 2018).

In modern psychiatry, mental health professionals most commonly use manuals, either the ICD-10 (*International Statistical Classification of Diseases and Related Health Problems 10th Revision*) or the DSM-V (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*) to guide the diagnostic process for schizophrenia (World Health Organization, 1992; American Psychiatric Association, 2013). Although, as demonstrated in Table 1, guidelines for diagnosis vary between manuals, they converge in terms of the most common associated features: distortions of thinking and perception, inappropriate or blunted affect, and certain cognitive impairments (World Health Organization, 1992; American Psychiatric Association, 2013).

The symptoms associated with schizophrenia typically surface between a person's late teens and mid-thirties—the peak age of onset being slightly earlier (early twenties) for males than for females (mid to late twenties) (American Psychiatric Association, 2013). Onset may occur abruptly, however it is more characteristic for symptoms to manifest gradually (American Psychiatric Association, 2013). Long-term outcome varies greatly from individual to individual. Favorable outcome has been connected to: early detection paired with appropriate treatment (Freudenreich, Holt, Cather, & Goff, 2007); normal functioning prior to onset of schizophrenia; sudden onset occurring at an older age; limited history of mental illness (especially schizophrenia) in family; positive initial response to medication; awareness/insight in terms of one's illness; minimal negative symptoms; social integration; and is more common for females (Torrey, 2013; Lang, Kösters, Lang, Becker, & Jäger, 2012).

With treatment during the initial acute phase, roughly 40% of individuals with schizophrenia demonstrate at least one period of global recovery, which Jobe and Harrow (2010) define as “a period of 1 or more years with no positive symptoms or negative symptoms, no psychiatric hospitalizations, adequate socialization, and at least half-time instrumental work function” (p.221). In about 20% of cases, the course of illness appears to be favorable, with a remission of symptoms and greatly improved functioning across social and vocational domains (American Psychiatric Association, 2013; Volavka &

Veveva, 2018; Veague, 2007). For the majority of cases (over 50%), individuals with a diagnosis of schizophrenia fall on a spectrum between those who require life-long living support, with symptoms appearing in an episodic cycle of intensification and remission, to those whose symptoms appear to gradually worsen over time, requiring that they undergo long-term hospitalization (American Psychiatric Association, 2013; Harrow & Jobe, 2010; Torrey, 2013).

Table 1

Comparing Schizophrenia Diagnostic Criteria of the DSM-V and the ICD-10

DSM-V	ICD-10
At least two of the following, each present for a significant portion of time during a 1-month period (or less if treated with success). At least one of these must be (1), (2), or (3).	At least two (more if less obvious) obvious symptom belonging to groups (a) to (d), or groups (e) to (h), clearly present for most of the time during a period of at least 1 month.
1. delusions	a. thought echo, thought insertion or withdrawal, or thought broadcasting
2. hallucinations	b. delusions of control, influence, or passivity, clearly referred to body/limb movements or specific thoughts, actions, or sensations; delusional perception
3. disorganized speech (e.g., frequent derailment or incoherence)	c. hallucinatory voices (i.e., auditory hallucinations)
4. grossly disorganized or catatonic behavior	d. other persistent delusions that are culturally inappropriate
5. negative symptoms (e.g., diminished emotional expression, avolition)	e. persistent hallucinations
	f. breaks or interpolations in train of thought, apparent in speech
	g. catatonic behaviour (e.g., posturing, or waxy flexibility, negativism, mutism, and stupor)
	h. negative symptoms (e.g., apathy, blunted or incongruent emotional responses)
	i. significant and consistent change in the overall quality of some aspect of personal behaviour

Note. Diagnostic criteria has been extracted and greatly distilled from that found in American Psychiatric Association (2013), and World Health Organization (1992).

Key Terms

Negative symptoms. The term *negative* is used to describe a symptom which demonstrates a *loss* or *disruption* of typical function —(LeCroy & Holschuh, 2012; McCance & Huether, 2014). Negative symptoms include affective flattening (apparent to others through unchanging facial expressions, affective non-responsivity, etcetera), anhedonia (an experience of emotional flatness, often experienced as an inability to feel joy and pleasure from physical and social activities), alogia (deficits relating to speech), inattentiveness, avolition (lack of goal directed behaviour), and apathy (McCance & Huether, 2014).

Positive symptoms. The term *positive* is used to describe an *exaggeration* or *distortion* of typical functioning, which often occurs during an episode of psychosis (LeCroy & Holschuh, 2012; McCance & Huether, 2014). Simply put, positive symptoms are that which should be absent, such as hallucinations, delusions, and bizarre behaviour (McCance & Huether, 2014).

Cognitive symptoms. *Cognitive symptoms* refer to impairments in cognitive functioning. The four most common areas of cognitive impairment in schizophrenia relate to attention/concentration, certain types of memory (primarily short-term), executive functioning, and insight/awareness into one's condition (McCance & Huether, 2014; Torrey, 2013).

Delusions. *Delusions* — “pathological distortions of normal ideation” (Noll, 2007, p.205) — are false beliefs relating to the self or some aspect of the external world, based on incorrect inference about reality, which remain even when the individual is provided with strong, contradictory information (Kurtz, 2016; Noll, 2007; McCance & Huether, 2014). Delusions often persist over time (i.e., *fixed delusions*), and seem implausible, irrational, and often bizarre, to others (Kurtz, 2016). Content of delusions commonly include (but is not limited to) paranoid beliefs, personalization of events or stimuli (for example, believing that a character on a television show is speaking specifically to oneself), feelings of grandiosity, nihilistic or religious beliefs, as well as sexual or somatic themes (McCance & Huether, 2014).

Hallucinations. *Hallucinations* — “disturbance[s] in perception” (Noll, 2007, p.205) — are sensory experiences (in a waking state) that are perceived in the absence of corresponding environmental stimulus, and may be experienced as originating from either within or outside of the body (David & Noll, 2007; Kurtz, 2016). Hallucinations may occur across any of the five senses: sight (*visual hallucinations*), sound (*auditory hallucinations*), touch (*tactile hallucinations*), taste (*gustatory hallucinations*), and smell (*olfactory hallucinations*) (Noll, 2007) appearing either alone, or in combination (McCance & Huether, 2014).

Chapter 4: Social Isolation and Schizophrenia

Several studies (Davidson et al., 2004; Kao, Liu, Chou, & Cheng, 2011) identify social isolation as one of the greatest challenges faced by the majority of individuals diagnosed with schizophrenia. Social difficulties are often evident before the onset of the illness, and remain, often worsening, over the course of a person's life (Cornblatt et al., 2007; Hooley, 2010) contributing to increasing isolation that becomes difficult to change. Effects of the illness make reciprocal friendships scarce, with the majority of interactions involving family members and professionals (Andersson, Denhov, Bülow, & Topor, 2014). Furthermore, numerous studies suggest that social isolation not only plays a significant role in the onset of schizophrenia, but exacerbates a wide range of symptoms associated with the illness (Gaskin, Alexander, & Fone, 2014; Jiang, Rompala, Zhang, Cowell, & Nakazawa, 2013). At the same time, symptoms of the illness, such as difficulties in social functioning, paranoia, and other psychiatric symptoms, contribute to an often present comorbid disorder of social anxiety (38%-43%), which poses yet another obstacle to interacting with others (Lowengrub, Stryjer, Birger, & Iancu, 2015; Pallanti, Quercioli, & Hollander, 2004; Aikawa et al., 2018; Gorun et al., 2015; Sutliff, Roy, & Achim, 2015). While pharmaceutical treatment for schizophrenia has proved an effective means of reducing many acute symptoms and improving the overall well-being of clients, these medications are often accompanied by strong side-effects, perpetuating social isolation through cognitive difficulties and lethargy (DiBonaventura, Gabriel, Dupclay, Gupta, & Kim, 2012).

Davidson et al. (2004) conducted a research demonstration project titled "The Partnership Project," investigating the role of social support in the improvement of quality of life for those experiencing serious mental illness. This research builds upon previous studies and surveys which, as mentioned earlier, identify social isolation as one of the chief difficulties faced by the population in question (Davidson, Hoge, Godleski, Rakfeldt, & Griffith, 1996). From their research, Davidson et al.'s (2004) determine that a number of factors, such as deterioration in social roles, a deficit in the availability of alternative social structure, stigmatization, and direct effects of symptoms, contribute to social isolation. The authors present the above conclusions that contrast with the "stereotype" which holds that people with psychotic disorders isolate out of a desire to be without a social network (p. 470).

Davidson et al. (2004) argue that emotional intimacy – reciprocal in nature - is a universal human need and that its absence creates a void within the life of the isolated person. The idea of intimacy as a human need, achieved by reciprocity, is reflected in much of the available literature (Myers, Spencer, & Jordan, 2009). In light of the above obstacles to socialization and this universal need, Davidson et al. (2004) believe that rehabilitation of people with serious mental illness must include supported opportunities for friendship, closeness, and intimacy. They emphasize that although people with mental illness – particularly those with psychotic disorders – may have relationships, these are often

unidirectional as the individual receives more support than they are able to provide. Addressing social isolation by creating more opportunities for meaningful connection could greatly contribute to the psychological growth of people with schizophrenia (Lonergan, 2017).

Cornwell and Waite (2009) propose two main forms of social isolation: social disconnectedness and perceived isolation. They characterize social disconnectedness as “a lack of contact with others” and explain that it is apparent by situational factors such as “a small social network, infrequent social interaction, and lack of participation in social activities and groups” (p. 33). Perceived isolation, on the other hand, can be characterized by “the subjective experience of a shortfall in one’s social resources such as companionship and support” which is often accompanied by feelings of loneliness, a lack of belonging, and a desire for more intimacy and companionship in one’s life (van Baarsen, Snijders, Smit, & van Duijn, 2001, p. 33).

In this research project, social isolation is understood as a combination of these two proposed forms: Social isolation refers to a lack of social contact characterized by a small social network, infrequent social interaction, and lack of participation in social activities and groups, which may or may not be accompanied by feelings of loneliness, not belonging, and a desire for a fuller social life (Cornwell & Waite, 2009; van Baarsen et al., 2001).

Contributing Factors to Social Isolation

Psychological.

Beliefs, attitudes, and expectancies. People with schizophrenia consistently report that they would like to have a richer social network and life, despite a common tendency to withdraw from social situations (Davidson & Stayner, 1997). Grant and Beck (2010) conducted a longitudinal study to better understand this phenomenon, examining whether asocial beliefs (including negative expectancies, dysfunctional attitudes, and self-defeating beliefs) significantly contributed to social functioning and whether they predicted asocial behaviour. The authors found that asocial beliefs— independent of positive symptoms, depression, anxiety, and demographic factors— predicted asocial behaviour one year later, and that asocial beliefs also predicted poor social functioning and impoverished social relationships in individuals with schizophrenia.

The authors explain the results, stating that individuals with schizophrenia who struggle in the social domain have protectively developed negative beliefs about the consequences of social interactions, although they maintain a desire for improved social relations, in order to guard against negative social experiences, such as rejection and disparagement (Grant & Beck, 2010). Further, they state that negative social experiences, including childhood abuse, bullying, stigmatization, and other forms of victimization, often play a significant role in triggering these negative beliefs, which both instigate and rationalize social withdrawal (Beck, Rector, Stolar, & Grant, 2009; Grant & Beck, 2010). The authors explain that these

negative social beliefs may be the missing link in understanding the discrepancy between social goals and social withdrawal (Grant & Beck, 2010). In this way, asocial beliefs, which are largely formed by negative social experiences, may cause individuals with schizophrenia to withdraw socially, despite having a desire for a social network and intimacy.

Boundary confusion. Giovacchini (1986) states that schizophrenia is the manifestation of defective boundaries and an underdeveloped psyche. He explains that many individuals with schizophrenia are unable to separate their psyche from the external world, and that because of this, the external environment is experienced as an “appendage” of the ego (p.136). In this way, the individual’s inner and outer worlds are enmeshed, resulting in a skewed perception of reality.

The idea of boundary development disruption as a way of understanding schizophrenia is echoed by Johnson (1988) who constructed and implemented a *Diagnostic Role-Playing Test* to look at the relationship between the rigidity and fluidity with which clients with schizophrenia take on and play with roles, and how this relates to paranoid symptoms of schizophrenia. Johnson found that individuals with schizophrenia experiencing paranoid symptoms demonstrate a tendency to over define and structure boundaries, whereas non-paranoid individuals with schizophrenia demonstrate a blending of boundaries.

Giovacchini (1986) explains that throughout the process of normal development, a *transitional space* is formed—a space where a child explores and ultimately develops a necessary understanding of the differentiation between their inner world and fantasy, and the outer world of reality. He asserts that infantile trauma—particularly disturbances in the nurturing and/or soothing aspects of the mother-child relationship—likely contribute to complications in this developmental process, and that many people with schizophrenia have experienced infantile trauma. In this way, as Giovacchini explains, individuals with schizophrenia never develop the capacity to separate their inner world— their psyche— from the environment. He elaborates, “the schizophrenic patient never moves to the final position of relating to a secondary-process oriented reality. His delusion lies within the transitional space, but, for the psychotic, this is not an in-between space. Nothing exists but the delusion. That is one of the reasons the psychotic cannot acknowledge or recognize anyone as belonging to the external world” (p.137).

Building on this, Giovacchini believes that this boundary confusion causes difficulties in reality testing, thought disorder, and difficulties of self-representation. He points out that the inability to define the self can be explained by both the blurring of ego boundaries and an “amorphous” view of the self, where all elements of the external world are experienced as a reflection of some part of the psyche, making it impossible to truly make contact with the external world (p.139).

Giovacchini asserts that this fusional state results in feelings of confusion, fear, helplessness, and vulnerability, which activates defenses. He explains that in order to protect themselves against these feelings, individuals with schizophrenia develop megalomaniac delusions so that they feel in complete

control of the external world. However, as he explains, there is often “power reversal,” whereby the individual shifts from feeling in complete control to feeling completely controlled (p.155). In this way, intimacy becomes a threat, which may lead to “catatonic withdrawal,” completely removing oneself from the outside world (p.155). Giovacchini explains that this defense of withdrawal manages feelings of vulnerability: By “denying needs, there is no ... inner yearning that requires a response from a world on which one may be dependent” (p.155).

In this light, social isolation may be seen as a by-product of an inability to truly connect to others as separate from oneself and intense feelings of vulnerability in relation to the outside world, caused by a fusalional space between one’s inner and outer reality.

Stigmatization, self-esteem, and social self-esteem. Social isolation is often exacerbated in the lives of those with schizophrenia due to social stigmatization, which often leads to social rejection and self-stigma (LeCroy, & Holschuh, 2012; Kurtz, 2016). Individuals with schizophrenia have been described as one of the most stigmatized groups in today’s western society (LeCroy, & Holschuh, 2012) and schizophrenia as “the modern-day equivalent of leprosy” (Torrey, 2013, p.356). Studies (Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002; Wahl, 1999) have identified stigma as something that at least two thirds of individuals with schizophrenia face. From negative media portrayal of individuals with schizophrenia to rejection by family members (Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002), effects of stigma create a tremendous barrier to interpersonal connection (Wahl, 2012).

In addition to social rejection, social stigma leads to self-stigma through a process of internalization, whereby a person not only takes on the negative beliefs about the group to which they belong, but begins to feel they do not belong in, and cannot positively contribute to, the larger social world (i.e., *negative social self-esteem*) (Reisman, 2016; LeCroy, & Holschuh, 2012; Lien et al., 2014). In this way, stigma not only causes individuals with schizophrenia to avoid social situations out of fear of discrimination, but also due to feelings of inferiority and incapability—feelings which arise out of internalized stigma (Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002; Wahl, 1999).

Research has demonstrated that internalized stigma leads to an avoidance of social activities in individuals with psychotic disorders, and that individuals with psychotic disorders display higher levels of internalized stigma than those with other mental illnesses (Lien et al., 2014). This suggests that shame, low self-esteem, low social self-esteem, and feelings of not belonging, which manifest through a process of internalizing social stigma, contribute to social withdrawal and thus, social isolation, for individuals belonging to this population.

Social skills. Poor social skills (e.g., lack of eye contact or limited displays of affect) is one of the defining characteristics of schizophrenia (Kurtz, 2016; American Psychiatric Association, 2013). Effective social interaction involves an integration of three particular social skills: (1) accurately

perceiving social cues (2) accurately *processing* social cues; and (3) *sending* social information—skills which are often challenging for individuals with schizophrenia (Kurtz, 2016; Tenhula & Bellack, 2008). Research has shown that impairments in social skills is highly correlated to worse psychosocial adjustment and challenges in developing consistent interpersonal connections (Kurtz, 2016; LeCroy, & Holschuh, 2012). Additionally, many negative symptoms that have been linked to dysfunctions in working memory, such as blunted and incongruent emotional expression as well as mental rigidity and lack of spontaneity, pose additional challenges to appropriate and effective social interaction (Kurtz, 2016, p.109).

Enhancing social skills can lead to an improved capacity for building interpersonal relationships, simultaneously increasing the availability of social support (Kurtz, 2016). Because of this, if an individual becomes more comfortable building a social support network, the likelihood of improved mental health and quality of life is greatly increased (Kurtz, 2016; Kurtz & Mueser, 2008). However, for many individuals, social isolation becomes cyclical and hard to change: The fewer social skills a person has, the more likely they are to become isolated—the more isolated they are, the less opportunities they have to develop social skills. Furthermore, many of the (negative) symptoms which translate to poor social skills are largely resistant to medication (Kurtz, 2016; Grant & Beck, 2019).

Impaired social cognition. Social cognition has been a major area of focus in schizophrenia research due to the “profound social disability” associated with the disorder (Kurtz, 2016, p.116). This area of research focuses on biases and deficits in information processing as they relate to the social world, and how uncharacteristic interpretations develop and cause difficulty (Penn, Corrigan, Bentall, Racenstein, & Newman, 1997, cited in Kurtz, 2016).

The domain of social cognition is divided into four subdomains—the two most relevant to this exploration are *emotion perception* and *theory of mind* (ToM) (Kurtz, 2016). Emotion perception includes the recognition of affect presented by another person, either through the physical body or paralinguistically (Kurtz, 2016). ToM speaks to the ability to realistically reflect upon one’s own and another person’s attitudes, feelings, thoughts, and desires (Kurtz, 2016; Frith & Frith, 2003). These two subdomains are also correlated to a person’s ability to relate to others effectively and empathically: emotion perception being important for affective empathy, and ToM being essential for cognitive empathy (Pijnenborg, Spikman, Jeronimus, & Aleman, 2012).

Deficits in all four of these sub-domains have been linked to a variety of adverse social and functional outcomes (Kurtz, 2016). For example, poor emotion recognition has been linked to difficulty in maintaining conversation (Kurtz, 2016). ToM deficits have been correlated with poorer community function and increased behavioural problems (Kurtz, 2016).

Impaired emotional perception. Individuals with schizophrenia commonly struggle with emotion perception, which has been observed in fMRI research measuring emotion perception, demonstrating abnormal amygdala activation (Kurtz, 2016; Ito, Matsumoto, Miyakoshi, Ohmuro, Uchida, & Matsuoka, 2013). As explained by Ito et al. (2013), emotion perception is critical for deciphering complex/complicated interpersonal messages, such as those that are meant to be ironic or sarcastic, as well as assessing the nature of social interactions.

Impaired ToM. A wealth of research (Corcoran, Mercer, & Frith, 1995; Drury, Robinson, & Birchwood, 1998; Frith & Corcoran, 1996; Sarfati, Hardy-Bayle, Besche, & Widlöcher, 1997) has indicated that a common characteristic of schizophrenia is difficulty attributing the mental states of other people, a difficulty which usually remains across the development of a person's mental illness (Lee, Quintana, Nori, & Green, 2011). This has obvious communication and intimacy implications, including the understanding that people may possess different needs and desires from one's own.

Blunted and incongruent emotional expression. Emotional responses are often limited/blunted for individuals with schizophrenia, (Kaiser, Heekeren, & Simon, 2011; Gruber & Kring, 2008) although the internal experiencing of emotion often remains active, quite similar to those without a diagnosis (Gruber & Kring, 2008). Similarly, affective expression is often incongruous, for example, laughing at something that typically would make most people sad (Living with Schizophrenia, 2018). These atypical displays of emotion cause significant communication challenges including being misunderstood, or appearing emotionally unavailable.

Mental rigidity and lack of spontaneity. Rigidity, or lack of spontaneity, is a common negative symptom of schizophrenia (Neuroscience Research Australia, 2016). Mental rigidity may be exhibited as an inability or resistance to alter beliefs and/or behaviours (Neuroscience Research Australia, 2016) which poses a barrier to relating to others with flexibility and openness and adapting behaviour to the demands of a social situation. This rigidity may also display itself as an inability to sensitively consider the point of view held by another person (Neuroscience Research Australia, 2016) affecting one's ability to empathize and understand the needs of others.

Additional considerations.

Apathy and avolition. Apathy may appear as a lack of motivation to participate in social activities (Living with Schizophrenia, 2018). Clients are often socially withdrawn (avolition), with an apparent lack of interest in interacting with others (Living with Schizophrenia, 2018). These negative symptoms contribute to common asocial behaviour, either due to a lack of interest in engaging with others, or as a result of anxiety associated with social situations (McLeod, Gumley & Schwannauer, 2014).

Positive symptoms and social anxiety. Positive symptoms including hallucinations, delusions, and racing thoughts may play a direct role in social withdrawal for a number of reasons. First, symptoms

such as racing thoughts may lead to agitation and/or overstimulation causing individuals with schizophrenia to withdraw socially in efforts to manage exposure to stimuli (Kurtz, 2016; LeCroy, & Holschuh, 2012). Second, symptoms such as hallucinations and delusions may lead to social withdrawal due to suspicious thoughts and/or beliefs, or preoccupation with one's inner world (Kurtz, 2016). Research also indicates that 38%-43% of individuals diagnosed with schizophrenia experience a comorbid social anxiety disorder (Lowengrub, Stryjer, Birger, & Iancu, 2015; Pallanti, Quercioli, & Hollander, 2004; Aikawa et al., 2018; Gorun et al., 2015; Sutliff, Roy, & Achim, 2015), which often leads to an avoidance of social situations due to fear of judgement or rejection.

Chapter 5: Literature Review

The following has been assembled through a process of reviewing and summarizing related available literature, with a focus on extracting information which may be applicable to answering the research question. As, to date, group drama therapy for adults with schizophrenia is an area which has been minimally documented and written about, the scope of this research has been widened to include individual therapy, therapy for psychosis and other severe mental illness, and other drama related therapy.

Jacob Levy Moreno (1944) “A Case of Paranoia Treated Through Psychodrama”

Jacob Levy Moreno, a Romanian psychiatrist largely responsible for the group psychotherapy model, also created psychodrama—the first documented work with individuals experiencing psychosis, which intentionally implements drama as a therapeutic vehicle. Psychodrama uses theatrical mechanisms to explore problems or issues experienced by an individual (or, the *protagonist*), and is highly interpersonal, as it relies on others (i.e., *auxiliary actors/egos*) to take on roles (i.e., *auxiliary roles/characters*) within that individual’s story (i.e., *drama*). Moreno works with individuals experiencing psychosis from the viewpoint that these individuals operate in the social world as if reality and fantasy were actually “fully integrated” (p.312). He writes about his experience treating a 23-year-old woman at a psychodramatic sanitarium in Beacon, New York. The work revolves around her fixation on a young man whom she had, in reality, likely never met.

Moreno’s approach is to attempt to have the client’s delusion “realized” in order to reduce anxiety associated with the delusion so that transformation becomes possible. He accomplishes this by embodying—with the client—a variety of progressive scenes associated with the client’s delusional material, supported by a staff comprised of auxiliary actors. Moreno’s therapeutic work begins by establishing a therapeutic relationship with the client, starting with the validation of delusions. He then collaborates with the client and staff to bring the delusion “to life” (*psychodramatic realization technique*) in an attempt to have it “realized” (*therapeutic confirmation of the psychotic world*) (pp.132-134). The final goal is to help the client achieve “absolute realization,” which Moreno believes helps loosen the grip of fixed delusions, making room for progression, newness, and transformation (p.132-134). In the case of the young woman whom Moreno writes about, absolute realization of the delusion occurs in a climactic moment during the treatment process when the young woman “marries” the object of her affection (played by an auxiliary actor) (p.318). Moreno found that following this climactic moment the client’s anxieties around the object of her affections (i.e., “realization paranoia”) decreased, signifying the beginning of detachment from the delusion and making way for a “new period in her psychotic development” (p.318).

Moreno (1944) divides his treatment process into three phases: (1) “the period of realization,” (2) “the period of replacement,” and (3) “the period of clarification” (p.318). In the first phase, delusional

material is validated, whereby the client (protagonist) is able to construct the reality they seek, with the assistance of auxiliary actors. This period aims to help the client organize ideas and emotions and attain catharsis. In the second phase, Moreno explains that because of the significant role the auxiliary actors play in the therapeutic process, the client begins to develop an attachment to them—an attachment which continues outside of the therapy space. This period helps the client shift from the hallucinatory world to that of people in real life and the atmosphere of the physical world. In the final phase, the psychodramatist begins to reveal particles of the truth by re-enacting scenes relating to the construction of the hallucinatory world which was embodied through the dramas. Here, the actual nature of relationships with those who took on auxiliary roles is reaffirmed, deconstructing the “fictitious foundation” upon which the treatment was built (p.321). Although the client engages with auxiliary actors with the understanding that the auxiliary actors are merely *playing roles* of people in their life, this process is important in helping the client re-affirm the distinction between fantasy and reality, as well as achieve some level of insight into the therapeutic process.

The diagnosis of the client whose therapeutic work is explored in Moreno’s text remains unclear. Even so, Moreno’s approach to working with delusional material is an important contribution to understanding how clients with schizophrenia—the majority of whom experience delusional thoughts—might find therapeutic benefit from exploring delusional material with a group, using dramatic interventions.

David Read Johnson (1980) “Effects of a Theatre Experience on Hospitalized Psychiatric Patients”

Psychologist/drama therapist David Read Johnson (1980) conducted a quantitative study examining the effects of *play creation* and play termination for hospitalized adolescents and young adults, most of whom had been diagnosed with schizophrenia, at a psychoanalytically oriented psychiatric hospital in New England. This study illuminates what Johnson explains to be the significant expressive, cognitive, interpersonal, and adaptive implications of play creation.

Johnson observes that during the rehearsal process, many clients appeared significantly less symptomatic and withdrawn, and more alert. Johnson attributes this, in part, to the highly personal material being explored, fostering involvement. He also observes that participants often became increasingly upset, isolated, or depressed, with clinical improvement disappearing in the 4 weeks following production — this he attributes to feelings associated with play creation and termination that clients were left to process without support.

Johnson implemented weekly meetings (extending after the final performance) where fears, anxieties, and interpersonal problems were explored. He explains that this not only helped the rehearsal run more “smoothly,” but also provided participants with a space to process loss: the loss of emotional support provided by those involved in the play, as well as the loss of task-oriented structure (p.271).

Johnson presents four aspects of theatrical production he believes to have therapeutic implications for psychiatric patients:

- Expressive: Johnson explains that plays require (and elicit) spontaneity, recreation of emotions and actions, and assertion of oneself in front of an audience. He believes that these demands may help clients develop such skills within themselves, however, they may also cause stress.
- Cognitive: Johnson states that plays require concentration, attending to stimuli, organization of nonverbal responses in a coherent manner, and the creation of representations of others which are both articulated and integrated. He believes that these requirements may challenge a participant's ability to organize their thoughts, as well as demand and elicit a level of energy and responsibility not often required of people who have experienced long-term hospitalization.
- Interpersonal: Johnson states that plays require the development of trust and cooperation among participants, as well as the managing of difficulties that can occur as intimacy deepens. He explains that these demands may also cause significant stress for participants who struggle with intimacy.
- Adaptive: Johnson states that plays require participants to attend lengthy rehearsals, accept responsibility for tasks, and develop organizational and communication skills.

Johnson explains that while many of these requirements may cause stress, the play creation process also helps participants *deal* with associated stresses, by (1) instigating emotional support from the group and staff members, and (2) providing a structure which helps order and organize participation.

Johnson determines continuity of group sense to be essential in helping participants integrate, understand, process, and mourn the play creation experience. He recommends that some form of continuous care (i.e., group or individual follow-up) be provided for 4-8 weeks following performances, in order to facilitate *therapeutic* termination. Furthermore, as discovered in the study, a client's level of difficulty with the termination of the play should be given close attention, as it parallels a client's level of need for support following termination in other contexts (e.g., discharge from inpatient care). Johnson also recommends that performances take place well before a client's discharge (in order to avoid dual-termination) and that therapeutic work be placed above theatrical success.

David Read Johnson (1981) "Drama Therapy and the Schizophrenic Condition"

Johnson (1981) presents potential challenges and benefits, gleaned from practicing drama therapy with clients with schizophrenia, at Yale Psychiatric Institute, in New Haven Connecticut. He writes from an object relations perspective, similar to that held by Giovacchini (1986): that social isolation in the lives of those with schizophrenia is largely due to a defense against boundary confusion. In this view,

development of boundary awareness, which most people experience during infancy, is underdeveloped in people with schizophrenia (i.e., *fundamental ego deficit*). According to Johnson, this manifests as a lack of “coherent, autonomous identity” in adulthood, causing feelings of fear, anxiety, and overwhelm (pp. 49-50). He explains that these feelings arise both in response to parts of the self that feel threatening and when in relation to others, and that these personal and external elements become experienced as a threat to retaining one’s sense of identity.

Johnson explains that in order to preserve a sense of identity and feeling of control over one’s experience, the individual with schizophrenia often withdraws from the social world, isolating into a world of fantasy. He connects this fear to difficulties associated with the process of individuation, whereby individuals with schizophrenia often struggle to find a middle ground (or, an autonomous self) between “complete engulfment” and a “radical isolation of the self” (p.47). He goes on to explain that this social withdrawal is paradoxical: The individual with schizophrenia needs people on whom they can depend, however their fear of intimate relationships often leads them to withdraw from people in whom they might find the support they need. Johnson believes that many schizophrenia related symptoms, for example when inner thoughts are perceived as reality (i.e., delusions), or when parts of one’s body are perceived as separate from one’s self (i.e., *depersonalization*), are by-products of this fundamental ego deficit.

Johnson poses that drama therapy may be used to address this fundamental ego deficit, or, boundary confusion, which leads to social isolation. He adds that a structured environment must be created where the client may feel free to safely express aspects of the inner self, so that these aspects may eventually be identified and integrated into the rest of the self, which they have been protectively cut off from.

Role-Playing. Johnson explains that unstructured role-play poses specific challenges for clients with schizophrenia. He describes these challenges as difficulty with maintaining relationship boundaries—boundaries that are required when acting in a scene with another person: *impersonal* (the relationships between the two characters or roles); *intrapersonal* (the relationship between a person and the role they are playing); *extrapersonal* (the relationship between a person and the role being played by another person); and *interpersonal* (the relationship between two people who are playing roles). Johnson explains that in role-play work, an individual’s specific struggle in maintaining identity and guarding against engulfment is revealed. He presents common displays of this struggle: confusing oneself with the role they are playing; resisting playing roles due to fear of being overwhelmed or confused; becoming overly-involved or inappropriately affected by their scene partner’s role; or becoming insensitive to scene partner’s role, maintaining their role in a rigid, unchangeable way. Johnson states that the drama therapist must provide the client with the necessary structure, support, and encouragement, explicitly clarifying

boundaries between roles and helping clients identify their source(s) of confusion in order to help them develop their ability to sustain relationships, while holding onto their own identity. He explains that this leads to more comfort and spontaneity when encountering others. Johnson adds that this process includes helping clients differentiate and elaborate on parts of themselves as they are revealed through role-playing, which helps build a stronger sense of self so that they may feel less threatened by engulfment.

Johnson explains that in a safe, protective drama therapy environment, clients with schizophrenia are able to express and release important emotions through *improvisation*— a space that also helps withdrawn clients share something of themselves with others. He adds that the imaginative, at times fantastical nature of drama therapy is enticing, allowing clients to feel free to reveal even fragmented inner material. He explains that because of this, clients with schizophrenia are able to bridge the inner and external world, which may help lower anxiety and integrate disorganized personalities.

Johnson stresses that social isolation is a major problem for those with schizophrenia, describing the illness as “radical isolation of the self from meaningful relationships with others” (p.60). He explains that drama therapy groups address this problem of integration in two ways: (1) by helping clients integrate their sense of identity whereby boundary confusion becomes diminished; and (2) by helping clients integrate into a group and develop mutually satisfying relationships.

Johnson also explains that there are several aspects of the group drama therapy process which support clients in becoming invested in one another. First, group drama therapy for clients experiencing common difficulties (e.g., schizophrenia) stimulates an experience where clients are able to see the struggles of others, many which they also face, creating a milieu of normalization and validation. Second, the creativity embedded in the process serves to address a need for belonging, and build group cohesion. Third, the shared atmosphere of giving, where group members perform for one-another, addresses feelings of deprivation. Finally, he states that group tasks are interpersonal, requiring cooperation, sensitivity for others, verbal and non-verbal communication, and spontaneity.

In Johnson’s view, clients are motivated to develop interpersonal skills throughout the drama therapy group due to positive reinforcement: the appreciation of others, and the feeling of accomplishment which accompanies the successful completion of group tasks. Additionally, he explains that clients develop a greater understanding of the impact of their behaviours on others through receiving personal feedback on their behavior from peers. Johnson explains that it is the drama therapist’s role to help facilitate relatedness by maintaining a safe and supportive atmosphere, addressing role enactment difficulties, monitoring group process, encouraging sharing of thought and feeling, and encouraging members to seek support from the group.

Johnson believes that as the difficulties experienced by individuals with schizophrenia stem from boundary confusion, the drama therapist must be sensitive to anxiety which arises from closeness,

encouraging but not forcing “slow tentative investments” in the group, simultaneously helping clients develop feelings of autonomy and self-control (p.62). He explains that the group must be “supportive, not engulfing; permissive, but not unstructured” (p.63).

Robin Reif (1981) “Drama Therapy with Short-Term Psychiatric Patients in a Hospital Setting: Observations of a Student”

Robin Reif (1981) presents observations made while assisting drama therapist Gertrud Schattner in 1976. Schattner was conducting group drama therapy on a short-term inpatient basis at Bellevue Psychiatric Hospital in Manhattan, New York. The group met for 1 hour weekly and was comprised of men and women ages 16-90, with diverse psychiatric illnesses, needs, and levels of functioning. Groups usually consisted of 10-15 members and were voluntarily attended. The structure of sessions was flexible so that it could be adapted to the needs and abilities of clients who attended on the given day. Activities included creative drama, movement and improvisation, pantomime, and a variety of theatre games.

Reif explains that the nature of the context did not allow for long-term goals — benefits had to be achieved in an individual session. This is a challenge which must often be taken into consideration, as the short-term inpatient context is one where group drama therapy for individuals with schizophrenia is likely to occur. Reif describes the value of drama therapy in this context as: (1) helping exhausted and isolated clients be reached by the joy and surprise of group activity; (2) providing structured activity to relieve loneliness and boredom; (3) breaking down barriers to communication by offering unique tools for self-expression (verbal and non-verbal); (4) fostering social interaction through activities requiring cooperation and coordination of group efforts to achieve mutual goals; (5) moving from withdrawal to engagement due to a feeling of liberation made possible by the warm, encouraging, “no fail” atmosphere facilitated by the drama therapist, and; (6) creating an experience of human connection and togetherness. These are common group drama therapy goals for many populations that remain extremely powerful for engaging clients with schizophrenia in a therapeutic interpersonal process.

Reif presents drama therapy activities with her observed correlating benefits:

- *Name Game*: One person in the circle says their name, the person beside them repeats their name, and then says their own, a sequence which is built upon until the final person in the circle repeats all the previous names, and then their own. In Reif’s view, this activity is an important introductory exercise for group and staff members, as group members change from session to session, in this treatment context.
- *Mirror Exercise*: Group members face a partner, taking turns leading and following (or, “mirroring”) each other’s movements. Instruction is given to move slowly so that the follower will be able to reflect movements, as a mirror would. Reif states that this activity requires cooperation, encouraging both self-awareness and awareness of the

other, providing members with the experience of being in both a leading and a following role.

- *Show How You Feel*: Group members express their present emotional state through movement. Reif explains that this exercise gives clients who have difficulty verbalizing their thoughts and/or feelings an opportunity to self-express and communicate, often at a time when they have great need to do so. She explains that this activity often leads to elaborative sharing, where members offer support to one-another, identify with what others have said, and become more willing to be vulnerable themselves.
- *Scene Improvisation*: Group members are offered the chance to enact, with the support of the group and drama therapist, a personally meaningful scene—real or fantasy. Reif explains that for improvisation to be successful, group members must work collaboratively. She explains that through this process group members receive attention from the group and have the opportunity to help one another. Reif also finds the highly personal and meaningful nature of scenes to be a powerful means of engaging clients.
- *Wishes and Gifts*: Group members stand in a circle and place their arms around each other's waists. Closing their eyes, they think of a wish they have for themselves, and a gift they would give to the group. When group members open their eyes, they have the option to act out their wish and/or gift as a pantomime for the group.

Renee Emunah (1983) “Drama Therapy with Adult Psychiatric Patients”

Drama therapist Renee Emunah (1983) writes about her seven years' experience working with adult psychiatric patients of various ages, diagnosis (affective and thought disorders), and levels of functioning, at Gladman Memorial Hospital Day Treatment and Pacific Medical Center-Northeast/Westside Lodges, in California. She describes what she conceives to be the primary attainable therapeutic objectives in this context as well as how they may be achieved. The following fundamental drama therapy objectives are described, as they relate to the topic explored in this paper.

Social interaction. According to Emunah, the collaborative, collective nature of drama is particularly effective in fostering social interaction in withdrawn clients because it necessitates a group process and interpersonal involvement—she states that a variety of improvisational and theatre games may be adapted to facilitate this type of interaction. Additionally, she explains that as trust, cohesion, playfulness, and feelings of safety are established within the group, members begin forming relationships with one another.

Release and control of emotion. Emunah points out that a chief difficulty for clients with psychotic disorders is releasing intense emotion appropriately and constructively, and that theatre games which arouse emotions while simultaneously *containing* through “clear-cut, built-in boundaries,” create

the needed feelings of safety and containment to explore the expression of emotion (p.78). She explains that these experiences help clients explore internal control, coming to understand their own limits.

Behavioural and role patterns. Emunah expresses that drama therapy provides a space where clients feel at ease experimenting with new roles, relationships, and responses, because one is merely “playing” or “acting” (p.79). She believes this to be important, as many individuals with schizophrenia are locked into rigid behavioral patterns and responses. She also explains that people with schizophrenia often struggle to make therapeutic use of insights because they are too immersed in *experiencing* to adequately self-observe and evaluate (Maslow, 1968, cited in Emunah, 1994) and that drama therapy helps clients attain insight by reducing inhibitions and resistance, simultaneously providing the *distance* required for the self-observing ego to develop. In her view, this translates to greater self-awareness, insight into familiar patterns, and access to a wider range of roles that clients may not have felt were accessible to them.

Self-esteem and self-confidence. Similar to the development of asocial beliefs which we have seen, Emunah explains that repeated experiences of failure often lead to low self-esteem and self-confidence in psychiatric clients. She states that drama therapy addresses this, in part, with theatre games that provide opportunities for success, eliciting strengths and feelings of achievement.

Emunah also provides structuring ideas for eliciting the aforementioned therapeutic benefits:

- According to Emunah, sessions should begin with an atmosphere of permission, where clients feel accepted as they are, leading to an openness to experimenting with different ways of being. An example that she provides is embracing the mood in which clients enter the room, and playing with it. For example, if clients enter with suspicion, they might be directed to greet each other in a suspicious manner. She explains that this allows for the feelings of members to be acknowledged, released, and shared, while helping clients warm up to the therapeutic process. As emotions are accepted and encouraged, defenses are minimized and an often “isolated state” is transformed to one of contact (p.81).
- Emunah describes difficulties that psychiatric clients often face, in terms of attention and sustaining engagement: emotional disturbances which preoccupy the mind and medications which have a numbing effect. Emunah suggests a fast-moving pace, physical momentum, and interventions that are connected and flow from one to another, leaving “little room for hesitation or withdrawal” (p.81).
- Emunah explains that psychiatric clients require a sense of structure (including, boundaries and limits) in session, in order to feel safe and motivated to engage with the therapeutic process. According to Emunah, this sense of structure should be paired with

spontaneity and improvisation, in order to spark a liveliness where change may occur. Emunah states that the therapist contributes to this sense of aliveness with a playful, enthusiastic energy (somewhat child-like, yet respectful for adult integrity). She explains that this feeling of aliveness, paired with structure, contribute to heightened involvement and concentration.

Finally, Emunah expresses that group issues such as commitment, separation in relationships, and termination, may be explored through scene work which examines those specific issues/themes. In a similar way, she explains that clients may address personal difficulties such as assertiveness or ambivalence, by taking on roles that allow them to practice adopting desired qualities.

Anna Bielanska, Andrezej Cechnicki, and Przemyslaw Budzyna-Dawidowski (1991) “Drama Therapy as a Means of Rehabilitation for Schizophrenic Patients: Our Impressions”

Clinical psychologists Anna Bielanska and Przemyslaw Budzyna-Dawidowski and psychiatrist Andrezej Cechnicki (1991) describe the “drama therapy” method they have been utilizing at Nicolaus Copernicus Academy of Medicine’s clinic, in Kraków. The authors create Shakespeare productions in outpatient groups, with clients with schizophrenia, following discharge from inpatient treatment. The primary aim of their work is to improve client functioning and interpersonal competence through the exploration of role and performance creation. They describe their work as a form of rehabilitation, involving a blend of psychotherapy and social skills training.

The authors elaborate that throughout the process of play creation, clients engage in script exploration, relaxed play, and experiment with behaviour. They explain that a major benefit of this work is the ability to help patients improve their communication skills, by, for example, modulating voice, tone, body posture, gesticulation, and facial expression. According to the authors, the theatre provides a feeling of safety where patients—similar to Emunah’s (1983) view— are more open to experimenting with behaviours previously viewed as impossible to them. They add that this process also serves as a way to explore relationships, such as the relationship a client has to their own role and the relationships between characters. The authors explain that this exploration translates to an increased ability to understand relationships in the personal lives of group members. In this work, clients are also offered a space to explore personal issues individually with a therapist.

The authors state that this process helps clients across various domains—the two most relevant to this exploration will be presented. First, that it helps clients develop their capacity for self-expression through a variety of exercises where both personal and character-related emotions are expressed. Second, that it helps clients better understand themselves and others by discussing (with the group) relevant themes in the play, characters, attitudes of patients towards characters, and relationships between the characters.

The authors summarize overarching goals of their outpatient groups as they relate to improving interpersonal competence: improved self-expression and knowledge of oneself as well as of others, experiencing cooperation and a sharing of responsibility, and receiving feedback from the group. They explain that certain structural elements of their process help attain these goals, including: stability and consistency of meeting place and time, the use of a script around which group work is focused, and clearly defined roles assigned to participants.

Examination of the work of two outpatient drama therapy groups. Groups were comprised of 24 individuals with schizophrenia. Characters/roles were assigned to participants, with individual goals in mind. The authors contend that the process of character development (achieved through psychological analysis, experimenting with behaviour, modulating body postures, etcetera) helped clients discover new strengths as well as develop a greater understanding and acceptance of human complexity. They also state that *distance* between acting and real life was an important consideration for the therapist, and that psychological analysis of the roles helped clients find this needed distance. They explain that relevant themes in Shakespeare's plays (e.g., mental illness) created a channel for personal exploration.

The final performances took place in front of an audience mainly comprised of patients' friends, family members, and clinic staff. The authors note significant results: Only 8 out of the 51 patients have been re-hospitalized, and only 5 have failed to remain in contact with their psychotherapists. Of the patients who have kept in contact, the authors report observing improved social competence (especially as it relates to interpersonal contact and communication skills), which they connect to improved self-image, resulting in "freer contacts with others" (p.573). It is important to note that the timeframe from termination of the group, to this moment of observation, has not been specified.

The authors express their belief that the "general attractiveness" of this type of group therapy (including, but not limited to the structure provided by the use of role) likely plays an important part in drawing clients to this method—clients who would likely not benefit from more traditional psychotherapy (p.575).

Alice M. Forrester and David Read Johnson (1995) "The Role of Dramatherapy in an Extremely Short-Term In-Patient Psychiatric Unit"

Drama therapists/psychologists Alice M. Forrester and David Read Johnson (1994) present what they regard as the fundamental challenges of providing short-term drama therapy in the context of inpatient psychiatry, as well as how and why drama therapy may be a useful treatment method, based on their practical experience. As this work is not specific to the application of drama therapy to individuals with schizophrenia, this summary will focus on an extraction of relevant themes relating to the topic of exploration. As in the Reif (1981) text, the context itself is an important one to consider, as the short-term inpatient psychiatry setting is one where group drama therapy, with this population, is likely to occur.

According to the authors, fundamental challenges that stem from the short-term, in and out nature of client attendance include minimal thematic development from session to session, and a disruption in the development of feelings of safety and trust. They pose that for drama therapy to contribute positively in such an environment it must satisfy certain conditions: “the entire therapeutic effect should be accomplished in one session”; “it must be an obvious contribution”; and “it cannot be expected to impact directly on an illness itself, such as schizophrenia” (p.126). They state that drama therapy can positively impact the treatment process in short-term inpatient units by: contributing to a feeling of being a “survivor” rather than “victim” of their illness; finding empowerment; reducing feelings of isolation and despair; and decreasing feelings of shame and humiliation (p. 127-131). They describe *play* as a method of *distancing* whereby clients are able to achieve self-revelation “under the guise of imagery and metaphor” (p.128).

Developmental Transformations. Developmental Transformations (DvT) is a highly relational, embodied, and spontaneous form of drama therapy, defined more thoroughly in the subsequent section exploring Butler’s (2012) article. This method is one that Forrester and Johnson (1995) have found to be a pertinent treatment method in short-term inpatient psychiatry, one which they explain fosters laughter, relief, equanimity, connectedness, unity, cooperation, group and social support, and which improves relationships between group members. According to the authors, warm-up activities such as tossing an imaginary ball among group members as they say one another’s names, foster the beginning of connectedness (eye contact, awareness of the other)—interpersonal connectedness which is usually absent upon beginning session. Forrester and Johnson also describe a closing technique— the *magic dramatherapy box*— an imaginary box, where clients “place” any questions they have, as well as take out whatever they feel they need. Questions which participants have asked are presented: “why am I so messed up?”, “will I make it?” whereby other group members spontaneously offer encouragement, “yes [you will make it]” (p.131).

Video Group. Forrester and Johnson write about their experience implementing a drama therapy format called the Video Group. Here, with the use of distance and humour, patients create short weekly “news broadcasts” and a corresponding skit to portray how the community is doing, and to explore any problems they are experiencing in living together—this is viewed by patients and staff. The authors explain that the video and skit become catalysts for discussion within the unit’s community, enhancing the sense of community by updating the unit on the fast-paced changes taking place, and by making associated challenges transparent and open for discussion.

The authors also state that the Video Group is a means of demonstrating patient competencies and helping them shift from a role of a “hopeless dependent” to that of a “responsible community member” (p.137). They explain that most patients are able to demonstrate mastery in one of the required roles,

including anchoring and reporting. Furthermore, they write that stepping into these roles can help clients experience themselves, and be experienced by others, in new ways (e.g., as having a great sense of humour).

Stephen Snow (1996) “Focusing on Mythic Imagery in Brief Dramatherapy with Psychotic Individuals”

Drama therapist Stephen Snow (1996) explores how the *mythological* content of a person’s acute psychotic episode may be used as the focus in brief drama therapy treatment. His work is greatly indebted to the psychological innovations of psychiatrist Carl Jung, Jungian analyst/psychiatrist, John Weir Perry, and Jungian drama therapist, Penny Lewis. Although Snow explores drama therapy on an individual basis, with clients experiencing an *episode of psychosis* (not necessarily schizophrenia), he presents a unique perspective of working *with* psychotic material, which might be applied to the group therapy context, with clients with schizophrenia, who are experiencing psychotic material.

According to Snow, acknowledgement and *embodiment* of such content—within the fluid flexible frame of drama therapy—assists clients by organizing chaotic images and fantasies into a transformative, creative experience, bridging the outer and inner world, leading to catharsis, healing, transformation, integration, enriched consciousness, and improved mental health. Most important for this present discussion might be the organization aspect and—similarly with Moreno’s (1944) work—transformation of delusional material and the bridging of the inner and outer world. Additionally, with reference to Giovacchini’s (1986) and Johnson’s (1988) ideas around retreating as a means of self-protection, Snow’s means of helping clients find integration and enriched consciousness would be of great value, in addressing boundary confusion.

Snow connects his theory to shamanic healing and therapeutic rituals involving mythic imagery, drawing parallels between psychotic episodes and the developmental *rites of passage* found in primitive societies, establishing the drama therapist as the guide figure who supports conversion of psychotic episodes into transformative experiences. Furthermore, he explains that the central themes in many psychotic episodes are connected to symbolic mythological motifs, for example: *death, returning to the beginning of time, cosmic conflict, threat of the opposite, and new social order*—symbols which parallel the ritual dramas of sacred kinship in ancient Middle Eastern cultures, and are deep-seated in the Western psyche (Perry, 1974, cited in Snow, 1996). Snow believes that the capacity of drama therapy to sensitively create a transitional space (or, a *playspace/liminal space*) where this mythological material can be “embodied, contained, explored, and worked through” sets it apart as an effective route to self-transformation, working on those area where individuals with schizophrenia often become stuck (i.e., fixed delusions) (pp.222-223). Integrating the *object relations* perspective, Snow states that the tendency for a person with schizophrenia to slip into an internal world of fantasy and delusion is connected to a

weak inner psychological structure or, underdeveloped or broken-down object relations. He explains that in order to develop a healthy psychological structure, as with children, a transitional space is required (Jacobson 1964, cited in Snow, 1996). Snow states that drama therapy is a practical means of helping individuals who are “overwhelmed by mythic imagery” because of its employment of a playspace — a frame that honors fantasy, illusion, and play as therapeutic vehicles (pp.119 & 223).

Also rooted in object relations theory, Snow explains that much of this psychotic fantasy and delusional material is defensive: Delusional beliefs are often a defense against fear of dissolution and/or invasion. Snow presents a number of skills that the drama therapist must employ in order to help a client with schizophrenia find coherence, as well as loosen, explore, and reconstruct these images. Relevant to this exploration are, the drama therapist must:

- develop a deep understanding of how the symbolic process unfolds in related psychotic episodes;
- be ready and able to attune to/”enter” into the client’s sometimes fragmented inner world of fantasy;
- not challenge, but rather, really *hear* delusional material in a way that is apparent to the client;
- build a trust rapport with the client;
- help the client develop object relations by becoming an internalized object for the client, conveying a message of strength and containment, and;
- understand and possess an ability to create a transitional space for psychotic material.

According to Snow, successful therapy will require that the drama therapist is able to help the client use this material to bridge a gap between their inner and outer world, in order to eventually integrate insight and parts of self that have been discovered through the process of embodying and playing with the client’s symbolic imagery. Snow describes this bridge as the transitional space, an in-between place —the playspace —where fantasy, present reality, and future possibility come together to elicit therapeutic growth.

Snow provides a brief case study, illuminating the integration of his theory into therapeutic work. The process began by composing a team of staff members, Snow, and the client (a 39-year-old male with schizoaffective disorder), whose present decomposition encompassed feelings of grandiosity and mythological delusions. The group improvised with the client’s images, accepting delusional material, whereby the client was able to experiment with identity, “deconstruct[ing] and construct[ing] himself at will” (p.228). Through this process of improvisation, a play was created and performed for staff and hospital patients—a play which served as a *transitional object*.

Snow describes the team as a “floating anchor” that helped to stabilize the client as he physically explored his internal world (p.229). Snow describes this process as being powerfully validating for the client who was able to share aspects of himself with others through the transitional space. He explains that the transitional space created a bridge between the client’s isolated internal fantasy life and the outside world: His internal world “became part of objective existence” (p.229). Additionally, Snow notes that the client appeared to develop ego organization and to access a personal strength in writing through this process. Following termination of the brief (4 month) drama therapy treatment, Snow notes the client complained less of symptoms, began to plan a future in the “real world,” and required shorter hospitalizations for his subsequent decompensations (p.229).

Snow presents three contexts where this work would be of value and how it might be of use. The two most relevant to this exploration are: for acute (possibly first) psychotic episodes in young adults, where the guide figure (therapist) helps to contain, explore, and make sense of symbolic imagery, with the belief that the psychotic episode is a manifestation of the psyche working through issues (Perry, 1974, cited in Snow, 1996). Secondly, for a client with a chronic, psychotic disorder, who is in a state of decompensation. In this context, the focus would be on using the decompensation as an opportunity to loosen rigid psychotic character structure and discover new aspects of the client’s personality, as was done in the case study.

John W. Casson (2004) *Drama, Psychotherapy and Psychosis: Dramatherapy and Psychodrama with People Who Hear Voices*

Dreams, (unconscious) phantasy, (conscious) fantasy, thoughts, emotions (including sexual feelings), voices, relationships may be impossible or difficult to control. The vulnerable ego may attempt control. Professionals may attempt control. Over-control may result in tension and anxiety. Letting go of control however may be frightening or difficult. Letting go will involve some relaxation of tension and can thus be therapeutic. Dramatherapy and psychodrama can offer a *safe experience of letting go of control* Control is often experienced in the body: a sense of someone/something having control of the body. Dramatherapy and psychodrama, in using physical activities, can provide physical release and foster a greater sense of physical self control. Dramatherapy and psychodrama also offer a *safe experience of being in control*. *Dramatherapy and psychodrama must, above all, empower people and return control into their own hands.* (Casson, 2004, p.50)

Drama therapist/psychodramatist John W. Casson (2004) writes about drama therapy and psychodrama for “people who hear voices,” following 6 years of doctoral research looking at this subject, as well as 18 years of clinical practice as a psychodrama and drama therapist (p.1). His research involved

21 male and female adults (age 20-50) with a variety of mental illnesses and trauma history, the majority of whom had been diagnosed with schizophrenia, and all of whom heard voices (i.e., auditory hallucinations). Casson conducted a variety of groups and individual sessions, with a total of 340 client sessions, throughout the process of his research. Casson values client choice and believes that drama therapy and psychodrama are significant treatment options to offer clients in this population.

Casson defines psychosis as “a process in which a person escapes from the intolerable reality and creates another fantastic ‘reality’” (p.40). In his view, psychotic fantasies contain and create distance from feelings and experiences that an individual seeks to escape, at times compensating for what is lacking in a person’s life (e.g., the manifestation of *friendly* voices). He asserts that ongoing stress and difficult life events often play a role in reinforcing and perpetuating psychotic symptoms, which would explain the phenomenon of fixed delusions. In this way, as Casson explains, what begins as a largely unconscious creative defense/means of coping may “destroy social reality” as well as impair one’s capacity to relate to and engage with the social world, leading to a largely isolated life (p.41).

Much of Casson’s work focuses on helping clients who hear voices develop a sense of empowerment. This is a relevant goal for the topic being explored, as helping clients find empowerment addresses the effects of self-stigma and self-esteem on social isolation. Casson explains that one of the major contributions drama therapy makes to the challenge of helping clients find empowerment is the use of role. Similar to Emunah (1983) and Bielanska et al. (1991), he explains that playing with role elicits spontaneity and supports the cultivation of an expanded sense of self and possibility.

Furthermore, Casson states that both drama therapy and psychodrama require that clients make choices to fuel the therapeutic process, helping them discover a sense of power through accessing their creativity and capacity for decision making. In relation to voices, his work focuses on helping clients develop a feeling of power over voices so that they are able to interact with voices, selecting which they choose to listen to, transforming feelings of victimization into feelings of strength and power. Additionally, in relation to Watkins’ (1998) theory that voices may increase as a client becomes more withdrawn due to sensory deprivation, this work focuses on reducing voices by targeting isolation.

Casson is sensitive to the often-present anxiety around connecting with others, which many individuals who hear voices face. He states that “given the social anxiety, lack of social skills, paranoia and the possibility that vulnerable patients may feel overwhelmed, it is important to build into the practice of dramatherapy some safeguards: to balance the risk with familiar ritual and safe structure that can contain anxiety” (p.180). He suggests beginning a series by instilling norms within the group, establishing a contract of respect, confidentiality, and non-violence in order to help clients feel more at ease with engaging in the group process. Casson also implements embodied and breathing interventions to help reduce anxiety associated with the group experience. He presents a variety of introductory

interventions such as *simple introductions* (e.g., introducing oneself, saying hello to others), and *name games*, as well as more embodied interventions, such as cooperatively *playing with a parachute*. In this way, clients are supported in establishing their presence and making initial contact with others. Casson recommends a lengthier warm-up period, with structured activities, for clients who are experiencing heightened barriers to engaging with others. He explains that this period is crucial in helping build a foundation of trust and cohesion, especially for those clients who experience more difficulty relating to others.

As sessions progress, Casson explains that connection may continuously be supported through a variety of structured interventions such as passing around an object/*talking piece* (facilitating structured sharing), *word games*, *mirroring*, *trust walks*, and emotional *daily check-ins*. He adds that facilitating communication, relatedness, and conversation is one of the great benefits of group drama therapy, describing it as “an antidote to isolation” (p.171). Casson explains that through this process clients may also reclaim a sense of empowerment by experiencing opportunities for speaking up for oneself, expressing oneself, and asserting one’s identity. Casson explains that “the group is about noticing and being noticed and about making connections in action, relationships, thinking and bringing meaning out of chaos” (p.180). He asserts that it is important that the therapist be ready to help clients find meaning in the time spent together so that they leave session with a sense of meaning, regardless of any challenges or interpersonal conflicts which may have arisen.

When more distance is required, Casson recommends collectively *imagining landscapes*, *creating maps*, *drawing mandalas*, *passing around a small globe* having clients explain their “world,” *writing poetry* or *short scenarios for plays*, and *using photographs, toys, or dolls*. He explains that these types of interventions provide containment and distance, whereby clients feel less threatened by the act of sharing their internal world with others. He explains that connection may also be facilitated in the here and now, by drawing on clients’ statements to create simple drama activities or improvisations. Additionally, he recommends creating *sociodramas*, where group members collectively create and embody fictitious, mutually meaningful stories, in order to explore power dynamics (as they relate to voice hearing, as well as to society) in a more distanced way.

Casson explains that many people with psychosis related illnesses have often fallen victim to the aggression of others. Instead of learning to express their corresponding aggression in healthy ways, such feelings become split from the person, who then experiences their own aggression as alien to them. According to Casson, these feelings often manifest in the form of voices (i.e., auditory hallucinations), directed towards the self, reinforcing feelings of victimization. Casson explores a variety of drama therapy interventions which he has implemented in order to help clients regain a sense of power over aggression, channeling and releasing these emotions in therapeutic ways so that associated voices may be

reduced. For example, he presents a *drumming intervention*, where clients are encouraged to drum while expressing themselves vocally, exploring their vocal power.

Casson states that group therapy has the capacity to be both empowering and helpful for people who hear voices, in part, because of the nurture and compassion it provides members. However, Casson explains that for some very isolated individuals, the group experience may feel too threatening, and would be more accessible to them by beginning with individual sessions. He states that establishing a “safe, nurturing relationship with the therapist” beforehand aids in the process of developing these types of relationships with peers, in later group work (p.163). He also offers suggestions for helping the group experience feel less threatening, ideas such as inviting members to *create their own, physical, personal space* in the room (with objects if desired), where they feel at ease and safe. In addition to helping the group experience feel less threatening, he explains that this intervention fosters feelings of control over one’s environment, simultaneously influencing agency over passivity. Casson also suggests providing a *row of audience chairs*, where clients may choose to go, to remove themselves from the “action,” while remaining engaged in the therapeutic process (in the role of a witness) when feelings of overwhelm arise.

Casson also explores numerous benefits the embodied nature of drama therapy offers clients who hear voices. First, he explains that embodied warm-ups (using a parachute, *breathwork, Tai Chi, physical games*, etcetera) may be used to help clients relax into the therapeutic process, while simultaneously stimulating spontaneity and creativity and providing opportunities for interaction among members. Secondly, that the use of more structured embodied interventions, such as creating a *web of string* between group members so that they may explore interpersonal connections, as well as *co-creating rituals*, help engage group members in “cooperative action” (p.166). Thirdly, he explains that personal power can, and even should be reclaimed through the process of embodiment. In Casson’s words, “empowerment cannot only be a mental concept but must be experienced in the body: power and control must be felt in the body and expressed through physical behaviour. For people who are survivors of abuse and who have psychotic experiences this issue of control is often experienced in the body: a sense of someone/something having control over the body” (p.166). Because of this, Casson explains that through the emphasis on physical activities and tasks, drama therapy can foster a sense of personal security and self-control. Finally, because drama therapy recognizes and values the connections between mind and body and thereby engages the whole person in the therapeutic process, he states that drama therapy helps clients develop a stronger, consolidated sense of self.

Casson also explores the benefits of group psychodrama for people who hear voices. He explains that this method is a powerful mode of bringing people together through the sharing of personal (often common) experiences, stimulating peer support and helping group members to “break out of pathogenic isolation” (p.199). He presents a variety of psychodrama interventions including, but not limited to,

sculpting, *role reversal*, and the *mirror technique*, describing how these interventions address specific obstacles to social integration: disempowerment, positive symptoms (voice hearing) and boundary confusion. In the sculpting technique, a client uses objects and/or group members in order to externalize their internal world so that they can examine power hierarchies and dynamics as well as identity and meaning, as they relate to voices. In role reversal, the protagonist exchanges roles with the auxiliary actor playing the role of one of the voices that the protagonist hears, in order to gain insight into, as well as a sense of control over voices. When more distance is required, the protagonist steps into the mirror position, where another auxiliary actor replaces the protagonist so that they can step out and observe the interaction between “themselves” and an aspect of their internal world—Casson explains that this technique is also a powerful means of addressing boundary confusion as the individual is able to view “themselves” in physical relation to another person. When working with the psychodrama method, Casson cautions that full length dramas may be too demanding for clients with intense concentration difficulties, suggesting in these cases shorter interventions or dramas/vignettes.

Throughout his research, Casson collected feedback from clients and combined this information with his own observations to create a model for conducting drama therapy work with this population.

Relevant guidelines have been selected and summarized:

- The therapeutic relationship: Establishing trust may be particularly challenging when working with this population, requiring time, patience, and support. Therapy should take place once a week, as intensive psychoanalytic psychotherapy has been found to be anti-therapeutic for this population.
- Positive support: Through unconditional positive regard, non-judgmental acceptance, warmth, encouragement, positive reinforcement for achievement and change, and affirmations, the therapist may help strengthen the client’s vulnerable ego. Through these conditions, as well as with group praise and the client’s own spontaneity and creativity, self-esteem may be strengthened.
- Accepting the client’s perspective and needs: The therapist must respect the client’s defenses and frame of reference, patiently helping them explore the content of their delusions and/or hallucinations, as well as how to cope with them. Therapeutic objectives should change in accordance with the client’s presenting needs.
- Working with the whole person: The therapist must be conscious of the whole person, healthy and sick, and work with an awareness and acknowledgement of the complexity of the person.
- Feelings: Any feelings that arise in the therapy space must be given room to be felt, named, and processed. Efforts should be made to identify the origins of split-off feelings, in order to find integration.

- Voices and delusions: Similar to Snow's (1996) concept around mythic imagery, Casson explains that voices and delusions contain meaningful, at times *metaphorical* content. He explains that they should not be denied but rather, listened to and explored, with an effort to uncover meaning.
- Structure: Drama therapy should provide clear structure, containment, and needed stimuli in sessions, while leaving space for autonomy and free play, with an awareness that this population often struggles with concentration, and anxiety.
- The use of containing objects: Objects are useful tools for containing projections and creating distance. This may take the form, for example, of *using singular objects within embodied play*, or, when more distance is required, *creating a small projective world* made up solely of objects.
- Metaphor: Similar to recommendations made by Snow (1996), Casson explains that drama therapists must be comfortable working with delusional material or voices, without needing to interpret them, leaving room for the client to uncover insight and links when they are ready. He explains that metaphoric content keeps personal material at a safe distance, and for this reason, must be treated with caution and care.
- Distance: Clients with psychotic disorders may have over distanced or split themselves, in an effort to self-protect against overwhelming feelings. The drama therapist manipulates distance to achieve *aesthetic distance*, so that clients are able to simultaneously observe and feel, guarding against overwhelm while maintaining enough connection to achieve meaningful therapeutic gain.
- The observer ego: Through drama therapy and psychodrama interventions (such as psychodrama's mirror technique and working with distance), the client's observer ego can be engaged and strengthened, as these techniques help facilitate reflection rather than overwhelm.
- Power and control: Clients find empowerment through dictating the direction of their therapeutic process, developing their locus of control. Therapists should offer interventions related to what the clients seems to want and need, and offer these suggestions without expectation. Casson explains that "a therapy where the therapist is the expert, in control, can reproduce the experience of the person who has been controlled and disempowered by another in the past" (p.245). At the same time, the therapist must be sensitive to any anxiety which may accompany that sort of responsibility. Like in the concept of co-therapy, the therapist should be open to power shifting back and forth between group members and therapist and in essence, becoming a "playmate."
- Role-play: Similar to the theories of Emunah (1983) and Bielanska et al. (1991), role-play provides an opportunity for clients to experiment with roles and identity the real world has denied them. This is important for a population who often experience limited opportunities for a variety of roles in their lives. As many individuals with psychotic disorders experience "role poverty"

(i.e., a “loss of roles in their life”), role-playing and satisfying “act hungers” in the playspace may facilitate a “re-creation” of the self (p.246).

- Role reversal: Role reversing with a voice can help a client gain empowerment by accessing, becoming closer to, and even owning the feeling(s) behind the voice—feeling(s) which they have defensively split-off. For more distance, clients may also take on the role of other group member’s voice(s) whereby they simultaneously continue to explore some aspect of their own experience with voice hearing. This more distanced role reversal can be particularly useful in building the observing ego and gaining insight.
- Individual versus group therapy: Small group therapy (6 members) with this population is ideal, as individual therapy may perpetuate isolation (however this is not an absolute).
- Timeframe: Therapy with this population is ideally long-term, with sessions lasting anywhere between 45 minutes to 2 hours, depending on the needs of group members and their capacity for concentration and relating to others.
- Closure: Throughout the process of termination, clients should be exploring what they will need in the future—a “self-help network”—so that they do not leave therapy to return to isolation (p.247). Following group termination, individual sessions may be useful in processing issues that arose during group therapy, in more depth.

Lambros Yotis (2006): “A review of dramatherapy research in schizophrenia: Methodologies and outcomes”

Psychiatrist/drama therapist Lambros Yotis (2006) conducted an extensive review of research (quantitative, qualitative, and theatre-based) which has looked at drama therapy as a treatment for schizophrenia, in order to create a springboard for future research, indicating that quantitative research in drama therapy is very limited. In order to achieve this, his primary focus relates to how research in this area has been conducted, findings, and how this research may be built upon. He notes that many drama therapy researchers report improvements in negative symptoms, with limited research looking at the effects of drama therapy on positive symptoms of schizophrenia. Overall, according to Yotis “research in the field of drama therapy provides evidence that this therapeutic intervention makes a beneficial contribution to the overall biopsychosocial treatment and rehabilitation of patients with schizophrenia” (p.197).

Having conducted a review of drama therapy literature in the field, much of what Yotis writes has been covered in the preceding literature review. Key finding of his review, as they relate to the current topic being explored, are that some of the major assets that drama therapy has to offer schizophrenia treatment are distance and metaphor, which create a space of safety for “severely disturbed individuals” (p.197). Yotis elaborates that drama therapy tools, such as working with role, *storytelling*, performance

creation, improvisation, constructing therapeutic rituals, working with *masks*, *puppets*, as well as with *symbolic objects*, provide clients with schizophrenia a “gradual, safe, non threatening, flexible exploration of their issues” (p.191). He believes this may account for why it has been used more than psychodrama, in recent years.

Rachel Ruddy and Dent-Brown (2008) “Drama therapy for schizophrenia-like illnesses”

Rachel Ruddy and psychologist/occupational therapist/drama therapist Kim Dent-Brown (2008) conducted a review of randomized controlled trials in order to analyze the effects of drama therapy and related therapeutic approaches in the treatment of schizophrenia and schizophrenia-like illnesses, comparing them to standard care or standard care and additional psychosocial interventions. The authors explain that drama therapy has been used in the UK as a form of psychotherapy for people whose difficulties are less responsive to more traditional talk therapy methods, for several decades.

Through their research, the authors identified two unique assets which drama therapy has to offer schizophrenia treatment: drama as a *container* and the use of aesthetic distance. In terms of containment, the authors explain that because individuals with schizophrenia and schizophrenia-like illnesses often experience thoughts and emotions that are “distorted and hard to contain,” more traditional talk therapy may not be successful, as it assumes that the client already possesses some ability to self-regulate thoughts and feelings and engage in basic reality-checking (p.2). Building on this, they explain that because drama may be seen as “make-believe” or “only a story,” it provides a “safety net,” making it easier for clients to explore sensitive material by playing with fantasy through metaphor and symbolism (p.2). The authors explain that personal stories explored through the use of myth, *fairytale*, and *folktales* may serve as a container for difficult material, while mirroring and normalizing those experiences (Bettelheim, 1976; Schmid, 2002, cited Ruddy & Brown, 2009). In terms of aesthetic distance, they explain that the distinction between the dramatic material and the real world of the group provides “environmental regulation” which compensates for a lack of self-regulation (Jones, 1993; Bielanska et al., 1991, cited in Ruddy & Brown, 2009, p.2).

The authors conclude that a minimal dropout rate in one of the studies, one that relied on voluntary participation, may indicate that drama therapy was experienced as an appropriate and appreciated method of treatment by participants, and that it did not produce negative side effects. Additionally, they conclude that psychodrama, as a compliment to antipsychotic medication and inpatient care, may contribute to improving negative symptoms, self-esteem, and feelings of inferiority.

Jason D. Butler (2012) “Playing with Madness: Developmental Transformations and the Treatment of Schizophrenia”

Drama therapist Jason Butler (2012) presents possible therapeutic implications for the use of the Developmental Transformations (DvT) method in the treatment of clients with schizophrenia. DvT is an

embodied, spontaneous, fluid, improvised form of drama therapy, which is practiced on an individual or group basis, and is largely focused on the communication and encounters which occur between client(s) and therapist (Johnson, 2013). In this method, the therapist is an active participant in the therapeutic play, working to help clients build their capacity to adapt, with flexibility and groundedness, to the unpredictability and instability of life (Johnson, 2013). Butler makes a link between the theoretical foundations of DvT—*embodiment, encounter, and transformations*—suggesting that schizophrenia pathology may be seen as “a disorder of embodiment, encounter, and transformations” (p.87). He states that schizophrenia is, in essence, “a disease that negatively influences an individual’s ability to connect with their own body, to connect with those around them and to transform in a healthy manner” (p.89). He explains that through this lens, DvT may be a viable approach to treating both negative and positive symptoms of schizophrenia.

Butler supports the need for psychotherapy in the treatment of schizophrenia with research, demonstrating that as already explored, psychopharmacological treatment is often the primary method of treatment, which leaves patients with unaddressed negative symptoms (Crawford & Patterson, 2001 cited in Butler, 2012). Furthermore, he presents research demonstrating that although there exists a common belief among clinicians that individuals with schizophrenia are often too limited (due to catatonia or thought disorders, for example) to benefit from psychotherapy, the ideal treatment for schizophrenia has been demonstrated to include a combination of psychopharmacology and psychotherapy (Turkington, 1994; Patterson & Leeuwenkamp, cited in Butler, 2012).

In defending the use of group *drama* therapy (in this case, DvT), Similar to Casson’s (2004) view, Butler explains that popular therapeutic group methods in the treatment of schizophrenia, such as cognitive-behavioral therapy, pose disadvantages for clients who experience cognitive limitations and/or fixed delusions, making the development of insight and/or the motivation required for these method difficult (Silverstein, 2007, cited in Butler, 2012). Additionally, he explains that many common forms of group treatment focus on raising awareness into, for example, the importance of taking medication, and that while this type of group has relevance, a therapy which helps clients develop a sense of social agency in addressing their mental illness, is often lacking. Butler also presents research demonstrating that *body focused psychotherapy* (a form of therapy possessing similar embodied interventions to DvT) significantly addresses negative symptoms in people with schizophrenia, in addition to fostering improved client attendance though interest and enjoyment (Röhrich & Priebe, 2006; Röhrich, Papadopoulos, Holden, Clarke, & Priebe, 2011, cited in Butler, 2012).

As stated earlier, DvT is a therapeutic means of becoming more comfortable with the unpredictability and instability of life. Encompassed in this are the many paradoxes of life, such as being “mind and body,” “a subject and an object,” and “living in a real and imagined world at the same time”

(Johnson, 2005, p.10). According to Butler, these ideas speak to many of the obstacles that people with schizophrenia face, which parallels Giovacchini's (1986) theories on boundary confusion. In Butler's words, "individuals with schizophrenia are continually navigating the experience of living in a real and imagined world at the same time. They are also impacted by the paradox of being both mind and body, navigating the frequent disconnects between the two" (p.89).

Butler explores the ideas of embodiment, encounter, and transformation in more detail (elaborated below), with the understanding that DvT attempts to help clients work with these conditions so that eventually, they become better able to tolerate the unstable/unpredictable nature of life, leading to fewer barriers and defenses when relating to the external world. In Butler's words, "through work in DvT, a client is able to encounter the world and others in a more embodied way and transform along with the world's unpredictability and instability" (p.89).

Embodiment. Butler states that because this form of psychotherapy is embodied with awareness often drawn to the physical manifestations of ideas, emotions, and images, it is a viable means of helping clients develop body awareness and integration.

Encounter. Butler states that because DvT uses no props, and is focused primarily on the interactions between client(s) and the drama therapist, encountering others becomes the focus, generating anxiety that can be playfully worked through.

Transformations. Butler states that because the content within the DvT playspace is constantly transforming, this method helps break through rigid defenses held by client(s) that have developed as a means of coping with the instability of life.

In terms of affect, Butler suggests that by encouraging clients to explore affective extremes of emotions that arise within the playspace, clients are able to experience fully embodying emotions, which may translate positively to their ability to express themselves in other encounters. Additionally, he explains that DvT promotes a *recursive process* when communicating with another person. This process is comprised of: *noticing* (a stimuli presented by another person); *feeling* (an emotional or cognitive response to that stimuli which is felt in the body); *animating* (a physical reaction- the feeling, in preparation for an active response); and *expressing* (an active response intended to communicate something back) (Johnson, 2013). Because of this, Butler believes that DvT is also an ideal method for addressing emotional recognition and expression difficulties in clients with schizophrenia (Butler, 2012). Butler adds that the DvT therapist aids in this process by commenting on the here and now, providing immediate feedback on behaviour and level of emotional attunement.

Butler believes that certain negative symptoms associated with schizophrenia— affective flattening, lack of motivation, and rigid behavioral patterns—lead to body disconnect and social withdrawal. According to Butler, DvT motivates clients to attend, because it provides immediate rewards

of fun and entertainment. Furthermore, he explains that rigidity or fixed delusions in people with schizophrenia might be viewed as a lack of motivation to change or an attempt to organize confusion caused by positive symptoms, respectively. He explains that because of the fluid, transformational and at times distanced nature of DvT, clients are able to weave in and out of roles and behaviors, with rigidity being playfully challenged, when it arises. Butler states that the therapist supportively challenges clients to engage in this process—to “step out of their comfort zone” in order to experiment with new roles and behaviour (p.90).

Butler also explains that positive symptoms of schizophrenia pose barriers to trusting information from one’s physical senses, making it difficult to be fully present with others, as well as causing rigidity. He states that DvT may be an ideal way to address the positive symptoms of the illness for several reasons. First, because the playspace is based on an agreement that what happens is not real, clients are more open to expressing delusional material, as well as allowing the therapist to explore that material playfully with them. In the same vein, due to the non-threatening, accepting nature of the playspace, he explains that clients are more inclined to explore and look at alternatives to delusional beliefs and rigid roles/behaviors. In Butler’s view, these aspects of the playspace create a therapy space where delusional material may be explored, reworked, and reintegrated.

Butler also states that DvT helps enhance quality of life for individuals with schizophrenia through playfulness and self-empowerment. The benefits of play, according to Butler, are twofold: The experience of play provides clients with a (sometimes absent, yet important) experience of “humour” and “delight,” while simultaneously motivating them to work on challenges within their lives (p.91). In terms of self-empowerment, Butler explains that the DvT playspace also allows clients, as we have seen, an important opportunity to experiment with alternate roles, which the real world may not have allowed them (such as that of a lover, boss, or healthy person). He explains that the felt experience of embodying these roles may lead to an integration of novel characteristics, opening new possibilities in clients’ lives. This idea of expanding a client’s role repertoire is greatly connected to the *role method* of drama therapy, created by drama therapist Robert Landy (1991). In the same vein, Butler explains that the playspace provides an opportunity to uncover and develop dreams for the future which in turn, develops self-agency. In Butler’s words “DvT encourages the client to imagine their future, to play with their potential and to have an embodied experience for future possibilities. By being able to project into the future, their own autonomy and ability to direct the course of their lives is greatly enhanced” (p.91).

Criticisms of treating schizophrenia with Drama Therapy. Butler (2012) challenges the common perspective in psychiatry, that drama therapy might exacerbate challenges in deciphering the boundary between reality and fantasy, by citing drama therapy authors (Casson, 2004; Emunah, 1983) who believe that playing with moving in and out of roles, of fantasy and reality, may in fact contribute to

an individual's capacity to decipher that very boundary. Butler states that "it is difficult to delineate any boundary when one is standing too far away from the boundary," stressing the importance of making that boundary explicit, through DvT's structural tools, such as entering and exiting the playspace through an *imaginary curtain* (p.92). Butler adds that DvT is not effective in the course of a psychotic episode and should be used at a time when the client might be more receptive to playful exploration and reality testing, and with the assistance of the client's support team and a qualified DvT practitioner.

DvT for a group of clients with schizophrenia. Butler outlines a loose structure specific to DvT group work with clients with schizophrenia. Relevant points are summarized below:

- Beginning in a circle formation, conduct a short physical warm-up.
- Use an entrance structure to bring group members into the playspace, for example, entering through a magic curtain (an imaginary curtain), which represents the boundary between the real world and fantasy play. Butler stresses the importance of this step in working with clients with schizophrenia, adding that the therapist should consistently be checking in with the group through observation, noticing the "level of discrepancy within their play" (p.92).
- Guide group members in taking turns offering a sound and movement to the group, which the group then joins/mirrors. Butler explains that the DvT therapist playfully helps group members notice the sound and movements, as well as encouraging them to join and find unique actions, working to gradually increase the physical, emotional, and interpersonal demand.
- As images arise from the collective, group members begin to experiment with roles (i.e., role-play). Butler explains that the DvT therapist encourages members to take risks and contribute to the flow of the session.
- In order to close the group, the DvT therapist may use the magic drama therapy box, encouraging clients to "pull a magic box down from the sky" where group members and therapist place salient images from session (p.93). The group then exits the playspace by the same method in which they entered (e.g., through the magic curtain). Butler explains that as group members leave the therapy room, careful observation is made to ensure that clients have truly left the playspace.

Butler also presents DvT therapist interventions which he believes are most relevant in working with clients with schizophrenia. These interventions are summarized below:

- *Joining*: Join the client in the action in order to "lend ego strength," providing support and a sense of safety as they experiment with new actions (p.92 – 93).
- *Intensification*: Bring actions to extremes, commenting on the intensification, fostering group members' awareness and attunement.
- *Transforming to the here and now*: Provide a "running commentary" on the action taking place, while maintaining playfulness and the playspace (p.93). Butler explains that through this

intervention, the therapist is able to draw attention to moments of misattunement and connection, as well as challenge delusional beliefs. Butler provides a pertinent illustration: If a client fails to mirror the emotion of the group, the therapist may playfully draw attention to this, as well as have the group members mirror the mis-mirrored emotion, fostering the client's emotional and facial expression awareness.

- *Diverging*: Offer discrepant/unexpected images, especially if the group is stuck in repetition, so that they must respond with spontaneity and flexibility to the unexpected.

Hod Orkibi, Naama Bar, Ilana Eliakim (2014) “The effect of Drama-Based Group Therapy on Aspects of Mental Illness Stigma”

Psychodramatist Hod Orkibi, creative arts therapist Naama Bar, and drama therapist Ilana Eliakim (2014) conducted an experimental study examining the effects of drama-based group therapy on the self-esteem and self-stigma of people with mental illness and on public stigma of university students without a mental illness. Five participants (age 22-60) with mental illness (borderline personality disorder, bipolar disorder, and schizoaffective disorder) and 7 university students (age 25-50) took place in a 20 session series, meeting for 2 hours, once a week. Although the participant group was not comprised of clients with schizophrenia, the study presents relevant findings which may be applicable to addressing social isolation via self-stigma in individuals with schizophrenia. In light of the research subject, the following summary will focus largely on how drama therapy between participants with mental illness addressed self-stigma.

Drama therapy was selected for its ability to facilitate social interaction and the sharing of human experience. Dramatic activities which foster spontaneity, creativity, and playfulness were implemented within this structure, with the goal of facilitating trust, personal expression, and authentic and meaningful encounters between all participants, regardless of mental health status.

Findings. Overall, self-esteem increased, and self-stigma declined, for participants with mental illness, during the series. Overall, for student participants, social stigma declined, during the series. These findings were all statistically significant. There was no statistically significant increase or decrease across any of these measures, between the intervention phase and the final, post-termination measurement (5 weeks following termination). The authors note that this carryover effect suggests changes were likely internalized.

Drama-based mechanisms of change. Although the study did not measure for effects of specific interventions, the authors hypothesize about possible mechanisms of change:

Surplus reality. Through the use of surplus reality (or, the playspace), individuals become liberated from the conventions of their everyday life, while having the opportunity to imaginatively concretize both their subjective personal experiences as well as interpersonal experiences. Role-play

within this imaginative space may have fostered insight into the origins of both social and self-stigma. Furthermore, this space may have created an environment where participants were able to challenge their self-perceptions and in essence, recreate themselves.

Spontaneity, creativity, and playfulness. Playfulness, spontaneity, and creativity may have allowed clients to experiment with new ways of interacting in the social world, within the safety of the group therapy space. This process may have contributed to improving self-esteem.

Encounter. Encounters in this program were constructed to encourage sharing of tasks, sufficient intimacy to facilitate self-disclosure, mutual acceptance, and mutual support.

Witnessing. By feeling validated and supported, the participants with mental illness may have experienced a decrease in self-stigma as well as an increase in self-esteem. Building on this, mutual witnessing, in particular, may have fostered feelings of universality and a sense of shared experience.

Michael D. Reisman (2016) “Drama Therapy to Empower Patients with Schizophrenia: Is Justice Possible?”

Michael D. Reisman (2016) writes about a model of group drama therapy based on DvT techniques, with the goal of helping clients with schizophrenia find self-empowerment and re-integrate into society. He illuminates his method with case examples of two groups, one in Czechia and one in the United States, whereby he suggests a universal value of his method.

Reisman contrasts his model with the primary medical model which focuses on symptom reduction through medication, associating it instead to the emerging recovery model which focuses on empowering clients. Reisman feels that this shift towards recovery-oriented treatment is important because, as he explains, the medical model focuses on the genetic, biological, and neurological origins of schizophrenia, and because of this, misses the opportunity to address the individual with schizophrenia as a “complete human being,” one whose illness and thus, complete being, is affected by the social world in which they live (Insel, 2010, cited in Reisman, 2016, p.91). Furthermore, he explains that even following inpatient discharge, individuals are often followed up with a similar treatment method: minimizing positive symptoms through medication, which also leaves patients with unaddressed negative symptoms and debilitating pharmacological side effects (Tollefson, Beasley, Tamura, Tran, & Potvin, 1997, cited in Reisman, 2016) —symptoms and side effects which pose considerable barriers to social integration.

Reisman makes a powerful claim that “the mental health system frequently forces patients to give up the power and relate to the world only through their illnesses, reinforcing the experience of social defeat” (p.93). In other words, this form of treatment reinforces the individual’s view of them self as a sick person, undermining their sense of self-efficacy, personal control, and independence, thus inhibiting their belief in their capacity to set and achieve goals, improve their quality of life, and reintegrate into the social world —negative personal beliefs which may also be viewed as a form of self-stigma (Reisman,

2016). Reisman presents significant research which demonstrates that self-stigma is indeed common among the schizophrenic population, leading to depression and avoidant coping, negatively affecting self-efficacy, self-empowerment, and quality of life (Brohan, Elgie, Sartorius, & Thornicroft, 2010; Vauth, Kleim, Wirtz & Corrigan 2007, cited in Reisman, 2016).

Reisman explains that DvT components (explored below) help clients find self-empowerment, by creating a “socially just” space in which the client and therapist can play on an “equal level” (p.94). In this space where “real-world power inequities” are “temporarily suspended,” clients are able to express their feelings in relation to the limits of the “real world” and explore stigma and power (Reisman, 2016, p.94). According to Reisman, through the experience of cultivating humanity and exploring the implications of maltreatment, in a socially just playspace, patients become more prone to experiencing social justice in the outside world. At the same time, he explains that clients may come to find liberation through a process of disillusionment, understanding that in some cases, actual justice may be a fruitless goal. In this way, the power dynamics which the DvT playspace fosters an exploration of, might help clients with schizophrenia gain insight into their experience of social oppression, challenging self-stigma and improving self-esteem. Reisman explains that in order for this therapeutic transformation to occur, the drama therapy group should begin with structure, with the therapist gradually lessening authority over the group in order to demonstrate confidence in the clients, beginning the process of internalization and empowerment.

Playspace. The therapeutic space (i.e., playspace) in DvT is comprised of four key agreements between members: restraint from harm, discrepancy, mutuality, and reversibility (Johnson, 2013). According to Reisman, three factors which the DvT playspace frame promotes, contribute to the empowerment of clients with schizophrenia: (1) the client’s permission to critique the therapist; (2) the sharing of decision making, and; (3) the exploration of status. Reisman states that the client-therapist mutually created playspace can be used as a “locus of justice” which ultimately provides encouragement for clients to re-engage with the social world and society at large (p.91).

Like Snow (1996), Reisman connects the DvT playspace to Winnicott’s (1971) transitional space in that it is a bridge between the inner and outer world, a space where clients may experiment with role, constructing and deconstructing the self—a space where transformation and development may occur. Furthermore, Reisman explains that it is a place where the client may experience *illusionment* with the therapist, eventually leading to healthy *disillusionment* (mirroring the process of separation-individuation with one’s mother) where the client sees the therapist as human, and not ultimately responsible for their well-being and recovery. He believes that this process helps clients gain confidence in exploring the outer world, while developing an autonomous self with social agency and healthy psychic structures.

Reisman describes DvT tools which he feels are most useful for conducting drama therapy in this context, and how they help achieve related therapeutic goals:

- *Pre-empting*: In this DvT tool, the therapist takes on the action or role characteristically assumed by the client, in order to “force” the client into experimenting with a new role or action (Reisman, 2016, p.93; Johnson, 2013). Reisman explains that this tool is especially useful in helping psychiatric patients, who are more used to taking on the dependent, “outcast” or “needy” role, experience more confident, independent ones (p.93). Furthermore, he explains that by playing with power and taking on the role of the oppressor, clients are able to benefit from perspective, as well as experience emotional release.
- Transforming to the here and now: In this DvT tool, the therapist speaks as them self—while maintaining the playspace—in order to comment on present dynamics and processes taking place (Reisman, 2016; Johnson, 2013). Reisman states that this tool is especially useful in helping clients feel that it is safe to explore their internal world, due to the distance which it provides.
- Therapist as the subject/*play object*: As previously stated, in DvT, the therapist is an active participant in play, often becoming the subject (i.e., the client’s play object) (Reisman, 2016, p.95; Johnson, 2013). Reisman explains that this allows the therapist to become a container for the client’s transference images/projections, as they relate to power, such as the “naughty child” or “figures of authority” (p.94). He adds that clients will often playfully challenge these roles/projections, which frequently leads to “annihilation” (p.95). He explains that by the therapist surviving this annihilation, the therapist contains the unconscious (often disturbed) contents of the clients’ inner world: By becoming the play object, the therapist may assist the client(s) in “dislodge[ing] the self-created fetters of oppression” (pp.95 & 98).

According to Reisman, a particular challenge which the drama therapist faces is that clients often have little enthusiasm or energy for creative arts therapy groups, due to being “physically degraded” by their experiences in the mental health system (p.94). He explains that to combat this, the drama therapist must demonstrate a playful way of being, drawing in resistant clients with humor and friendliness, demonstrating that it is safe (and pleasurable) to join in the playspace.

Reisman also expresses that the drama therapist must remain sensitive and empathetic towards the client’s situation, with an understanding that many of their difficulties arise out of power dynamics which contribute to feelings of powerlessness and helplessness (Mack, 1994, cited in Reisman, 2016). This theory is similar that of Scottish psychiatrist Ronald David Laing (1967), who believes that many of

the symptoms which are viewed in psychiatry as being related to mental illness should rather be understood as a coping response to oppression, which arises out of common social constructions on mental health/mental illness. To combat the perpetuation of inequality and abuse, Reisman states that the therapist must be aware of their vulnerability to feelings of disgust and impatience towards the client, and be open to therapeutically playing with these feelings as they arise in the playspace. Additionally, he states that the therapist must release the role of the all-knowing therapist, in order to develop a more honest and authentic relationship with the client. Finally, like Giovacchini (1986) and other authors, Reisman writes about external elements as being experienced as threats to engulfment. In his view however, drama therapy may be used to address this fear of the external world by promoting confidence, self-empowerment, and self-governance.

Chapter 6: Drama Therapy, Schizophrenia, and Social Isolation: What's Been Done

Making Therapy Possible

The research suggests that there are certain core elements of the drama therapy method that foster client attendance and involvement. This is important for two reasons. First, being part of a group experience itself, addresses social isolation. As Casson (2004) explains, “group therapy is an antidote to isolation and offers people an opportunity to talk, communicate, and relate to others” (p.171). *Drama* therapy has a unique ability/tools which enhance these features of group therapy, facilitating collaboration, social interaction, and the sharing of human experience (Orkibi, Bar & Eliakim, 2014). Second, many clients with schizophrenia lack insight into their illness (anosognosia), which is the single best predictor of whether or not an individual will accept treatment (medication, therapy, etcetera) (Amador, 2011). Without finding an appealing, non-threatening way of engaging clients in the group drama therapy process, which does not necessarily rely on a client’s insight into a need for treatment, any other potential therapeutic gain in the area of socialization, would not be possible. Below are these core elements, followed by corresponding descriptions, and how they help engage clients with schizophrenia in the therapeutic process. These terms will be referred to throughout the text.

Playfulness. Playfulness is a therapeutic way of engaging with personal material, the self, others, reality, and the world at large, which includes creativity and spontaneity (Jones, 2007) and often, humour. Approaching problematic material with playfulness helps a client develop creative responses to problematic material, where they may have previously felt stuck (Jones, 2007). Playfulness is both a way of engaging in the therapeutic space to elicit therapeutic growth, and a therapeutic goal, in its own right (Jones, 2007). Facilitating spontaneous playfulness is especially relevant, when considering the often-present rigidity of clients with schizophrenia. Playfulness (which also appears to be an important quality for the drama therapist) creates an exciting, appealing space, motivating clients who experience symptomatic obstacles to participation such as apathy, anosognosia, as well as lethargic effects of medication.

Playspace. The playspace (also known as dramatic or surplus reality) is where drama therapy takes place—it is a state of being rather than a physical space. This transformative space involves the combination of exploration, thought, feeling, and creativity (Jones, 2007) which brings together reality and fantasy in an exploration of alternatives (to a person’s past, present, future, behaviour, etcetera) in the here and now (Pendzik, 2003). The playspace is engaging for similar reasons to playfulness. Additionally, a key aspect of the playspace which engages clients with schizophrenia is its embracing of fantasy, illusion, symbolism, and metaphor, whereby they may become more open to exploring such aspects of their internal world with others (Johnson, 1981; Snow, 1996; Butler, 2012).

Distance. Distance in drama therapy refers to working with personal material with some degree of perspective (Jones, 2007). It is highly correlated to *dramatic projection*: dramatic representation of some aspect of a client's internal state into something external, and aesthetic distance: the space where transformation can occur; as the client is not overcome by feeling, they are able to observe, as the client remains connected, they remain affectively engaged (Landy, 1994). In drama therapy, the drama therapist plays with distance through a variety of tools, including character, metaphor, symbolism, story, myth, script, masks, sculpture, photographs, visual art, figurines, and endless other objects, in order to achieve aesthetic distance.

Emotional experiencing is an area which is greatly affected by the illness of schizophrenia. Research has demonstrated that a common associated feature of schizophrenia is emotional dysregulation/challenges in self-regulation (Perry, Henry, & Grisham, 2011). Furthermore, that overwhelming feelings (especially feelings relating to self-esteem such as helplessness, hopelessness, and worthlessness) often trigger an experience of depersonalization (an alteration of perception in relation to the self, body, or external world, whereby these subjects are experienced as detached, strange, unreal, or unfamiliar) (Maggini, Raballo, & Salvatore, 2002), leading to social avoidance (Michal, Kaufhold, Overbeck, & Grabhorn, 2006). Taking these ideas into consideration, it is important to provide a therapy where clients are able to explore feelings and experiences without becoming flooded by those feelings, triggering a process of depersonalization and an impulse to isolate—a therapy which helps compensate for deficits in self-regulation. The manipulation of distance (to achieve aesthetic distance) helps clients remain present and engaged in the therapeutic process, with the possibility of gaining insight and strengthening the self-observing ego.

Containment. Containment refers to the feeling of safety which is created by a holding framework (human, relationship, object, idea), whereby a client feels safe exploring their emotional world. In the case of drama therapy, the drama therapist, distancing tools, and the therapeutic play frame help contain emotions. Containment is especially important for a population who often defensively split off from difficult/overwhelming feelings. Such individuals require additional support in order to feel safe to explore (and integrate) extreme emotions and emotional experiences.

Humanistic approach. As drama therapy is a humanistic form of psychotherapy, great emphasis is placed on the therapeutic relationship, featuring warmth, empathy, genuineness and unconditional positive regard (Rogers, 1957). Studies (Mental Health Foundation, 1997; Rogers & Pilgrim, 1994) have demonstrated that these qualities are indeed most valued aspects of psychiatric treatment, fostering client attendance and involvement. Encompassed in this humanistic approach is also the perspective that individuals possess an intuitive capacity to heal and grow, and that this process flourishes with the support of the therapeutic relationship. Drama therapy offers constant choice for clients whereby they are

able to guide their therapeutic process and find empowerment, while feeling validated and safe. Interventions such as creating a safe, personal space when beginning session (Casson, 2004), are built around this fundamental principle.

The humanistic framework is very much in line with psychologist Xavier Amador's (2011) LEAP (listen, empathize, agree, partner) —an acronym created as a framework for developing an alliance with individuals who experience anosognosia. Like the humanistic approach, this system is based on respectful, validating listening, whereby the helper and the client may work together to identify aspects of a client's life they would like to improve, while offering support in helping the client realize their goals. This method has been tested and improvement noted in terms of active involvement in all aspects of treatment for this population, and might comfortably be integrated into the group drama therapy process.

How Drama Therapy has or Could be Used to Address Social Isolation

Although much of the available literature does not explicitly address the research question, it appears that a substantial amount of what has been written is applicable to addressing the phenomenon of social isolation in individuals living with schizophrenia, through drama therapeutic means. In the following section, comparisons and links are made between related drama therapy work and theories explored in chapter 5, and how they may address factors contributing to the phenomenon of social isolation, presented in chapter 4.

It is apparent that aspects of the psychodrama method may be pertinent to addressing the phenomenon of social isolation for individuals living with schizophrenia. With the understanding that psychodrama is a separate field from drama therapy, pertinent psychodrama-related concepts have been integrated in the following sections, with the rationale that psychodrama and drama therapy, while different, both base their therapeutic methods on theatrical processes as vehicles for eliciting therapeutic growth.

The term *real/reality* will be used to describe the common cultural understanding of what is real and not real, with sensitivity to the fact that reality remains in part subjective, based on a person's experiences and perceptions.

Psychological.

Beliefs, attitudes, and expectancies. The drama therapy group experience might be described as a positive social experience in its own right, thus combatting the effects of negative social experiences on social beliefs. Because of its focus on supporting clients (with sensitivity, structure, distance, and containment) in cooperative action, collaboration, communication, and interpersonal support, paired with playfulness, humour, and the care and support provided by the drama therapist (and often, group members as well), the overall group experience appears to be a uniting one, providing many opportunities for joint success, pleasure, and meaning.

Drama therapy has the capacity to support clients with social behaviour, and the social behaviour of the group, creating a foundation which allows for these positive social experiences to take place. A common group drama therapy practice is to establish group norms (or, a group contract) between members (Casson, 2004). This might be particularly vital in helping create a positive social experience for clients who have been living largely insular lives, who experience social anxiety, and who have experienced interpersonal trauma, and/or struggle with social skills. This contract might be an important means of helping clients relax into the process, with a clear understanding of what will be expected of them, what they can expect from other group members, as well as to identify how they might contribute to creating a therapeutic space.

Many interventions are built around facilitating engagement and integrating into the group (Johnson, 1981). Casson (2004) explains that in group drama therapy work with this population, he begins sessions by supporting clients in establishing their presence and connection with others, using name games, or other introductory exercises, such as passing around a globe whereby each group member talks about their “world” (p.180). This warm-up period often also includes breath work and playful embodied exercises (Casson, 2004) which are important in relieving initial anxiety. Forrester and Johnson’s (1995) ball toss provides a structured way for clients to begin making contact with one another, through learning one another’s names and making eye contact.

Casson (2004) presents numerous group interventions, which provide clients with opportunities to experience cooperative action, collaboration, and interpersonal support, with sensitivity for the distance and containment which is often needed for clients who have been living largely in isolation. For example, he suggests providing group members with a long piece of string, which they might use to create an interpersonal web in order to explore the connections between one another. He also suggests creating or using mandalas, maps, toys, dolls, photographs, and imagining landscapes or scenarios for a short play — he explains that these types of distanced interventions stimulate discussion among members, so that they might begin to share aspects of their internal worlds and find points of connection with others.

Additionally, authors (Reif, 1981; Emunah, 1983; Johnson, 1981) have stated that collaborative group tasks provide a structure for clients to experience positive, meaningful, and successful experiences with others, where their contribution to group activities is valued by peers. The use of video (Casson, 2004; Forrester & Johnson, 1995) has been implemented as a distancing method of fostering collaboration, exploring interpersonal conflict with humour, and experiencing joint success and pride. More under-distanced interventions have also been used, such as drawing themes from client’s statements to create short improvised scenes, fostering playful, spontaneous, supportive interactions between group members (Casson, 2004). Through taking on the witness role, clients often experience feelings of universality, coming to understand that others face similar struggles (Johnson, 1981). The common use

of closing ritual (Casson, 2004) such as Reif's (1981) wishes and gifts, and Forrester and Johnson's (1995) magic drama therapy box create structured opportunities for clients to experience mutual care and support for one-another, while providing a sense of safety, through consistency and structure. Emunah (1983) explains that through these types of interventions, cohesion and trust is built among group members which often translates into meaningful relationships.

Certain methods such as play creation and psychodrama appear to possess an inherent ability to bring group members together. Play creation, while often challenging a client's capacity to cope with interpersonal issues and stress associated with intimacy and collaboration, encourages healthy resolution, such as seeking and offering emotional support, and improving communication (Johnson, 1980). In terms of psychodrama, Casson (2004) explains that work which explores voices is especially helpful in uniting group members through feelings of universality and support, due to the highly personal material which is explored in the dramas. This might also apply to dramas which explore any other shared challenges which the group faces.

These meaningful experiences, facilitated through group drama therapy interventions and methods, become associated with a group context, possibly contributing to more positive social beliefs. An important aspect of the drama therapist's role in helping clients convert group drama therapy experiences into positive social beliefs appears to be helping group members make sense of and find positivity in their experiences in group therapy, even when faced with difficult material or experiences during sessions (Casson, 2004).

Boundary confusion. Authors (Snow, 1996; Reisman, 2016) have compared the drama therapy playspace to Winnicott's (1953) transitional space, as it is a space where boundaries are identified, object relations developed, and healthy psychic structures formed. Reisman (2016) explains the potential role of the drama therapist: Like the child-mother relationship, where a child moves towards a point of healthy disillusionment with the mother, gaining a sense of independence, so does the client in their work with the therapist (Reisman, 2016). In this way, the playspace becomes a developmental space where the client establishes a stronger sense of self through a supported process of self-exploration, constructing and deconstructing the self, and finding integration. A stronger sense of self would transfer to diminished fears of engulfment through clearer boundaries between self and not self, more confidence engaging with the outer world, and most pertinently, to diminished fears of intimacy.

Casson (2004) explains that because drama therapy engages both a person's mind and body in the therapeutic process, clients are better able to develop a stronger, united sense of self. Certain authors (Moreno, 1944; Snow, 1996; Casson, 2004) intentionally work with delusional material in an embodied way, in order to help clients develop organization and integration of aspects of the self which they have

been split off from. This process is a group effort, with members (and potentially the therapist) taking on various roles within a person's psychic structure.

From the object relations perspective, because of the underdeveloped psyche often present with this population, distance between acting and the real situation is an important consideration (Bielanska et al., 1991). Bielanska et al. (1991) have addressed the need for distance between role and self by engaging clients in a process of psychological analysis of the role they are playing. It is also possible that with a high level of support from the drama therapist, role-play in scene work makes transparent the particular interpersonal challenges—as they relate to boundary confusion—that a person faces, and that this becomes a means of helping clients develop a deeper awareness of, and cope with, those specific challenges (Johnson, 1981; Casson, 2004). The process of identifying spaces where personal/interpersonal boundaries become blurred, and practicing authentic interaction with those vulnerabilities in mind, may positively translate to a person's ability to interact with others with less defenses, or, without feeling threatened by engulfment.

A common criticism of the use of drama therapy with clients with schizophrenia is that intentionally engaging with fantasy may perpetuate delusional symptoms. As Butler (2012) states, “it is difficult to delineate any boundary when one is standing too far away from the boundary” (p.92). Drama therapy embraces the world of imagination, with an understanding that intentionally moving in and out of the imaginative world strengthens a person's capacity to distinguish that very boundary (Butler, 2012). Specific interventions have been implemented for this purpose, such as psychodrama's mirror technique, in order to help clients see the physical boundary between self and other, with an added benefit of distance, which aids in the process of internalizing insight gained (Casson, 2004).

In addition to the therapist support and distancing methods mentioned above, specific interventions such as ritualistically entering and exiting the playspace through a magic curtain (Butler, 2012) or transforming to the here and now to comment on delusional beliefs which surface in play (Butler, 2012), help clients build their capacity to differentiate fantasy from reality, while protecting them from further disorganization. Drama therapists are sensitive to this boundary becoming blurred, carefully attending to each member as they leave the playspace, to ensure that they truly *have* left it behind (Butler, 2012). A key role of the drama therapist appears to be to help the client remain grounded as they embody aspects of their internal world, a “floating anchor” (Snow, 1996, p.229) so that the client does not become lost.

Stigma, self-esteem, and social self-esteem. Numerous authors describe the ability of drama therapy to help clients with schizophrenia develop increased self-esteem and empowerment (Butler, 2012; Casson, 2004; Johnson, 1980; Orkibi et al., 2014; Forrester & Johnson, 1995; Reisman, 2016; Emunah, 1983), which is highly connected to social self-esteem. Drama therapy offers a supportive space where

clients are empowered to make choices which inform the therapeutic process of working through and developing insight into their experiences and negative feelings towards the self. At the same time, it offers opportunities for responsibility and accomplishment, as well as mutual compassion, nurture, and support, such as playful collaborative drama therapy games, active witnessing, and the creation of a play (Johnson, 1980; Emunah, 1983; Casson, 2004). Together, these aspects of the group drama therapeutic process foster increased self-esteem, and social self-esteem: Clients experience the feeling that they are able to make positive choices and succeed while contributing to an interpersonal experience with a sense of meaning, capability, and value.

Drama therapy provides a multitude of mechanisms which help an individual to achieve an improved self-image. As Bielanska et al. (1991) explain, improved self-image likely leads to freer contact with others, which in turn leads to opportunities to develop social skills and a richer social life. One way in which the drama therapist may directly help in this process is by becoming the container (or, the client's play object as in the DvT method) for negative self-projections of clients, containing and creating distance so that clients may play with and work through them (Reisman, 2016). The DvT method also encourages a sharing of power (between group members, and between clients and therapist) where clients may access their own power, as well as understand the origins of their disempowerment. Negative self-beliefs may also be explored through psychodramas, where clients explore personal stories, with the support of the group (Casson, 2004). If more distance is required, sociodrama may be used to explore similar issues in a more distanced way (Casson, 2004). In the same vein, plays with relevant themes (such as mental illness) provide a distanced means of exploring and processing sources of shame/negative self-beliefs, with the added strength and validation provided by working through a script which demonstrates the universality of the client's struggles (Bielanska et al., 1991).

Casson (2004) explains that people are more spontaneous when playing a role, which in turn expands their sense of self. In terms of social self-esteem, it appears that through playing with role, drama therapy helps foster increased social self-esteem by providing a space where clients may experiment with and gain experience in taking on roles (such as a romantic partner or an employee)—roles which they may have previously felt were inaccessible to them (Casson, 2004; Emunah, 1983; Bielanska et al., 1991; Butler, 2012). Characteristics of roles may be integrated into an individual's sense of self (Butler, 2012), fostering hope for new interpersonal possibilities in their lives. This richer sense of possibility in the social world may instill the needed confidence to motivate individuals with schizophrenia to seek social encounters and relationships which they desire. For clients who are resistant to exploring new roles, drama therapy offers specific interventions, such as DvT's diverging and pre-empting, which playfully nudge clients into experimenting with new behaviours and roles (Butler, 2012).

Social skills.

Impaired ToM. Many drama therapy interventions require that group members collaborate with one another and that they take on and/or understand another person's point of view. These common aspects of the group drama therapy process are significant ways of developing one's capacity to relate with sensitivity to another person's needs, intentions, feelings, and desires.

Beginning as early as in the warm-up phase, playful collaborative activities require communication and understanding to accomplish tasks. As sessions progress, interpersonal conflicts may be worked through in scene work, with the distance provided by story and role (Emunah, 1983). Scene work and role-reversal may also help clients develop their ToM ability by requiring that clients take on another person (or character's) perspective. Additionally, group analysis which looks at relationships between characters in a scene or play, and the actors' feelings towards characters, provide ample opportunities to learn about how others think and feel (Bielanska et al., 1991). The highly interactive and collaborative play creation process is also a viable means of strengthening one's ToM ability, as it is a place where interpersonal difficulties often surface (Johnson, 1980). Interventions such as Johnson's (1980) weekly meetings create an intentional space where associated issues may be processed, with the guidance of the drama therapist. In exploring and working through interpersonal issues, clients will likely become aware of moments when they misunderstood another person and how it led to conflict, positively contributing to their ability to navigate a social world filled with endless alternative perspectives to one's own.

Impaired emotion perception. Drama therapy appears to be an effective means of addressing deficits in emotion perception because it incorporates not only the mind, but also the voice and physical body, into the process of exploring emotional attunement and identification. This is essential, as emotions are experienced in the body and often expressed both physically and vocally.

The recursive process in DvT (Butler, 2012) helps a client break down the communication system, which begins by noticing a difference (including, physical and vocal cues) in another person. The drama therapist may help clients build the skill of noticing emotions expressed by others by constructing interventions around this first step. Certain interventions which already exist, such as the sound and movement circle (Butler, 2012) and the mirror exercise (Reif, 1981), foster emotional identification, attunement, and empathy, and greatly rely on a person's ability to notice emotional expression and changes in another person. These interventions may be adapted, with emotion perception as an even greater area of focus. In such a case, the therapist might ask clients to name emotions being conveyed through the group/their partner's expressions. By transforming to the here and now, the drama therapist may also provide clients with immediate feedback on the degree to which they have appropriately perceived an emotion expressed by another group member (Butler, 2012). The mirroring aspect of these interventions also serves in building empathy: Clients may come to recognize how emotions are vocally

and/or physically conveyed by others through the process of first sensing the feeling evoked in their own body through the sound and/or movement, realizing that that same expression may be linked to similar feelings experienced by others.

Blunted and incongruent emotional expression. Drama therapy is a space where all emotions are encouraged. This open, safe, accepting space creates an atmosphere where clients feel more comfortable exploring emotions, whereby they are able to gain insight into the origins of emotions that they have defensively split off from (Casson, 2004). Exploring and re-integrating these emotions, as well as investigating the range of familiar feelings, increases the availability of a wider range of emotions when interacting with others. Additionally, as for emotion perception, drama therapy places a strong emphasis on building emotional awareness and capacity for expression through implementing the body (i.e., embodiment) (Butler, 2012).

The structure of drama therapy activities (Emunah, 1983), the distance attained through role (Emunah, 1983), the use of objects (Casson, 2004) or story, and interventions such as joining (Butler, 2012) help clients feel safe expressing emotions—emotions that may feel foreign due to splitting, or overwhelming, due to a lack of self-containment and emotional-regulation. These features of safety and containment give withdrawn clients the opportunity to experiment with emotional expression (Johnson, 1981), exploring extremes and self-control (Butler, 2012) so that they are able to build the self-observing ego and as a result, feel more able and at ease when revealing emotion to others (Emunah, 1983).

Drama therapy offers a wide variety of interventions that require clients to effectively convey their emotional state in an active, embodied way. Some drama therapists begin sessions with a short physical warm-up, or with a sound and movement circle (Butler, 2012) in order to help clients warm up to this process. Reisman's (1981) show how you feel requires that clients intentionally convey their emotional state to other group members, building emotional awareness and a capacity for emotional expression. DvT places a strong emphasis on exploring emotional extremes so that clients develop their capacity to express themselves effectively with others (Butler, 2012). Other types of drama therapy groups explore emotional expression through voice, body posture, facial expression, and gesticulation, during the process of play creation (Bielanska et al., 1991)—a process which poses the added challenge of conveying emotion in front of an audience (Johnson, 1980).

Drama therapy also facilitates the displaying of *appropriate* affect. As explored earlier, DvT's recursive process helps a client break down the communication process—in the final step, expressing, the client intentionally conveys an emotion back to their communication partner (Butler, 2012). Slowing down and attuning to this process would translate to more mindful and connected emotional responses. Interventions such as transforming to the here and now or peer feedback from other members of the

drama therapy group (Johnson, 1981) create a space where clients come to understand how their expressed emotions are received by others.

Mental rigidity and lack of spontaneity. All interactions in the social world might be seen as an improvisation, requiring flexibility, openness, and creativity, in order to respond effectively to the unpredictability ever present when in relation to another human being. As such, any improvised scene work builds a client's capacity to respond spontaneously and effectively to others. DvT, without the structure of story, bids for an even higher level of spontaneity, where which clients must improvise in highly relational and transformational conditions (Butler, 2012).

In more structured scene work, emphasis has been placed on helping clients come to understand the nature of their struggle in maintaining authenticity when interacting with others—by challenging these difficulties in scene work, their capacity to respond to others with spontaneity is enhanced (Johnson, 1981). Specific DvT interventions such as diverging (Butler, 2012) challenge a client's rigidity in a non-threatening playful way, working through defenses and building the client's capacity to respond to the unexpected in human interaction.

As Butler (2012) explains, “the therapist continually works to enable clients to step out of their comfort zone and try something new” (p.90). DvT appears to be specifically useful in this regard, as clients are constantly responding to new roles and situations which arise in the playspace. Role—in DvT and other methods, as well as story—hold the added benefit of distance, making experimenting with new behaviours and responses appear less threatening.

Additional considerations.

Apathy and avolition. The drama therapy group has the ability to motivate attendance and participation as it is engaging, fun, welcoming, and encourages the use of imagination. Authors (Reif, 1981; Emunah, 1981) have explained that used respectfully, playfulness and humour are assets of the drama therapist which help draw in resistant, withdrawn, and tired clients. Methods such as DvT use the drama therapist as the client's play object, whereby the drama therapist is involved in play during the entire session. By the drama therapist modeling a playful way of being, group members become more likely to adopt this quality, contributing to a lively, playful, and enticing group experience.

The playful nature of drama therapy often elicits humour, which Butler (2012) explains is often missing from the lives of those with schizophrenia. Furthermore, lively, stimulating drama therapy exercises which flow together with momentum, leave little room to hesitate or withdraw (Emunah, 1983). For clients with little motivation to attend, an elevated focus has been placed on the warm-up phase, using playful, structured activities to help clients engage (Casson, 2004). Finally, with its openness to fantasy, clients holding delusional material often feel more open to participating, as any aspect of their internal world will be accepted and welcomed (Snow, 1996; Johnson, 1981).

Positive symptoms and social anxiety. Group drama therapy appears to be an especially useful means of engaging clients who struggle with overwhelming positive symptoms and/or social anxiety, which might otherwise pose barriers to participation in a therapeutic group experience. The drama therapeutic framework has the capacity to provide structure, containment, flexibility, and validation, which helps reduce associated anxieties relating to participation (Emunah, 1983; Casson, 2004; Yotis, 2006). Simultaneously, it creates an inclusive atmosphere where, with sensitivity, positive symptoms are honored, acknowledged, and taken into consideration. In addition, drama therapy appears to be an effective means of gaining insight and transformation in regards to positive symptoms, such as delusional material and hallucinations.

Group drama therapy sessions may begin with body focused interventions such as breathing, Tai Chi, dance, or mirroring, in order to reduce anxiety (Casson, 2004)—these types of warm-ups help clients relax (and warm up to the therapeutic process), simultaneously teaching tools for self-regulation. Furthermore, interventions such as creating a row of audience chairs help clients remain engaged when they feel overstimulated, overwhelmed, or anxious, as they provide an alternative means of participating (as a witness) when positive symptoms (Casson, 2004) or anxiety arise.

Many authors describe the drama therapy group as structured, yet flexible (Reif, 1981; Johnson, 1980; Emunah, 1983; Casson, 2004). As anxiety is about the unknown, the structure of collaborative activities, roles, scripts, etcetera, gives clients a point of focus with which to ground themselves, as they take on something that might feel quite unfamiliar and/or intimidating: engaging in interpersonal tasks. At the same time, the flexibility of drama therapy makes it adaptable to client needs (Reif, 1981). This combination of structure, flexibility, and free play, produces an experience where clients feel both contained and autonomous (Casson, 2004).

Many authors place emphasis on validating delusions (Snow, 1996; Moreno, 1944) while others simply focus on the validation of any emotion present (Emunah, 1983) and creating a “no-fail” environment (Reif, 1981). For example, in Emunah’s (1983) intervention adopting the mood of the group, the therapist validates any mood in which a client arrives, encouraging them to play with it. Validation, in this way, sends the message to the client that they will be unconditionally accepted. Acceptance is key for fostering participation, as well as for creating an environment in which transformation may occur.

Group drama therapy also appears to be an effective means of helping reduce barriers to social integration, as they relate to positive symptoms. For example, Casson (2004) writes about the ability for clients to regain a sense of control over voices through implementing the body, which he explains is important, as feelings of power and control are accessed through the body. Building on this, he explains that embodied exercises which foster a sense of empowerment and control (e.g., breathing, Tai Chi,

physical games, working with a parachute) are important, as many voice hearers have been the subject of abuse, leading to psychotic symptoms which mirror associated feelings of being under someone else's control (e.g., voices encouraging self-harm). Casson also writes about voice hearing as a byproduct of hostile and aggressive emotions. To address this, he uses interventions (e.g., drumming, rhythm, shouting, exploring the full range of one's physical voice) which help a client explore and express such emotions, as well as access the power of their own voice, which he has found often leads to a reduction in associated voices.

For more advanced work, Casson (2004) uses psychodrama to explore the meaning and identity of voices. This approach includes specific interventions: sculpting, doubling, and role reversal (among others). Sculpting is used as a means of finding empowerment through exploring dynamics of a person's inner world, as well as the meaning and origins of voices. Doubling is used as a means of helping clients express repressed thoughts and emotions. As Casson explains, doubling is often successful because it is supported by an experience of empathy and advocacy, which may have been absent in the protagonist's life. Finally, role reversal is used so that the protagonist may come to understand and reintegrate aspects of the self which they have been split off from.

Similar to Snow's (1996) work, Moreno (1944) uses psychodrama as a means of addressing delusional material. The overarching goals of this work are to create movement in fixed delusions as well as to develop personal connections based in the real world. To achieve this, auxiliary actors take on roles relating to the protagonist's/client's delusions, acting out aspects of the protagonist's fantasy, so that they are able to achieve some degree of resolution, release, or, catharsis, in order to reduce associated preoccupation and anxiety. Simultaneously, the content of delusional material is used to build a dependence on people in the real world by having auxiliary actors help the protagonist explore their delusional fixations in an embodied way. Moreno finds this to be an effective way of building interpersonal relationships which then transfer to interpersonal connections outside of the therapeutic context.

Relevant structural implications. The way in which sessions are structured appears to be an important consideration for conducting group drama therapy work with this population. Bielanska et al., (1991) recommend consistency in terms of time and location. Casson (2004) explains that for very withdrawn and isolated clients, it may be beneficial to begin treatment in an individual context, transitioning into a small group (roughly 6 members) once a safe, nurturing relationship has been established with the therapist. He also recommends that treatment be long-term in order to provide the needed time for socially withdrawn and paranoid clients to develop trust within the group. However, as Forrester and Johnson (1995) explain, this is not always possible, as treatment for this population often takes place in a short term, inpatient setting. This must be considered as, as Forrester and Johnson (1995)

recommend, the therapeutic objectives must be relevant and attainable for the treatment context with thought given to the fact that milieus with transient client attendance experience a disruption in the establishment of feelings of safety and trust.

Casson (2004) recommends that the length of sessions (45 minutes to 2 hours) be determined based on the needs and functioning of the group in order to create an accessible group experience with opportunities for success. He places added emphasis on the need to establish trust and cohesion early, focusing on structured warm-ups to help more isolated clients feel comfortable engaging with the group process. Reisman (2016) proposes that drama therapists begin with a high level of structure and control over the group, gradually loosening these qualities when clients are ready, in order to help them find empowerment. In the same vein, Casson (2004) stresses that therapists must be sensitive to the newness of this experience for some clients, and incorporate choice to foster self-empowerment. He also recommends that drama therapists show sensitivity around the difficulties with concentration often faced by this population and that they plan shorter interventions or dramas (vignettes, when working with psychodrama) within each session. Similarly, Emunah (1983) recommends that sessions be structured with momentum and flow in order to help clients remain engaged.

Johnson (1980) stresses the need for therapeutic termination and follow-up. Casson (2004) stresses the importance of creating a plan for the future during the termination process so that clients do not leave group to return to isolation. Structuring in continuity and support might be important factors in ensuring that clients are able to continue on a path of social integration and healing. Furthermore, deliberately processing the group experience, including the loss of associated social support, will help ensure that clients are able to leave the group with a sense of meaning and hope for their social lives, instead of associating the experience with feelings of loss.

Chapter 7: A Synthesis of What Could be Done

The authors whose works are explored throughout the literature review possess varying views on what causes social isolation for individuals with schizophrenia. Their views on this greatly impact the way they choose to work. Some authors see social isolation as the result of stigma and disempowerment, while others focus on the direct effects of clinical symptoms, such as affective flattening and apathy. Most commonly, drama therapists seem to work with the idea of boundary confusion and a defensive retreat into one's internal world.

What appears to be most relevant, across all viewpoints and methods, is finding a way to engage clients in a group process whereby they are better able to understand themselves, understand themselves in relation to others, experience themselves in new ways including a wider range of social roles, and be part of a positive, meaningful experience with others. This "way in" appears to be greatly enhanced by aspects of drama therapy as discussed in chapter 6: playfulness, the playspace, distance, containment, and the humanistic orientation.

In building a drama therapy social integration intervention model for this population, another major consideration (not surprisingly) appears to be the context in which group drama therapy takes place. For short-term inpatient treatment, more structured and distanced methods appear to be useful. In this context, relevant goals appear to include addressing social skills, social anxiety, social self-esteem, as well as building meaningful connections, and fostering positive social experiences to combat negative social beliefs, attitudes, and expectancies. For more long-term treatment, aspects of the psychodrama and DvT methods appear to be beneficial, in addition to role-play and play creation. Further, these long-term treatment methods appear a constructive means of addressing negative symptoms and boundary confusion.

Conclusion

This research sought to understand how the group drama therapy process might be used to address the phenomenon of social isolation in adult clients living with schizophrenia. It appears that drama therapy has a wealth of methods and interventions that may be useful in building a framework to address specific obstacles to social integration, which this population faces, including asocial attitudes, boundary confusion, the effects of stigmatization, deficits in social skills, apathy and avolition, positive symptoms, and social anxiety. Notably, the play-frame of drama therapy appears to have a strong capacity to engage individuals in a therapeutic, interpersonal process, which is a specific challenge in working with this population, due to apathy and anosognosia. This play frame also appears to be a powerful way of addressing positive symptoms which pose barriers to interpersonal connection (such as delusions and auditory hallucinations) which, interestingly, may be worked through in the group therapy

encounter. Additionally, the group drama therapy experience appears to have a great capacity for facilitating positive social experiences, which may lead to improved social attitudes and the development of reciprocal relationships.

The literature reveals that the setting in which individuals with schizophrenia are most likely to receive drama therapy treatment (the hospital setting) poses specific challenges, such as diverse diagnosis and level of functioning, as well as transient attendance which hinders the development of trust and cohesion. As such, more research is recommended in the area of short-term, inpatient treatment for clients who are living with schizophrenia. Other recommended areas of exploration, as they relate to drama therapy, social isolation, and schizophrenia, include: the effects of integrated drama therapy work (for clients with schizophrenia and clients without mental illness), the effects of drama therapy play creation and performance, and quantitative research which demonstrates the direct effects of specific interventions. The hope is that this research project will lay the groundwork for further advancements in this area, as well as provide meaningful interventions for drama therapy practitioners working to help individuals with schizophrenia access their own goals, insights, and strengths and ultimately, lead richer, more empowered lives.

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