

**A Mixed-Methods Study Examining the
Effectiveness of an Integrated Creative Arts Therapies
Intervention on a Group of Depressed Adolescent Females**

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ABSTRACT

A Mixed-Methods Study Examining the Effectiveness of an Integrated Creative Arts Therapies Intervention on a Group of Depressed Adolescent Females

Ron Scott

Depression is a serious mental disorder affecting a large percentage of female adolescents in contemporary society, which, due to a combination of psychiatric, environmental, social, and developmental factors, presents a remarkable challenge to the mental health professional. This paper evaluated the effectiveness of a group-based, combined art and drama therapy approach in treating three depressed adolescents. The study adopted a mixed methods approach, combining a quantitative and qualitative research methodology. A quantitative portion, in the form of a quasi-experimental, pre-post research design, was utilized in order to objectively demonstrate the effectiveness of the intervention with respect to the participants' levels of depression, anxiety, suicidality, self-esteem, conduct disorder, and global level of functioning. The qualitative portion provided some greater detail into the quantitative findings by means of descriptive case studies. Results of most quantitative measures were inconclusive, although all participants experienced an increase in self-esteem. However, the qualitative evidence presented some rationale for the inconclusive evidence, and demonstrated some additional improvements in levels of depression, self-awareness, and emotional expression. Due to the significant limitations of the study, it was concluded that the study holds validity as a pilot study, but that further research is necessary to empirically demonstrate the effectiveness of this intervention.

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Chapter 1 - Introduction

Depression and Adolescence

All individuals occasionally experience periods of sadness or depressed mood, usually to varying degrees of intensity. A significant percentage of the population, however, are afflicted with clinical depression, a significantly disruptive and debilitating mental illness (Edwards, 2002; Papolos & Papolos, 1997). Medically speaking, depression has been defined

as a condition of intractable low mood and dispirited attitude that is associated with sluggish function of brain (as in retardation of thought) and body (in particular, poor appetite, constipation, loss of weight, lack of libido, and a reversal of the diurnal rhythm of sleep and energy patterns). The quality of depressive ideation is particularly distinctive, consisting when severe or profound pessimism and a self-devaluation of the patient's achievements accompanied by a remorse for perceived past failings. The joy of living is replaced by hopelessness, abject despair and suicidal intimations. (Karp, Holmes, & Tavon, 1998, p. 231)

Depression is one of the most prevalent and damaging mental illnesses affecting contemporary Western society. According to the *Diagnostic and Statistical Manual IV-TR*, it is approximated that 10 to 25% of women and 5 to 12% of men will express symptoms of depression in their lifetimes (American Psychiatric Association, 2000a). For example, in a study comparing 107 mental disorders, depression was the fourth highest disorder with respect to global mortality and disability (Garber & McCauley, 2002). The extremely troublesome and injurious nature of depression is heightened by its high

incidence of recurrence; in fact, depression has the highest lifetime prevalence of all serious mental illnesses in the general adult population (Karp et al., 1998). Similarly, Garber & McCauley list depression's fundamental challenges as: 1) its chronic, episodic course; 2) its considerable functional impairment; and 3) the substantial health care costs it incurs.

Adolescents, especially, are particularly susceptible to clinical depression, due to the abundance of developmental stressors that this population faces. In fact, depression, in its mild form, is the most common psychological disturbance among the adolescent population (Steinberg, 1999). The following section will discuss, specifically with respect to the adolescent population, the current status of this disorder as well as popular contemporary treatments.

Prevalence.

The rate of prevalence of depression increases markedly from pre-pubescence to adolescence (Garber & McCauley, 2002). However, the exact rate of prevalence of depression in the global adolescent population is a contested point, with varying estimates including 4-8% (Garber & McCauley), 21% (Edwards, 2002), 28% (Steinberg, 1999), and 30% (Hendricks, Robinson, Bradley, & Davis, 1999). Some academicians split their estimates, giving a minor versus a major level of infliction. For example, Edwards claims that between the ages of 9 and 17, 21% display emotional difficulties, although only 11% are significantly impaired at home, school, or with their friends. Moreover, another estimate holds that 25% of all adolescents display minor forms of depression, whereas

major depression is only expressed in 3% of the population (Steinberg). I feel that this lack of agreement with respect to prevalence percentages may be due to the variation in intensity of, and thus the resulting difficulty in diagnosing, depression, as well as the fact that adolescents may not receive nor even seek treatment for their depression.

Furthermore, estimates may be too high due to over-diagnosis of the illness. However, most studies examining the prevalence rates of depression tend to use different measures, which may also account for these different reports of prevalence rates. Since different studies incorporate the use of varying assessment tools which measure different symptoms, it is thus difficult to make definitive conclusions with respect to actual prevalence rates. Lastly, the difference in reported prevalence rates may be due to variables such as utilizing varying definitions of depression or placing emphasis upon different symptoms.

Despite this general lack of agreement, there seems to be some agreement that 1 in 5 of all adolescents, or 20%, experience at least one episode of major depression by the age of 18 (Garber & McCauley, 2002; Hendricks et al., 1999). This statistic alone demonstrates the considerable impact that depression has upon adolescence, and has implications for the need for more effective treatment and prevention programs.

There is also a significant recurrence rate for depression in adolescents (Edwards, 2002; Garber & McCauley, 2002; Papolos & Papolos, 1997). Again, like the prevalence statistics, there is a degree of disagreement with respect to recurrence rates; however, the general agreement is that if an individual has experienced an episode of depression in adolescence, she or he has a significantly higher chance of recurrence. According to

Papolos & Papolos, approximately 70-85% of all adolescents experiencing at least one episode of depression also experience a recurrence of the illness either later in adolescence or in adulthood. Likewise, it has also been estimated that if an adolescent has had an episode of major depression, he or she has a 3 to 4 times higher chance of recurrence (Edwards). Garber & McCauley expand upon this and claim that not only do 72% of adolescents experience recurrence of symptoms, 40% of children and adolescents experience recurrence within 2 years of the first episode, and 75% experience recurrence within 5 years of the first episode. Moreover, almost all individuals experiencing a major depressive episode in adolescence will experience a recurrence of depression by adulthood. Again, this demonstrates the significant need for appropriate and effective treatment of depression for adolescents.

As well, depressive adolescents have a high incidence rate of suicidality. Psychological autopsies show that 90% of adolescents who have completed suicide had a psychiatric disorder at their death (Garber & McCauley, 2002). In fact, depressive adolescents have a 30 times greater chance of completing suicide than if non-depressed (Garber & McCauley). Suicide is the third highest global cause of death in 15 to 19 year olds (Edwards, 2002), and approximately 5 to 10% of all American adolescents attempt suicide. Likewise, approximately 30% of American adolescents endure suicidal ideation, whereas 60% know someone else who has attempted suicide (Steinberg, 1999). Furthermore, Edwards states that 1 in 10 pre-adolescents who suffer major depression before puberty go on to commit suicide as an adult. The high mortality rate of depressed, suicidal adolescents also implies that more effective treatment is needed.

Symptoms.

There are multiple symptoms that depressive individuals can experience.

According to the *DSM-IV-TR* (2000a) there are nine fundamental symptoms experienced by individuals suffering from depression. In order to be clinically diagnosed with depression, patients must exhibit 5 out of 9 of the following symptoms:

- (1) depressed mood most of the day, nearly every day. . . feels sad or empty. . . or appears tearful. **Note:** In children and adolescents, can be irritable mood.
- (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day. . .
- (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
- (4) insomnia or hypersomnia nearly every day
- (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- (6) fatigue or loss of energy nearly every day
- (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- (8) diminished ability to think or concentrate, or indecisiveness, nearly every day...
- (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing

suicide (p. 356)

Along with the above diagnostic symptoms, adolescent depression sufferers may also experience social and interpersonal difficulties, deviancy, irritability or moodiness, chronic boredom, poor school performance, substance abuse (Edwards, 2002), dejection, apathy, loss of appetite, loss of energy (Steinberg, 1999), hostility at the self or family (Starr, 1977), and negative cognitions about the self or future such as hopelessness, pessimism, or self-reproach (Garber & McCauley, 2002; Starr; Steinberg). As well, depressed adolescents tend to neglect their appearance (Edwards), and have remarkably low self-esteem (Edwards; Garber & McCauley; MacKay, Gold, & Gold, 1987). Finally, depressed females tend to also possess eating disorders (Edwards; MacKay et al.).

Comorbidity.

Depression is also extremely debilitating due to its high comorbidity rate with other mental disorders. It has been demonstrated that two-thirds of those afflicted with depression also have a concurrent clinical mental disorder (Edwards, 2002). For example, depression tends to be highly comorbid with substance abuse disorders (Edwards; Garber & McCauley, 2002; Papolos & Papolos, 1997); in fact, depressed adolescents have a 3 to 4 times greater risk of also having a substance abuse disorder. However, it is arguable that one disorder may trigger the other. As well, anxiety disorders are also highly comorbid with depression (Edwards; Steinberg, 1999), as are disruptive disorders (Edwards; Garber & McCauley). Suicidality also tends to occur simultaneously with depression (Garber & McCauley). Furthermore, depression tends to also be comorbid

with learning disorders, eating disorders, and attention deficit disorder (Edwards).

Risk Factors.

There are a number of risk factors that contribute to an adolescent experiencing depression. As Weissman & Paykel (1974) state, “depression in any single patient probably results from a convergence of causes. This includes stressful life events, genetic predisposition, vulnerability to certain stresses based on personality and other factors, and probably biologic and neuropharmacologic abnormalities” (p. 17). Genetic factors do seem to play a role in depression. Approximately 20 to 50% of depressed individuals have a family history of depression. For those adolescents with depressive parents, there is a 3 (Edwards, 2002) to 4 times increased risk of the adolescent also experiencing depressive symptoms in their lifetime (Garber & McCauley, 2002); moreover, this rate is increased even further if the parent experienced early onset (Edwards) or recurrence, or if both parents were depressive (Garber & McCauley). As well, the child of a depressive parent has a 40% chance of developing depression by the age of 20, and has a 60% chance of developing the illness by the age of 25. Similarly, children of depressed parents have a higher risk of frequent medical system use, behavioural and school difficulties, suicidality, and substance abuse than do children of non-depressed parents (Garber & McCauley).

There are also other factors that contribute to the adolescent exhibiting depressive symptoms. According to Garber & McCauley (2002), a history of mood disorders, anxiety disorders, or disruptive disorders can increase the individual’s risk of experiencing depressive symptoms later in life. Likewise, the chance of developing major depression is

heightened if the individual experienced mild, chronic depressive symptoms prior to onset. Family dysfunction, as well, increases an individual's susceptibility to depression. That is, if the individual experiences high levels of discord, criticism, and lack of involvement in the home, this environment is a significant contributing factor to the expression of depressive symptoms. However, it is difficult to separate the factors of dysfunction and parental depression, and therefore conclusions with respect to the actual involvement of family dysfunction in depression are provisional. As well, dysfunctional family environments increase onset and recurrence, and also interfere with recovery from symptoms. Finally, gender may also be a contributing factor to the development of depression, in that adolescent females have a higher incidence rate of depression than do adolescent males (Garber & McCauley).

Gender Differences.

There are significant gender differences with respect to the prevalence of depression. As Edwards (2002) states, it has been demonstrated that twice as many females as males are afflicted with depression. As well, whereas more males successfully complete suicide, more females attempt suicide (Edwards). This difference has customarily been attributed to hormonal changes in females, which make them more susceptible to depression (Edwards; Starr, 1977). However, Steinberg (1999) contests this assumption, claiming that there is little evidence to support it. Instead, he claims that social factors play a greater role in this gender imbalance. For example, female adolescents tend to feel more conflict over achievement, due to the perception that

academic success for females is unattractive. Further, female adolescents experience higher anxiety over physical appearance, greater concern over peer popularity, as well as more pressure to behave in a sexually stereotyped manner. As well, females tend to be more vulnerable to loss of social relationships, emphasize hurtful events and reflect over outcomes, and engage in more self-blaming and helpless cognitions (Edwards).

Furthermore, according to Steinberg (1999), female adolescents tend to experience higher levels of stress than males. This is because females are more likely to experience concurrent multiple stressors and to experience stressful life events; for example, they experience more pubertal bodily change stress than males. As well, female adolescents also have a higher rate of sexual abuse during childhood, which is correlated with depression in later life. In general, females react to stress by turning their feelings internally which results in mood disorders such as depression, whereas males turn their feelings externally which are then expressed through aggressivity and substance abuse.

However, it is possible that other factors contribute to the perceived gender difference. For example, males may use substances such as drugs or alcohol to stave off depressive feelings. In fact, it has been shown that substance abuse is more prevalent for males than females (Steinberg, 1999). This difference in how the emotional disorder is handled may contribute to the differential prevalence rates. Lastly, it is possible that the gender difference is merely fabrication. Males are less prone than females to seek medical treatment for an emotional disorder, which may skew the gender prevalence rates. Therefore, there may be fewer gender differences than originally thought (Starr, 1977).

Treatment of Depression.

There are multiple treatment opportunities available for those suffering from depression with varying degrees of effectiveness. However, despite the abundance of treatment measures available for depressed individuals, it has been found that 70% of children and adolescents with depression do not get the help they require, due to the illness not being recognized or help not being available (Edwards, 2002). As well, any single treatment approach only alleviates the symptoms of 50 to 60% of those treated (Garber & McCauley, 2002). Interestingly, females tend to respond to psychotherapy more effectively than do males (Steinberg, 1999).

As Starr (1977) states, depression sufferers experience significant levels of hostility and anger, although are typically only aware of hopelessness and worthlessness. Thus, psychotherapeutic treatment with depressed individuals is usually structured to help the patient acknowledge and accept his or her anger and depression, and to help the patient understand the origin and consequences of the illness. Furthermore, psychotherapeutic treatment usually helps the depressed individual to communicate his or her needs, wishes, and emotions (Starr). Psychotherapeutic treatment is also often combined with pharmacologic medication. Selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs) are generally understood to be effective in ameliorating symptoms of depression. Electro-convulsive therapy (ECT) has also been demonstrated to be effective in treating depression (Papolos & Papolos, 1997).

However, almost no treatment programs integrate prevention programs, despite the benefits of this approach. That is, without prevention, the high prevalence of mental

illnesses such as depression may precede high levels of suffering and loss of productivity. As well, prevention is more cost effective than treatment, and requires fewer mental health professionals. Prevention for depressed adolescents is especially important for those who have already experienced a depressive episode, due to the high recurrence rate (Garber & McCauley, 2002).

Current Psychotherapeutic Treatments.

As I have said, there is an abundance of psychotherapeutic treatments for individuals with depression, which emphasize a wide range of goals. This raises questions as to the effectiveness of many of the existing interventions. As Anton Chekhov said, “if many remedies are prescribed for an illness, you may be certain that the illness has no cure” (cited in Solomon, 2001, p. 135). Whereas this is arguable, the variety of treatments available may make it difficult for the depressed individual to uncover one that is appropriate for him or her. As well, since the depressed adolescent does not have the motivation necessary to undertake such a search, they tend to often enter into the treatment program at a local facility. Although the effectiveness of the multitude of depression treatments is beyond the scope of this paper, I will take this opportunity to briefly mention a number of these interventions.

Two of the most common psychotherapeutic treatments for treating depression are the psychodynamic perspective and the cognitive-behavioural perspective. In psychodynamic treatment, which emphasizes our unconscious internal conflicts (Funder, 1997), the main points emphasized are the contract between client and therapist,

intensification of transference and counter-transference, and the direct working with client resistance (Dokter, 1996). In contrast, in cognitive-behavioural therapy (CBT), the emphasis is on altering maladaptive thought patterns and cognitive restructuring (Garber & McCauley, 2002). CBT has been found to be especially effective in a group format, as has been seen in various school- and family-based interventions (for a more complete overview, see Garber & McCauley).

Along with these common interventions, there are numerous alternative interventions that claim to be effective in decreasing depressive symptoms. A small portion of these alternatives include: gestalt, encounter groups, T-groups, transactional analysis, behavioural modification groups, social skills training (Jennings, 1987), sensitivity training groups, human awareness groups, human relations groups, human enrichment groups, Synanon games, personal growth groups, sensory awareness groups, nude weekend therapy groups (Yalom, 1970), marathon groups (Bach, 1966/1994), discussion groups, family therapy (Starr, 1977), and rational group therapy (Ellis, 1963/1994). As well, Solomon (2001), in his description of various alternative treatments he sampled during his own personal battle with depression, says:

among the more serious alternative treatments I count repeated transcranial magnetic stimulation (rTMS); the use of light boxes for people with seasonal affective disorder (SAD), eye movement desensitisation and reprocessing (EMDR) therapy; the plant Saint-John's-wort; S-adenosylmethionine or SAMe; homeopathy; Chinese herbal medicine; group therapies; support groups; and psychosurgery. (p. 137)

Indeed, there are a high number of treatments available for depressed adolescents.

Interestingly, the majority of interventions utilized with this population tend to be group-oriented in focus (Starr; Yalom). The following will examine the benefits of group therapy interventions with depressed adolescents.

Adolescent Group Therapy

There has been much research in the area of adolescent therapy, and the overwhelming majority of scholars agree that group therapy is the most appropriate form of therapeutic intervention. For example, a study by Tillitski (1990) demonstrated that adolescents do better in group therapy than in individual therapy, and calls for a group component to be included in all adolescent treatment programs. The primary advantage of adolescent group therapy is that it takes advantage of peer grouping, one of the fundamental developmental needs of adolescence. That is, the period of adolescence involves the search for autonomy and the separation from the family unit, which is manifested by a desire to communicate with the peer group as opposed to the family. In essence, the adolescent's peer group becomes a surrogate family, and acts as a replacement for the parental influence and structure (Riley, 1999). Thus, the structure of group therapy takes advantage of this developmental requirement, making the group therapy atmosphere more conducive to comfort (Tibbetts & Stone, 1990) and openness. In fact, it has been demonstrated that group therapy does indeed increase verbal interaction and therapeutic involvement in a shorter time than does individual therapy (Riley; Tibbetts & Stone).

Group therapy also seems to reduce the threat and stigma of therapy. For adolescents who are resistant to treatment because of the stigma of being ‘crazy’ or ‘mental’, the presence of a peer group increases the security and reassurance desired by the adolescent (Riley, 1999; Tibbetts & Stone, 1990). Moreover, the presence of a group helps the adolescent with reality testing (Brandes, 1977). Group therapy can also teach the adolescent to express his or her feelings clearer and more readily, can provide the adolescent with a sense of universality or shared experiences, as well as allowing a safe space for feedback to be given or received (Corder & Whiteside, 1990). Finally, group therapy prepares or fosters a positive attitude in the adolescent with respect to other forms of therapy, such as individual or family therapy (Brandes; Riley).

As well, there are other, more universal benefits of group therapy that are applicable to the depressed adolescent population. Some believe group therapy to be a more effective therapy than individual therapy (e.g. Perls, 1967/1994; Yalom, 1970). Whereas this may be debatable, there are indeed numerous benefits of group therapy. As Perls states:

[I]n the group situation something happens that is not possible in the private interview. To the whole group *it is obvious* that a person in distress *does not see* the obvious, does not see the way out of the impasse, does not see (for instance) that most of his misery is a purely imagined one. In the face of this collective conviction of the group, he cannot use his usual phobic way of disowning the therapist when he cannot manipulate him. Somehow, trust in the group seems to be greater than trust in the therapist – in spite of all so-called transference

confidence. (p. 241, italics his)

Group therapy also holds other, more practical benefits. For example, group therapy is useful in that it can reach a greater number of individuals in a shorter amount of time, it can be adapted for the school system (McWhirter, McWhirter, & Gat, 1996), it can be mixed in terms of sex and age (Brandes, 1977), and it involves fewer resources than does individual therapy (Garber & McCauley, 2002).

As well, according to the group therapist Yalom (1970), there are 10 fundamental curative factors specific to group therapy: (a) imparting of information, (b) instillation of hope, (c) universality, (d) altruism, (e) the corrective recapitulation of the primary family group, (f) development of socializing techniques, (g) imitative behaviour, (h) interpersonal learning, (i) group cohesiveness, and (j) catharsis. These processes are not intended to be separate entities, but instead overlap as part of a dynamic process. As well, not all possess an equal value; instead, their value is dependent upon such factors as the goals of the group, the type of therapy being practiced, the stage of therapy, and patient differences (Yalom). This is especially true with adolescent groups, where the primary curative factors tend to be universality, interpersonal learning, group cohesiveness, catharsis (Kymissis, Christenson, Swanson, & Orlowski, 1996), and the corrective recapitulation of the primary family group. Due to the appropriateness of this theoretical approach to working with adolescents, the present study chose to utilize these five factors to structure the intervention used. Therefore, in the following I will outline in further detail the five primary curative factors specific to the adolescent population.

The first of these curative processes, universality, is an important process in

adolescent group therapy. This factor involves allowing individuals to realize that they are not “unique in their wretchedness, that they alone [do not] have certain frightening or unacceptable problems, thoughts, impulses, and fantasies” (Yalom, 1970, p. 10). Through witnessing the experiences of other group members, depressed clients can disconfirm their feelings of uniqueness and social isolation. Universality is thus an appropriate curative factor for working with adolescents (Kymissis et al., 1996), since adolescents tend to be particularly affected by social isolation and to feel alone in their experiences.

The second curative factor fundamental to adolescent group therapy involves the corrective recapitulation of the primary family group. This factor views the group as analogous to the adolescent’s family, and thus any interpersonal problems worked through in the group may be also indirectly addressing issues from the family. As well, disallowing maladaptive behavioural patterns and relationships in the group may stimulate change in the adolescent’s family relations. Thus, group therapy can challenge behaviour stereotypes, provide reality testing, explore relationships, and provide an avenue to test out new behaviours (Yalom, 1970). The third main curative factor of adolescent group therapy as outlined by Yalom (1970) is that of interpersonal learning. In essence, this factor entails providing the adolescent insight into *what* kinds of behaviour they engage in, *why* they engage in these behaviours, and *how* these behaviours affect others. Generally speaking, the adolescent’s behaviour in the group is analogous to how they would behave outside of the group. Through relations with others in the group, consensual validation, and self-observation, the group may draw the adolescent’s attention to their own maladaptive behaviours, strengths, limitations, and distortions, all which elicit responses

from others. As well, as Perls (1967/1994) states, the “group’s observation of the manipulative games which the neurotic plays, the roles he acts out, in order to keep himself in the infantile state facilitates their own self-recognition” (p. 241). Ideally, insight and self-awareness gleaned through self-observation and group feedback should result in behavioural change in the adolescent, which, in turn, may result in less distorted interpersonal relations and less social anxiety. These improvements may then stimulate increasingly rewarding relationships and more approval from others outside of the group, as well as higher self-esteem. However, change in behaviour is dependent upon many factors, such as the client’s motivation for change, the level of discomfort with his or her current modes of behaviour, the level of personal involvement in the group, the need for acceptance by the group, personal respect or appreciation of other group members, rigidity of personality, and the depth and meaningfulness of awareness, which is itself reliant upon the associated level of affect. That is, more emotional experiences beget more potent insight and awareness (Yalom). Thus, due to the high value adolescents place upon social acceptance, this can be seen to be a particularly useful curative factor for adolescents.

The fourth curative factor, which is also particularly relevant for adolescent group therapy, is that of group cohesiveness, which describes the level of attraction group members have for the group and for other members (Yalom, 1970). Cohesion denotes a high level of acceptance and support, as well as the presence of meaningful relationships in the group, which are all particularly important for conflict resolution, for other curative factors to occur, and, ultimately, for a successful group therapy outcome. A cohesive

group will reinforce positive behaviours, which will in turn increase self-esteem. Group cohesion is relevant for adolescent group therapy due to its inherent social healing factors, and due to its ability to increase members' openness to and decrease resistance to the therapeutic intervention (Yalom, 1970). As well, as Kymissis et al. (1996) point out, "the most important factor in the prognosis of children with psychological problems is their ability to have successful peer relationships" (p. 46).

The final curative factor expounded by Yalom (1970), which is also relevant for adolescent group therapy, is that of catharsis or ventilation. This process involves the strong expression of affect, which is an indispensable part of therapeutic process. However, as Yalom states, catharsis is a "part process" (p. 72), and is not necessarily therapeutic or a goal in or of itself. Instead, catharsis should be used in conjunction with the other curative factors and as one portion of a more complete therapeutic process. For example, the amount of interpersonal learning tends to be directly proportional to the level of affect intensity, and thus should be used accordingly.

Since adolescents are such a difficult population to work with (e.g. Emunah, 1985; 1990; 1994; Jennings & Gersie, 1987), it is certain that difficulties will arise in adolescent groups. For example, adolescents may have extreme body boundaries and may be extremely resistant to touch, may attempt to shock others with sexual allusions or comments, or may 'play dumb'. As well, they may explicitly express or feign boredom, which has been demonstrated to signify a defence against change. Contrarily, they may appear restless, which tends to signify a longing for change. Despite the social factors of group therapy, adolescents also may resist group processes due to feeling silly or

regressive. Adolescents, especially in outpatient groups, tend to engage in absenteeism, and their resistance or rejection of suggestions may manifest their desire to remain absent. However, an adolescent group is bound to face considerable chaos and internal conflict (Jennings & Gersie).

In conclusion, the available treatments for depression vary widely, with emphases ranging from unconscious internal conflicts to the altering of maladaptive thought patterns and cognitive restructuring. Regardless, most therapies tend to concentrate on helping the depressed patient accept their depression, and also with directly communicating their needs, wishes, and emotions. As well, many treatments for depression tend to utilize group therapy structures, which claim to possess such benefits as contributing to clearer and more voluntary expression of feelings, reducing the threat of the stigma of therapy, providing a safe space for feedback to be given and received, and peer grouping. Moreover, group therapy with adolescents suggests such curative factors as universality, interpersonal learning, group cohesiveness, catharsis, and the corrective recapitulation of the primary family group. The creative arts therapies, another group of therapies that also lend themselves to group processes, also purport to possess similar benefits and curative factors as do other treatments for depression.

Creative Arts Therapies

Of the multiple therapeutic interventions for adolescent depression groups, some particularly effective interventions seem to be the creative arts therapies (CATs). The fundamental premise of the creative arts therapies is that creativity is an inherent healing

process, and that clients can heal and gain insight through fostering their creativity (e.g. Cattnach, 1996; Emunah, 1994; Jennings & Gersie, 1987; Johnson, 1982; Landy, 1986; Moon, 1998). Whereas this is an oversimplification, the use of creativity in therapy appears to be the fundamental overlapping feature in these otherwise very different forms of therapy. Specific details of how each creative arts therapy uses creativity will be discussed below. Generally speaking, however, the use of creativity as well as projective techniques in therapy provide a safe distance from individual issues, which, in turn, can result in clearer and more voluntary expression of emotions, a reduction in the stigma associated with therapy, and the presentation of a safe space for feedback to be given and received. As well, although individual sessions are possible, the creative arts therapies lend themselves well to a group therapy structure. This is because they “combine the safety, structure, and benefits of artistic self-expression and peer interaction with the acceptance and guidance of the artist-therapist” (Moon, p.173). Adolescents’ preference for group structures provides the peer grouping benefit that is important to adolescent therapy. According to Storr (1972), the creative arts therapies are also particularly useful for treating depression in that creativity helps to alleviate depressive symptoms and low self-esteem through providing tangible evidence of worth. That is, a creative artistic product can be positively reflected upon, which thus works to increase self-worth.

There are four primary creative arts therapies that are generally discussed in mental health literature: dance/movement therapy, music therapy, art therapy, and drama therapy.

Dance/movement therapy is the use of movement as a psychotherapeutic process in order to assist an individual’s cognitive, social, and physical integration (American Dance

Therapy Association, 1999). Similarly, according to the American Music Therapy Association (1999), music therapy is the prescribed use of music with individuals with health or educational problems in order to effect positive changes in their psychological, cognitive, physical, or social functioning. Drama therapy and art therapy, which were used in the current study, will be described in more detail below.

The Use of Empirical Research in the Creative Arts Therapies.

Despite the steadfast belief of creative arts therapists in the validity of their work, very little empirical research has been undertaken to quantitatively demonstrate the effectiveness of these interventions. In his exhaustive research of various alternative treatments for depression, Solomon (2001) states that “many remedies are prescribed for depression – in addition to the standard measures, a stupefying number of alternatives. Some of these are. . . . perfectly ludicrous: the emperor has a whole new wardrobe in this business” (p. 135). In fact, due to the lack of empirical research, many academicians, scholars, and mental health professionals may also hold this potentially negative attitude specifically with respect to the creative arts therapies. In their comprehensive search for empirical art and drama therapy studies, Burleigh & Beutler (1996) make a plea for more controlled creative arts therapies research:

[A] critical mass of well controlled studies that establish treatment efficacy does not exist These limitations do not allow us to draw more than a provisional and tentative conclusion regarding the effectiveness of these treatments.

In sum, the majority of art therapy literature consists of narrative case

studies on samples whose particular problems are poorly identified. This method lacks clearly defined variables and objective data and is difficult to replicate (Rosal, 1989). . . . [A] number of clinical writers have emphasized that quantitative measures used in empirical studies are inadequate for identifying the complexities of the changes that occur during treatment (Hagood, 1990; Kellerman, 1987). Junge and Linesch (1993) suggested a variety of qualitative research techniques for assessing the effectiveness of art therapy. However these methodologies lack experimental control and, to date, are not considered acceptable evidence of efficacy or effectiveness by the Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1996). . . . Most research on these interventions as treatments lack the levels of definition and operationalization needed for replication. . . . [T]he multiplicity of procedures, the subjectivity of evaluating their benefits and the variability of their use are all decided limitations to the question of their validity as therapy procedures. (pp. 377-79)

Burleigh and Beutler (1996) continue their critical analysis of creative arts therapies research by claiming that most constructs researched are immeasurable, and those constructs that are measurable have not been done so in controlled research. Furthermore, there is an absence of empirical findings on clinical populations, which decreases the validity of the creative arts therapies as therapies for clinical disorders.

In fact, despite the drama therapy community's claims to the contrary, Burleigh & Beutler (1996) found no systematic, controlled studies empirically demonstrating the efficacy of drama therapy as valid therapeutic interventions. There have been considerable

efforts made to demonstrate the effectiveness of drama therapeutic techniques as assessment methods (e.g. Johnson & Quinlan, 1980; 1985; 1993); this does not, however, demonstrate the supposed effectiveness of drama therapy as a therapeutic intervention.

In order to rectify this oversight and to advance knowledge as to effective techniques, the creative arts therapies need to produce more studies utilizing uniformity in outcome measures, as well as quantitatively valid measurement techniques, research design, and sample populations. It is also pointed out that not only does objectivity increase acceptance and validity of therapeutic techniques, but that it also may ultimately improve the individual therapist's practice and client care. However, as Burleigh & Beutler (1996) point out, if the creative arts therapies do not take steps to improve their acceptance in the mental health field, drastic consequences may occur:

Without the proper substantiation, it is unlikely that the therapeutic potential of the creative arts therapies will be realized and quite probably that the political movement to require empirical justification will result in the eventual abandonment or restriction of these interventions by third-party payers. (Burleigh & Beutler, p. 380)

Art Therapy.

Art therapy has been defined as the use of:

[A]rt media to help clients express their thoughts, feelings and experiences. The use of art as therapy implies that the creative process can be a means of both reconciling emotional conflicts and of fostering self-awareness and personal

growth (Larose, 1987). Creating a work of art provides the client with a vehicle for self-expression, communication, and growth (Franklin, 1992). Both the product and the associative references may be used by the therapist in an effort to help the client find a more compatible relationship between his/her inner and outer world. Process, form, content and/or associations become important for what each reflects about personality development, personality traits, and the conscious behavior [*sic*] and unconscious motivation. . . (Saunders & Saunders, 2000, p. 100)

Art therapy claims to be effective using a group therapy structure. According to Brooke (1995), group art therapy affects more general social aspects of self-esteem than does individual therapy. Group art therapy is also effective in that it takes advantage of the universality principle of symbols and images; that is, what occurs in one client's artwork may also hold significant meaning for others in the group. Also, clients can control their level of participation in an art therapy group. Adolescents may produce artwork without otherwise actively participating in the group process. This concrete artwork can thus communicate for the adolescent that which they may be unwilling or unable to impart. Furthermore, the use of artwork provides a concrete object that can be returned to and reflected upon in future sessions. In essence, group art therapy differs from traditional group therapy in that the process involves group members occasionally separating from the group to create their own art. In this way, group members can still express their individuality while still working and identifying with the group (Dalley, 1993).

As well, art therapists claim that their modality is particularly appropriate for adolescent therapy. This is because the non-verbal nature of art therapy is suitable to adolescent resistance or inability to communicate verbally (Saunders & Saunders, 2000). Furthermore, art therapy provides adolescents control over the nature and extent of their verbal disclosures, an outlet for personal creativity, an element of pleasure in the therapeutic environment, as well as the means to utilize age-appropriate metaphors and symbols (Riley, 1999). Moreover, Moon (1998) outlines 10 methods of using art therapy with adolescents. He states that art therapy can be viewed as: (a) *the natural language of adolescents*, or a more comfortable method of articulating feelings; (b) *engagement with 'stuff'*, or working in the here and now; (c) *existential expression*, or a method to metaphorically deal with anxieties about meaning, isolation, death, and creative freedom; (d) *personal metaphor*, or the use of action and image metaphors to articulate, express, free, and define the art maker; (e) *relationship*, or the act of being witnessed and accepted by group; (f) *structure and chaos*, or expressing with structure that which is inexpressible; (g) *empowerment*, or using the individual's power over the artwork as a metaphor for retaining power over life; (h) *reparative experience*, or the use of art to depict or comment on relationships without consequences; (i) *self transcendent hope*, or using art to instill hope and decrease self-absorption; and (j) *a way of being with adolescents*, or the act of using art to set up and maintain the group, establish the group culture, and keep the focus of the group to the 'here and now' (Moon).

Interestingly, it has been found that female adolescents draw more pictures about relationships, displaying both positive and negative attitudes towards relationships,

whereas males draw more solitary objects (Silver, 1993). This propensity is particularly significant for art therapy practice with depressed adolescents, considering that many depressed adolescent females report relationship difficulties as the source of their depression (Edwards, 2002).

Further, art therapy supposedly provides depressed adolescents with a sense of mastery and control that they may not retain otherwise (Raghuraman, 2000). However, despite these claims, there is very little empirical research with respect to the effectiveness of art therapy with depressed adolescents. One study conducted by Tibbetts & Stone (1990) demonstrated positive effects of art therapy on depression and anxiety levels in emotionally disturbed adolescents, as measured by the Burks Behavior Rating Scales (BBRS), which measures the frequency of specified behaviours, and the Roberts Apperception Test (RATC), which is a standardized projective personality test. However, it was found that negative behaviours were not affected by the intervention. In another study conducted by Linesch (1988, cited in Burleigh & Beutler, 1996), which used an N=1 design, 10 adolescents with varying symptoms and emotional disorders displayed some positive progress following an art therapy intervention. Despite the shared physical and sexual abuse history of the participants, the N=1 design was chosen due to the lack of consistent symptoms. However, although a correspondence was found between use of art and the patients' progress, the study did not clearly establish generalizability or validity, making its claims questionable. Finally, whereas a study examining the effects of art therapy on inpatient adolescents with a number of emotional diagnoses showed a significant improvement in their global level of functioning, there was no improvement

with respect to levels of assertiveness, sociability, or responsibility (Kymissis et al., 1993).

Art therapy is claimed to not only serve as an outlet for depression, but that it also aids adolescents in developing their personal sense of identity and self-esteem which is associated with depression (Battle, 1990). These results are due to the empowerment that art making incurs (Brooke, 1995; Franklin, 1992). Burleigh & Beutler (1996) outlined a sound empirical study that demonstrated that art therapy increased self-confidence in adolescents as compared with a traditional counselling intervention. Ozimo & Ozimo (1989) and Stanley & Miller (1993) also empirically demonstrated the effectiveness of art therapy on adolescent self-esteem. Finally, art therapy has also exhibited its efficacy in improving self-esteem in adult sexual abuse survivors (Brooke, 1995).

Drama Therapy.

Drama therapy, the fourth creative arts therapy, has been defined as:

[T]he intentional use of creative drama toward the psychotherapeutic goals of symptom relief, emotional and physical integration and personal growth. . . .

Specifically, . . . [it] refers to those activities in which there is an established, therapeutic understanding between the client and therapist and where the therapeutic goals are primary . . . broadly defined [drama therapy] includes any therapeutic use of role-playing . . . and which [drama therapists] base their techniques on improvisation and theatre exercises. (Johnson, 1982, p. 83)

Similarly, Gersie (1996) defines drama therapy as:

[A] number of treatment modalities which use theatrical elements, improvisation

and role-play to treat people who experience mild or severe emotional and psychiatric difficulties. . . . [uses] scenic representation of life-events, the working through of painful experiences by means of dramatic work, the spontaneous enactment of imagined actions and the preparation for anticipated life-events through role-play. (pp. 3-4)

There is an abundance of literature expounding the proposed benefits of drama therapy. For example, drama therapy theoreticians and clinicians make claims as to its effectiveness with respect to increasing creativity and spontaneity, revealing hidden aspects of the self and personality styles (Burleigh & Beutler, 1996), assisting practice with ego control, reducing impulse control problems, controlling developmental fears, generating a sense of enjoyment and well-being, forming healthier attachments (Schaefer, 1993), improving interpersonal relationships, reducing anxiety, reducing depression and distress (Kellerman, 1987), and increasing self esteem (Kellerman, Wilkinson, Srikumar, Shaw, & Orrell, 1998). Through the dramatic medium, drama therapy creates an environment for the sharing of fantasies of both a compensatory and a regulatory nature. As well, it allows clients to rehearse and to test possible alternative behaviours to real-life situations. Finally, it claims to heal participants through providing an opportunity to relive past stressful events and to express previously withheld emotions (Schaefer). However, despite the fact that many of these claims have been demonstrated through qualitative research, very little empirical research has been undertaken in order to quantifiably demonstrate these claims.

Since drama is essentially a social activity, drama therapy is thus an inherently

group process which explores dramatic engagement and interaction between group members (Jennings, 1987). As well, many claims have been made linking drama therapy with ancient healing rituals (Jennings; Snow, 2000), which were fundamentally group and community based. Since it primarily uses a group therapy structure, Gersie (1996) claims that drama therapy shares Yalom's (1970) ten curative factors of group therapy as outlined above.

It has also been claimed that group drama therapy is effective as a brief therapeutic intervention (Dokter, 1992; Grainger, 1990; van Shaik, 1993, cited in Dokter, 1996; Young, 1994). Brief therapy has been said to be particularly effective with clients engaged in a life crisis or developmental stage transition, such as adolescence (Gersie, 1996). In fact, brief therapy has been demonstrated to be more effective than no treatment, and equally as effective as long-term treatment with any population (MacKenzie & Livesley, 1986). Moreover, brief therapy is practical in that it enables a higher number of clients to receive treatment at a lower cost, with a more predictable outcome, and with a clearer evaluation of its efficacy strategies than does long-term treatment (Gersie, 1996). As well, brief therapy is beneficial due to its concentration on limited treatment goals, which may improve overall success (Poey, 1985). Furthermore, according to Emunah (1996), the witnessing, participation, and responsiveness of the drama therapist and the drama therapy group help to concretize and support any alterations made to behaviour in a faster time than does traditional group therapy. As well, dramatic enactment engages clients, reduces need for long explanations, and enhances the client's level of emotional connectedness to presenting issues. Thus, brief group drama therapy may be a viable, practical therapeutic

intervention; however, as Gersie points out, brief therapy may provide the client with unrealistic expectations as to the length of time needed to ‘get better’.

Drama therapy is also claimed to be particularly effective in aiding clients with emotional difficulties, such as depression (e.g. Emunah, 1994; Grainger, 1990). A fundamental concept and practice in drama therapy, and especially useful in the treatment of depressed clients, is the use of *distancing* (e.g. Jones, 1996). Essentially, the individual partaking in drama therapy can achieve personal insight and emotional catharsis while remaining in the metaphorical state provided by a character or role. Individuals can disclose and express difficult emotions with more ease since it is done through a character; that is, difficult emotions and issues do not have to be owned by the individual, providing a higher level of safety. The individual uses the role or character to disguise themselves as someone or something *distant* from themselves. In this way, clients can disclose difficult or anxiety-inducing issues. As Grainger (1990) states, since the drama therapy client is “protected by the contrived nature of the play we can stand back *as ourselves* while remaining in relationship with the other people involved, both actors and audience” (p. 49, italics his). Grainger goes on to state that depressed individuals do not feel free or confident enough to engage in the universality principle, or to express mutual experience. This is due to a lack of personal distance between depressed patients, leaving each depressed client without any sense of separation or uniqueness. Drama therapy, however, can purposefully manipulate aesthetic distance, which provides the client with the freedom and the confidence necessary to experiment with personal images, such as the distance between themselves and others. This use of over-distancing and projection is used to help

the depressive to restore a sense of balance (Landy, 1986).

J. L. Moreno, the father of psychodrama and modern action-based group psychotherapy, also used distancing with depressive patients. He stated that the most effective way to assist a client out of their depression is to allow them to play the role of someone else who is not depressed. As Zerka Moreno, his widow and fellow psychodramatist states,

[i]t is remarkable how even a depressed person can be lifted out of a depression, at least momentarily. The patient can be made to feel what it is like not to be depressed, even for 5 or 10 minutes. That in itself is an eye-opener – the fact that they can warm up to a new emotional state. (1975, cited in Karp et al., 1998, p. 99)

Grainger (1990; 1991, cited in Dokter, 1996) offers paradoxical opinions with respect to cognitive restructuring with depressed clients. He claims that individuals with depression are susceptible to mood shifts because of their tendency to integrate events into their personal constructs that are not easily assimilated. This results in destructive cognitions with respect to inadequacy and failure. Thus, drama therapy methods should focus on cognitive restructuring. Contrarily, he also emphasizes the importance of the somatic nature of drama therapy and its ability to provide emotional catharsis at a pre-cognitive level. I feel that both are essential in the healing of depressed individuals, and thus drama therapy should alternate the therapeutic focus between cognitive and pre-cognitive structures.

In addition, the social nature of drama therapy makes it ideal for working with

depressed patients. Since depressed clients tend to feel socially isolated, drama therapy provides the “creative acceptability” (Grainger, 1990, p. 49), or social acceptance through artistic processes necessary to achieve healing. Drama therapeutic processes enable the depressed individual to interact with others in a meaningful way, which helps to counteract the sense of being socially isolated (Grainger).

Drama therapy is also held to be effective in working with adolescents. This seems to be particularly true with female adolescents, who are generally more comfortable with dramatic expression (Walsh, 1990). For example, Emunah (e.g. 1990), a prominent drama therapy theorist, has done much work with adolescents:

[T]he healing properties of the arts during adolescence lie not only in the outlet for expression they provide, but in the way they enable containment, and in the way. . . [they may] lead to expansion. . . . [T]he balance and interplay between expression and containment are central. (pp. 102-3)

Jennings (1987) also claims that drama therapy is especially useful for adolescents due to its active nature, which counteracts the adult-directed quality of traditional verbal therapy, which can place pressures upon the adolescent that are similar to those they face in everyday life. Jennings & Gersie (1987) claim that drama therapy is particularly effective for adolescents for a number of reasons. For example, due to the use of distancing, drama therapy is conducive for reporting or divulging difficult information, for making reparation or amends in fantasy, as well as allowing the adolescent the space to come to terms with difficult life events. Moreover, drama therapy’s emphasis on emotional expression allows for effective ventilation or letting off steam for the adolescent. Drama therapy can also be

used as 'rehearsal for life', which allows the adolescent the opportunity to explore alternative forms of behaviour or to obtain help with making decisions. Finally, the group nature of drama therapy makes it ideal to provide acceptance of the adolescent by their peers, as well as to assist the adolescent with the development of their superego or conscience.

Recent literature has drawn attention to certain difficulties that drama therapy work with adolescents raises. Specifically, the developmental needs of adolescents can conflict with a fundamental premise in drama therapy, that of dramatic play (e.g. Emunah, 1994; Jones, 1996). Since a primary developmental need of adolescence is to secure an adult identity and to reject childish attributes, adolescent drama therapy clients may feel threatened by the playful nature of this work. That is, fear of regressing or appearing 'childish' may result in significant resistance from the adolescent. As well, adolescents may feel threatened by the drama therapist, since they are an authority figure who is not only interested in the adolescent's internal world of thoughts and feelings, but also evokes dependency and supports regressive play (Johnson & Eicher, 1990). However, drama therapists assert that play is essential to appropriate and successful development (e.g. Blatner & Blatner, 1997; Cattanach, 1996)

Despite its claims of being effective with children and adolescents with emotional difficulties (e.g. Dequine & Pearson-Davis, 1983; Emunah, 1985, 1990, 1994, 1996; Irwin, 1981; Shuttleworth, 1981; Walsh, 1990), drama therapy has very little empirical research demonstrating its effectiveness as an intervention with depressed adolescents. In fact, after an exhaustive search, only two empirical studies could be found. The first

study, conducted by MacKay et al. (1987), examined the effects of an 8-week drama therapy approach on depression and self-esteem levels in 5 sexually abused teens between the ages of 12 and 18. It was found that depression levels were significantly reduced as measured by the Symptom Check List-90 (SCL-90), and also showed reduction that approached significance as measured by the Beck Anxiety Inventory (BDI). Self-esteem levels, however, while demonstrating an increase, did not achieve significance. The improvement in the subjects was attributed to the provision of an opportunity “to express themselves in role-play with strong energy” (p. 82). However, this study had serious limitations, such as its small sample size and its lack of control group. As well, since the subjects of the study were sexually abused adolescents, it is difficult to assess the effectiveness of the intervention on only the adolescents’ depression. The second study, conducted by Dray (2001), used an N=1 design to examine the effects of a drama therapeutic intervention with suicidal adolescents. Subjects demonstrated substantial improvement with respect to levels of depression, self-esteem, suicidality, and global level of functioning. However, this study, as well, lacked a control group and a large sample size.

After further inquiry, it is possible to discover empirical studies demonstrating positive results with respect to drama therapy being used with other clinical diagnoses related to depression. For example, drama therapy interventions have demonstrated positive changes when used with adolescents with developmental disorders, drug addiction, low self-esteem (Frehner, 1996), school difficulties (Stuart-Smith, 1994), and behavioural problems (Chandler, 1973; Stuart-Smith). As well, drama therapy has shown

effectiveness with assisting children and adolescents to develop skills in critical thinking, problem solving, and logical decision-making with respect to alcoholism, suicide, divorce and family life, eating disorders, peer pressure, responsible dating, stress and anger, and special education (Hery, 1996). However, all attempts at empirical studies display significant limitations in research design. Some fundamental challenges of conducting research with clinical populations include the fact that ethics and practical limitations make the use of control groups and large sample sizes in clinical research a rarely avoidable limitation. However, this fact does not diminish the serious hindrance to research validity that these limitations present.

Role Play.

Role play, a fundamental concept to the practice of drama therapy (e.g. Emunah, 1994; Jones, 1996), has been defined as not being confined to dramatic ways of working with role functions. It is used in its wider sense, describing a fictional identity or persona which someone can assume, and is also a concept used to understand the different aspects of a client's identity in their life as a whole. (Jones, pp. 196-7)

Role play has also been used separately from drama therapy in empirical studies. For example, in an occupational therapy study with a 40 year old man, role play was found to improve the subject's self-esteem and feelings of self-worth, and his ability to solve difficult social situations, as well as teaching him stress management techniques and social skills (Custer & Wasink, 1991). Furthermore, in an empirical study conducted by

Chalmers & Townsend (1990), role play was used as a method to improve interpersonal functioning in delinquent adolescent females. It was found that the use of role play enhanced the subjects' performance on a measure of social perspective taking. As well, the adolescents' levels of interpersonal problem analysis, empathy, acceptance of individual differences, and prosocial behaviours also improved. Marsh, Serafica, & Barenboim (1980) also found that role play increased interpersonal problem analysis in adolescents.

As well, role play, has shown significant potential as an effective assessment method. For example, an effective method was formulated for using role play to assess the difference between paranoid and non-paranoid schizophrenics (Johnson, 1988; Johnson & Quinlan, 1980, 1985, 1993). Role play has also been found to display differing levels of effectiveness with respect to assessing social skills behaviours (Beck, Forehand, Neeper, & Baskin, 1982; Edleson, Ordman, & Rose, 1982), social competence (Bellack, Morrison, Mueser, Wade, & Sayers, 1990), and heterosocial behaviour (Kern, 1982), and is claimed to be similar to actual behavioural styles (McReynolds, DeVoge, Osborne, Pither, & Nordin, 1981). However, research as to the effectiveness of role play as an assessment method does not assist in demonstrating its effectiveness as a therapeutic intervention.

Psychodrama.

Psychodrama is

[a] way of practising living without being punished for making mistakes. The

action that takes place in a group is a way of looking at one's life as it moves. It is a way of experiencing what happened and what did not happen in a given situation.

All scenes take place in the present, even though a person may want to enact something from the past or something in the future. The group enacts a portion of life seen through the eyes of the protagonist (or subject of the session). The personal representation of truth by the protagonist can be eye-opening for someone else watching, who may see themselves reflected in the struggle to express what is real. (Karp et al., 1998, p. 3)

Whereas there is significant difference between psychodrama and drama therapy (Davies, 1987; Garcia & Buchanan, 2000; Snow, 1996), there is also considerable overlap between the two fields. For example, as Davies points out, "both approaches evolved from the relatively straightforward use of drama as a source of creative self-expression into more deliberate and ambitious attempts to facilitate social learning and even to resolve deep-seated emotional conflicts" (p. 104). In fact, many drama therapists use psychodrama as one component of their drama therapy work (e.g. Emunah, 1994), claiming that it is the most effective method for quickly facilitating change, making it ideal for brief therapy interventions (Emunah, 1996). Psychodrama, like drama therapy, also claims to be effective in treating depression (Karp et al., 1998) and improving self-esteem (Verhofstadt-Denève, 2000). Karp et al. claim that one cause of depression is the disruption of social relationships. Since psychodrama emphasizes enacting relationships and provides an opportunity to complete unresolved interactions, it is thus beneficial for decreasing depressive symptoms. In his account of his struggle to overcome depression,

Solomon (2001) describes his participation in a psychodramatic-type treatment, claiming that he found it to be the “most subtle and nurturing” group therapy treatment, and described also how the intervention had “some effect on me, and I saw that it had enormous effect on others in the group” (p. 158).

Despite psychodrama’s claims of effectiveness with depressive patients, empirical testing has produced less than promising results. One study conducted by Weide (1986) found that a psychodramatic intervention with incarcerated offenders did not significantly reduce depression or anxiety as compared with a placebo intervention or with no treatment. Similarly, a psychodramatic intervention with inpatient adults demonstrated no significant reduction in depression or anxiety when compared with traditional group treatment and with no treatment. However, psychodrama was found to induce more intense emotional expression, and perhaps more loss of control, than did the traditional treatment or control groups. The results demonstrated that the female participants experienced more anxiety and less extroversion across the three treatments, and the conclusion was drawn that psychodrama treatment thus has a greater emotional effect on females. Furthermore, it was extrapolated that experiencing catharsis such as induced in psychodrama results in a higher degree of optimism and interpersonal closeness (Fretz, 1981).

Like drama therapy, there has been only one empirical study examining the efficacy of psychodrama with depressed adolescents. The study investigated the effectiveness of a psychodramatic intervention with middle school girls experiencing trauma-induced depression and anxiety. The research found the intervention to significantly decrease

depression, anxiety, and withdrawn behaviour in the participants, as well as increasing levels of competence, self-efficacy, and coping ability. It was theorized that participation in the group was essential for successful resolution of the trauma, and also significantly contributed to the observed positive changes. That is, witnessing and participating in others' psychodramas reinforced the participants' gains, offered them an opportunity to help others with similar difficulties, and assisted them to feel part of a collective (Carbonell & Parteleno-Barehmi, 1999).

Integrated Creative Arts Therapies Approaches.

A recent popular movement in the creative arts therapies is to combine two or more approaches into one integrated approach. Payne (1993) notes that the creative arts therapies all focus on non-verbal communication combined with creative processes. These work together to create a safe, trusting environment that is conducive to uncovering and expressing intense emotions. In fact, the overlapping elements of the different creative arts are such that integration of the arts is a natural, and possibly inescapable, option in the practice of creative arts therapies. It has been noted that this trend dates back to the shamanic traditions, where the four primary arts were integrated holistically in the healing process (Moreno, 1991). There are a multitude of rationales for the use of this integrated approach. For example, as Grodner, Braff, Janowsky, and Clopton (1982) point out:

Current thinking in psychology suggests that the concept of integrating various sense modalities, such as changing from sensory motor experiences (movement) into more symbolic forms of thinking ([drama,] art and spoken language), may be

useful for learning and for changing psychological set (Brunner, 1964; Lachman, 1973). A number of therapists have utilized and written about body movement and its connection with visual art. Cane (1951) and Elkisch (1966) have advocated the use of free art movements and rhythmic body experiences to free people in their subsequent art work. (pp. 217-218)

On a basic level, the use of an integrated creative arts therapies approach increases the treatment possibilities, goals, and objectives; that is, each modality heals in different ways (Zagelbaum & Rubino, 1991). Indeed, it has been approximated that any single treatment approach helps only 50-60% of those treated (Garber & McCauley, 2002); thus, through combining treatment modalities, the approach may ideally help a greater percentage of clients. Essentially, combining treatment modalities promises a treatment greater than the sum of its parts (Steinhardt, 1994).

As well, many creative arts therapists feel that, with the integrated approach, the distinct art forms complement and assist one another in the therapeutic process. For example, the drama therapist Emunah (1990) claims that other arts modalities serve to support and amplify her dramatic interventions. Furthermore, it has been postulated that a combined approach would increase the level of safety and comfort for clients. Through working with more than one modality, clients feel more freedom to experiment with new behaviours and expressions, which results in the client obtaining a higher level of trust for the therapist and group and engaging in less resistance to explore and accept emotions (Potocek & Wilder, 1989). Similarly, Gibson (1980) states that combining creative arts therapies (a) facilitates the uncovering and expression of therapeutic material, (b)

encourages group interactions, (c) enhances self-esteem, and (d) stimulates participation in ego building activities.

Moreover, combining creative arts therapies has been cited as contributing to greater empathy in clients (Moreno, 1991) and as being less threatening to clients' families (Springer, Phillips, Phillips, Cannady, & Kerst-Harris, 1992). As well, with specific reference to adolescents, Moon (1998) states that "painting, drawing, sculpting, writing poetry, playing music, dramatizing and dancing engage the adolescent in integrating disparate aspects of experience in the service of creating a new meaningful whole" (p. 5). Finally, I would emphasize the need for more integrated creative arts therapies approaches in order to counteract the current trend of derision between creative arts therapists. For example, as Riley (1999) states when evaluating a combined treatment approach, "[t]he program offered drama, movement, and art therapy. It has been a great success. . . . The art therapy was seen by the boys as the 'real' therapy" (p. 106). Unfortunately, this is not an isolated example of contempt and disrespect for the work of other creative arts therapists. If the creative arts are to survive and flourish as a valid treatment approach in the mental health profession, then a greater level of acceptance and integration is necessary.

This use of the integrated approach can be seen in an abundance of creative arts therapies literature, although, again, very few are empirical. After an exhaustive search, I uncovered no empirical studies examining an integrated creative arts therapies approach with depressed adolescents. This is most likely due to the relative recency of its usage. MacKay (1987), did examine the effects of a storytelling, an element of drama therapy,

and face painting, an element of art therapy, approach with 10 emotionally disturbed adolescents; however, rather than attempting to reduce symptoms, she instead found that the approach successfully uncovers buried aspects of the self. There is thus a great need for further empirical studies examining the effects of an integrated approach with depressed adolescents.

There are a number of empirical studies examining the effects of an integrated approach on adolescents, although not those suffering from depressive symptoms. For example, Chin et al. (1980) examined a combined art therapy and video therapy approach with 'educationally unserved' adolescents. Results demonstrated a significant increase in self-esteem and interpersonal skills; however, the study lacked a control group. Another study investigated an art therapy and play therapy intervention with anxious adolescents, using 4 different anxiety measures. Results of this study showed a significant decrease in anxiety on one scale, but not on the other 3 scales (Foret, 1997). Yet another study used drama, music, and art therapy approaches to provide early adolescents with social skills training, which met with partially successful results (Walsh, 1990). Finally, a combined art and play therapy intervention was used with children of substance abuse parents, using both peer groups and family interaction groups. They found that the intervention resulted in significant improvement in competence and behaviour problems; however, the study contained glaring design limitations (Springer et al., 1992).

Some research has also been done with respect to integrated approaches and depression. Wilkinson et al. (1998) attempted to conduct an empirical study using a drama and movement therapy approach with seniors with dementia, using a multitude of

scales, including one for depression. However, no significant results were found, and the study possessed serious limitations, such as non-randomized selection, unclear inclusion criteria, and the control and experimental groups being unbalanced with respect to level of cognitive impairment and gender. Furthermore, a study by Grodner et al. (1982) examined the effects of a dance and art therapy intervention with schizophrenic or depressed psychiatric patients, aged between 16-68. They found that the intervention at least temporarily improved the patients' moods and social interactions, enabled the subjects to partially express their impulses and feelings either through art or movement; and reversed the social isolation felt by the participants. However, this study also had serious research design limitations, including a small sample size, non-random assignment, short treatment duration, and a lack of follow up evaluation.

There are also a plethora of non-empirical descriptions expounding a variety of work using creative arts therapies combinations. It can also be seen that many of these interventions follow the principle of the various modalities supporting each other. For example, Kobak & Neinken (1984) used an integrated drama and poetry therapy intervention, where the poetry was used for projective means, and the drama aspect added "a visual or sensate perception and heightened emotional involvement" (p. 134). As well, Abell (1998) used a combination of poetry and play therapy, where the poetry was used to facilitate communication and to stimulate play.

Moreover, psychodrama tends to be frequently integrated with other creative arts therapies. For example, one creative arts therapist developed the integrated use of psychodrama and sandtray therapy ('sandrama'), in which the sandtray figures were used

as a warm-up to, and as auxiliaries for, the psychodrama (Toscani, 1998). J. J. Moreno, the son of psychodrama creator J. L. Moreno, incorporates the use of music therapy into psychodramatic practice. Moreno (1991) found that the incorporation of music into psychodrama (a) increases the level of empathy in scenes; (b) decreases the importance placed upon the verbal aspect of psychodrama; (c) helps to develop group sensitivity, rapport, and disclosure; (d) increases spontaneity; and (e) acts as a support system, if the music is matched with the individual's emotional state.

Art therapy, as well, tends to be a popular addition to integrated creative arts therapies approaches. For example, art therapy was combined with play therapy as a way of increasing self-esteem in young sexually abused girls. It was found that the girls demonstrated more compliant behaviour, more assertiveness, and less sleep disturbances following the intervention (Corder, Haizlip, & DeBoer, 1990). Potocek & Wilder (1989) also used an art and dance/movement integrated approach with men and women with substance abuse. The study used a qualitative case study method to describe the approaches benefits. Similarly, a case study design was used with a dance, music, and art therapies approach with a 51-year old woman with a developmental disability. The researchers found that the subject demonstrated significant gains in interpersonal relations, and experienced less social isolation (Zagelbaum & Rubino, 1991). In addition, Goldstein-Roca & Crisafulli (1994) described some level of success with a depressed, suicidal patient using an 'ICAT', or 'Integrated Creative Arts Therapies', approach combining verbal, poetry, music, and art therapies. Finally, children with divorce stress were administered a literatherapy, storytelling, play therapy, and art therapy approach, which also met with

some success (Ayalon & Flasher, 1993).

As well, drama therapy tends to be frequently incorporated as one element of integrative approaches. Johnson & Eicher (1990) describe their use of drama to stimulate dance/movement therapy work. They found that the dramatic activities provided the required structure needed to elicit images of patients' inner lives. As well, the use of drama helped to avoid the chaos or boredom adolescents would generally feel with respect to dance/movement therapy, as well as to increase group cohesion, all which resulted in a higher level participation and openness to the dance/movement therapy. Furthermore, playback theatre, which is considered by some to be a form of drama therapy (Scott, 2003), regularly incorporates the use of music into the dramatic performances. Playback theatre by nature emphasizes emotional reality, and the music is used to (a) evoke and depict feelings, (b) heighten the meaning and impact of the story, (c) create atmosphere, (d) assist in shaping the scene, and (e) convey emotional development of the story (Salas, 1992). Turner (1985), as well, described his use of an approach integrating psychodrama, theatre techniques, and role playing with students at risk of dropping out. Finally, Casson, Meekums, & Smith (1995) described the use of drama and dance therapy combined with psychodrama in the treatment of a difficult patient with obsessive, depressed, and delusional tendencies. Through the use of doubling, the genogram, the 4Fs, movement, therapeutic holding, storytelling, and participation in both drama therapy and dance therapy groups, the patient was described as experiencing a complete recovery.

Finally, art and drama therapy seem to be a frequent pairing when integrating creative arts therapies approaches. For example, Powell & Faherty (1990) used a group

therapy approach combining art therapy, puppets, and role play with sexually abused girls.

The goals of the intervention were to assist in strengthening the girls' egos, and although no concrete results were reported, the researchers claim that "[t]he combination of the creative arts therapies and group process promotes positive, empowering, and dramatically corrective resolutions in the treatment of sexually abused girls" (p. 47). A further integration of art and drama therapy used the performance model of drama therapy, and used 4 sessions with a large group to create and perform a piece.

Participants had the choice of either performing or creating art to be used as scenery (van Schaik, 1993, cited in Dokter, 1996). Steinhardt (1994), as well, combined the use of art therapy and puppets, and found that the two approaches worked symbiotically in the creation of stories. Finally, Harnden (1995) used a drama and art therapy approach with adults with eating disorders. She rationalized the intervention by claiming that both art therapy and drama therapy encourage expression, and that since drama therapy can be viewed as a confrontation with the self, and art therapy can be seen as exploration of the self, the two approaches are thus complementary and are a natural choice to be integrated.

Summary

In conclusion, based on the above exhaustive literature search, the following conclusions can be drawn:

1. Depression is a serious mental illness affecting contemporary society, and significant steps are needed to curb its serious effects;
2. Depression is highly co-morbid with other disorders, such as anxiety, conduct

- disorder, and suicidality, and results in significantly lowered self-esteem;
3. Depression has a high prevalence in adolescent females;
 4. Group therapy has been shown to be the most effective treatment approach with adolescents;
 5. Brief therapy has been demonstrated to be as effective as long-term therapy;
 6. Creative arts therapies, such as art and drama therapy, may be especially effective in treating depressed adolescents;
 7. Integrated creative arts therapies approaches are also effective in treating depressed adolescents; and
 8. There is a need for more empirical studies to empirically demonstrate the effectiveness of the creative arts therapies.

I have therefore based the current study on the above premises, with the realization that despite the trend in literature towards these conclusions, never before has an attempt been made to address these issues together. Thus, I propose a study that incorporates the use of a combined art and drama therapy intervention in treating a group of depressed adolescent females. Based on the literature search of comorbid symptoms, I have decided to examine the effects of this intervention not only upon the level of depressed mood, but also upon levels of self-esteem, anxiety, conduct disorder, suicidality, and global level of functioning. More specifically, I postulate that the study will demonstrate that the combined treatment approach will: (a) demonstrate its effectiveness with respect to working with 3 adolescent females; (b) result in a significant reduction in depressive, anxious, suicidal, and negative behavioural symptoms; and (c) result in an increase in

levels of self-esteem and global level of functioning. In the following, I will describe my research design and intervention.

Chapter 2 - Methodology

Introduction

This study was designed to assess the effectiveness of a combined art and drama therapy approach with respect to a number of measured variables. My intention is to demonstrate, through the use of a mixed methods approach, that this combined art and drama therapy approach can achieve positive results with depressed adolescents. Through manipulation of the independent variable, the integrated drama and art therapy treatment approach, I hope to effect positive change in the dependent variable (levels of depression, suicidality, self-esteem, anxiety, negative behaviours, and global functioning). That is, I will describe my usage of Emunah's (1994, 1996, 2000) developmental Integrative Five-Phase Model of drama therapy to structure the intervention, which incorporated the egalitarian use of drama therapy, art therapy, and psychodramatic techniques.

Participants

Participants of the study were 3 clinically depressed adolescent outpatient females, aged 15-17. The names of all clients, places, and other related identifying elements have been changed for confidentiality reasons. All participants completed a consent form at the start of sessions, which encapsulated all aspects of the research (Appendix A). A small age range was decided upon so that the clients would experience similar drives and sexual or social behaviours. As well, females in late adolescence were chosen, because they are typically, as Riley (1999) states, past the discomforting phase of bodily changes and total omnipotence. It has been demonstrated that this age group uses therapy as a decision

making tool and also to help solidify advances towards early adulthood (Riley).

Originally, 5 patients were referred to the psychiatric ward of a children's hospital in a large urban centre through admittance to the emergency room. The adolescents were then administered a family assessment by a team of mental health professionals, including a psychiatrist, a social worker, and a family therapist and art therapist. Two drama therapy interns and two art therapy interns also sat in on the family assessments. Following the assessments, if the adolescent was diagnosed with a clinical disorder, an appropriate referral was then made for treatment of the patient. In this case, since these patients were diagnosed with clinical depression and fit the required age range for the study, they were referred to the drama therapy and art therapy group for depressed adolescents.

The original group consisted of 5 adolescents, 1 male and 4 females, between the ages of 15 and 17. Attrition rate was 40%, or 2 of the original 5 clients. The first dropout, a 16-year old female, had severe social difficulties, and found the group therapy environment intolerable. She left the group halfway through the first session, and thus did not have a significant impact upon the themes or outcome of future sessions. The initial group also included one 16-year old male. However, he underwent significant stressors and changes outside of the group, which made his continued attendance impossible. He dropped out of the study after session 6. He thus had a significant impact upon the themes and events with respect to early sessions, although his attrition did not seem to noticeably affect later issues for other group members. However, his dropping out of the study can still be considered a limitation of the study.

Inclusion criteria for the subjects included: (a) falling within the appropriate

demographic categories, (b) presenting as depressed to the ER and to the assessment team, and/or (c) scoring as being clinically depressed according to the Beck Depression Inventory (BDI) and the Diagnostic Inventory Schedule for Children (DISC).

Validity

Due to the small sample size and lack of a control group, this study holds very little empirical validity. However, this study can still be seen to be a reasonable pilot study in that it can be given a more valid treatment with future testing. In addition, through triangulation of methods, or using both quantitative and qualitative measures, the internal validity of the study can be raised (Brannen, 1992). That is, through mixing both quantitative and qualitative approaches, it may be easier to rule out competing explanations for behaviour. Despite conflicting views on the validity and effects on results of methods triangulation, “the preponderance of judgment by experienced researchers is that it is worth . . . using multiple methods . . . to enhance the quality and credibility of findings” (Patton, 1990, p. 467). I have incorporated the use of mixed methods assuming the validity of the integration concept, which involves the

combining of research strategies as a means of examining the same research problem and hence of enhancing claims concerning the validity of the conclusions that could be reached about the data. . . . [T]he assumption [is] that the data generated by the two approaches, which [are] assumed to focus on the same research problem, [are] consistent with and [are] to be integrated with one another. (Brannen, pp. 12-13)

Through this form of methods triangulation, I hope to increase the internal validity of the study, and also to use the qualitative data to illuminate confusing quantitative data.

Specifically, whereas the quantitative portion of the study incorporated the use of valid measures (see below), the qualitative data is, by nature, more difficult to validate. According to Palys (1997), valid qualitative data requires the researcher(s) to become close with the research participants, in order to get to know them, to feel close with them, and to improve empathy for them. Similarly, Reason & Rowan (1997) claim that

[t]he primary strength of [qualitative] research, its fundamental claim to being a valid process, lies in its emphasis on personal encounter with experience and encounter with persons. . . . [A] research process which does not rest on experiential knowledge is not research about persons but hangs in a predicative void. (p. 242)

This principle was achieved through the use of the humanistic perspective, and through emphasis upon the in-session relationship between the therapists/researchers and the participants.

Further, both researchers took great pains to corroborate observations and personal analyses of the content of sessions in order to fulfil the assertion made by Reason & Rowan (1981) that valid “[e]xperiential research involves the joint encounter of co-researchers” (p. 242), and that “[t]he validity of research is much enhanced by the systematic use of feedback loops, and by going round the research cycle several times” (p. 247). Through constant inter-researcher checking and the embracement of multiple researcher viewpoints, perspectives, and perceptions, we hoped to increase the levels of

convergent and contextual validity, which enhances the overall validity of any particular piece of data (Reason & Rowan). However, the study did not incorporate member checking with the study's participants, which probably decreases the overall level of validity of the qualitative data of the study.

Measures

The current study incorporated the use of six measures to quantitatively assess levels of depression, conduct disorder, anxiety, suicidality, self-esteem, and global level of functioning. Three measures were clinician-administered structured interviews, and three measures were self-report questionnaires. The clinician-administered measures, in the order that they were administered, were: (a) The Spectrum of Suicidal Behavior Scale (Pfeffer, 1986); (b) The Children's Global Assessment Scale (CGAS; Shaffer, et al., 1983); and (c) The Diagnostic Interview Schedule for Children (DISC 2.25; Costello, Edelbrock, Dulcan, Kalas, & Klaric, 1984). The three self-report measures, in the order that they were administered, were: (a) The Beck Anxiety Inventory (BAI; Steer & Beck, 1997); (b) The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961); and (c) The Rosenberg Self-Esteem Scale (RSE; Fischer & Corcoran, 1994).

The Spectrum of Suicidal Behavior Scale.

The Spectrum of Suicidal Behavior Scale (Pfeffer, 1986) is a brief, semi-structured, clinician-administered outcome measure that assesses the level of suicidality in

the individual. The assessment was rated using a 5-point Likert scale of increasing severity: 1) Non-suicidal; 2) Suicidal ideation, or thoughts or verbalization of suicidal intention; 3) Suicidal threat, or verbalization of intention to attempt suicide; 4) Mild attempt, or a non-serious act of self-harm which would not conceivably result in loss of life, which may or may not be associated with suicidal thoughts; and 5) Serious attempt, or an actual serious attempt at taking one's own life. Information was gained with respect to the adolescent's status over the past 3 months. Inter-rater reliability for the scale was found to be significant ($K=.55$, $p<.0001$, $N\geq 69$) (Pfeffer et al., 1991).

The Children's Global Assessment Scale (CGAS).

Shaffer et al. (1983) devised this short semi-structured interview to assess the most impaired level of functioning of children and adolescents. Questions asked dealt with such areas as level of functioning with respect to family, friends, school, hobbies, career goals, relationships, eating, sleeping, drugs and alcohol use, police involvement, and mood. The adolescents were then rated along a 100-point scale, ranging from 1, the most impaired, which reflects that the adolescent '[n]eeds constant supervision (24-hour care)', to 100, the healthiest, which reflects that the adolescent has '[s]uperior functioning in all areas'. Information was gained with respect to the adolescent's status over the past month. Inter-rater reliability was found to be .83, suggesting a 95% probability that the rating was within 7.5 points of the 'true' rating. As well, concurrent validity for the CGAS was found by running Pearson correlations between CGAS scores and Total Scores on the Parent Child Behavior Checklist, which found current and 6 month correlations to be .58

and .57, respectively (Kymissis et al., 1993).

The Diagnostic Interview Schedule for Children (DISC 2.25).

This measure, devised by Costello et al. (1984), is a standardized, structured interview used to aid in a variety of clinical diagnoses, based on the criteria found in the *DSM-III-R* (1987). Only the sections devoted to assessing depression and conduct disorder were used in this study. Information dealt with the adolescent's status over the past year. A computer algorithm applied to the DISC responses was used to determine diagnoses. Inter-rater reliability testing found internal consistency to be between .80 and .90 for depression, and above .60 for conduct disorder (Breton, Bergeron, Valla, Berthiaume, & St-Georges, 1998).

The Beck Anxiety Inventory (BAI).

Steer & Beck (1997) devised this scale in order to determine levels of anxiety in individuals, as discriminated from depression, while still demonstrating convergent validity. This brief, 21-item self-report questionnaire rated the level of anxiety through assessing severity of anxious symptoms. To rate severity of symptoms, the BAI used a Likert-scale ranging from 0, 'Not at All', to 3, 'Severely'. Possible scores range from 0 to 63. Levels of anxiety were rated to be:

05-09 Considered average level of anxiety

10-18 Mild to moderate anxiety

19-29 Moderate to severe anxiety

30-63 Severe anxiety

Scores below 04 were considered below normal, and thus indicative of denial or faking; scores above 40 were indicative of exaggeration, although significant levels of anxiety were still possible. The scale has obtained a range of reliability ratings, including an internal consistency and an item-total correlation ranging from .30 to .71, and achieved a test-retest reliability score of .75. The BAI also obtained a significant level of validity when compared with a variety of self-report and clinician-administered anxiety scales, ranging from .25 to .51. As well, the BAI was ascertained to possess convergent and discriminant validity to differentiate between homogeneous and heterogeneous diagnostic groups (Nova Southeastern University, 2002).

The Beck Depression Inventory (BDI).

This measure, devised by Beck et al. (1961), was used in this study to further assess levels of depression. This instrument is a self-administered 21-item self-report questionnaire, which rates the level of depression through assessing the severity of behavioural manifestations of depression, including disruptions in mood, satisfaction levels, weight, sleep, motor, fatigue, guilt, concentration, and suicidal ideation. To rate severity of symptoms, the BDI uses a Likert-scale ranging from 0, no or minimal symptoms, to 3, severe symptoms. If more than one score was chosen on any given question, only the highest given score was factored. Possible scores range from 0 to 63. Levels of depression were rated to be:

05-09 These ups and downs are considered normal

10-19 Mild to moderate depression

19-30 Moderate to severe depression

30-64 Severe depression

Scores below 04 were considered below normal, and thus indicative of denial or faking; scores above 40 were indicative of exaggeration, although significant levels of depression were still possible. A great deal of research has been done demonstrating the validity and reliability of the BDI. Internal consistency has been found to range between .73 and .95 with a variety of populations, and has a specific consistency rating of .80 for major depressive disorder, single episode, and .86 for major depressive disorder, recurrent episode (American Psychiatric Association, 2000b). Despite Beck et al.'s resistance to test-retest reliability due to complications created through memory, Groth-Marnat (1990) found that reliabilities ranged between .48 and .86 (University of Melbourne, 2002). The BDI also has a high correlation with clinical ratings, ranging from .55 to .96.

Furthermore, the BDI has moderate to high correlations with other measures of depression, including .73 with the Hamilton Rating Scale for Depression (Ham-D), .76 with the Zung Self Reported Depression Scale (Zung SDS), .76 with the Minnesota Multiphasic Personality Inventory Depression Scale (MMPI-D) (University of Melbourne), .76 with the Symptom Checklist-90 (SCL-90), and .60 with the Beck Hopelessness Scale (BHS) (American Psychiatric Association).

The Rosenberg Self-Esteem Scale (RSE).

This scale, devised by Fischer & Corcoran (1994), is a 10-item self-report scale

intended to assess level of self-esteem in high school students. The RSE has displayed an internal consistency of .92, demonstrating a high level of reproducibility. As well, test-retest reliability has proven to range from .85 to .88.

Treatment

Treatment consisted of 12 90-minute long group therapy sessions, occurring on a weekly outpatient basis, which has been suggested as the most appropriate and beneficial for the adolescent population. (Riley, 1999) Each session consisted of approximately one-half drama therapy interventions, and approximately one-half art therapy interventions. A considerable amount of verbal therapy and counselling interventions were also utilized in the approach. The researchers/therapists attempted to follow a specific pre-designed treatment plan, while also accounting for the needs of the clients being treated.

Study Design

The present study was conceptualized as a mixed methods design. The quantitative portion of the study can be classified as quasi-experimental, in that the subjects have not been randomly assigned, and also because there is no between group comparison, due to the lack of a control group. As well, the current study follows a double-blind structure, in that the trained research assistant used was blind to the details of treatment, and the participants used were also blind, in that they were not informed as to the details of the hypotheses or goals of the study. The research assistant administered three clinician-administered interviews, and three self-report questionnaires. A

professional trained the research assistant to properly administer the measurements. Moreover, the research assistant was responsible for arranging individual assessment meetings with each subject. Each one-on-one assessment meeting ranged between 60 and 90 minutes, after which the research assistant scored the instruments accordingly. Assessment measures were administered in a structured, replicable manner to avoid bias or confounds. Pre-test assessments were conducted 1 week before the introduction of the treatment to obtain baseline measures, and the post-test meetings occurred 1 week after treatment termination. Inter-rater reliability is not applicable for this study, since the measures used required no interpretation. As well, the same research assistant was used for both pre- and post-tests for all three subjects. Interviews were administered first, in the order of the shortest to the longest in terms of administering time. These interviews assessed such areas as level of suicidality, friends, school functioning, hobbies, family relations, criminal activity, and long term goals. After the interviews were administered, the participant was then asked to fill out the self-report questionnaires, which measured levels of anxiety, depression, and self esteem, respectively. The specific assessment measures were chosen not only for their valid measurement of desired variables, but also because of a short administering time, thereby decreasing, although not eliminating, the effects of any fatigue factor.

The qualitative data included in this study was obtained through painstakingly coding and summarizing in-depth notes and discussion by the co-researchers following every session. These notes were based on detailed observations of each session made by the two researchers. Although the researchers did not engage in member checking with

research participants, both researchers corroborated the data from each session. As well, both researchers included and discussed their personal counter-transference and perspectives with respect to the qualitative data, in an attempt to achieve “polyocularity” (Reason & Rowan, 1981, p. 250) and thus improve validity. The qualitative data was analyzed with respect to similar variables as those examined through the quantitative data; that is, the qualitative data also examined the effects of the intervention upon levels of depression, anxiety, negative behaviours, self-esteem, suicidality, and global level of functioning. However, the addition of qualitative inquiry also allowed for hidden meanings and patterns of behaviour to be emphasized.

Chapter 3 – Procedure

Integrated Drama and Art Therapy Intervention

The two therapies used in this study were “employed either sequentially or simultaneously within a give therapy session. One modality [was] not subordinate to the other” (Grodner et al., 1982). The integrated drama and art therapy approach used for this study was based upon the Integrative Five Phase Model of drama therapy, as outlined by Emunah (1994, 1996, 2000). This model follows a developmental framework with respect to dramatic ability and openness to personal insight, and begins with the earliest developmental capacity, dramatic play, and moves through increasing levels of difficulty and ability. Emunah herself views her theory as more organic than do many of the drama therapists who use the model, and she asserts that the stages overlap and the boundaries between each phase are blurred (Emunah, 1994). The Integrative Five Phase Model is a very comprehensive theory, and encapsulates many of the processes and concepts created or used by other theorists. It is easy to see the natural progression of Emunah’s Five Phases, which parallels the progression of the level of trust and dramatic ability within the group with the clients’ level of introspection and depth and intensity of the work.

Phase One, *Dramatic Play*, is the foundation for the work to follow. This phase centres on fostering a sense of community, interaction, cohesion, and playfulness. Fundamental to the first Phase are the ideas of trust and spontaneity, which are both seen as imperative for the development of the therapeutic process. Trust is essential for

acceptance of oneself, of other group members, and of the therapist, and out of trust develops group cohesiveness. Spontaneity is the primary component of improvisation, which is, for Emunah, the most useful method of acting in drama therapy (1994). As well, spontaneity and trust result in social interaction, which is typically one of the fundamental goals of drama therapy. Throughout the Dramatic Play phase, the therapist can come to understand, through the client's use of projection and general dramatic capabilities, the client's issues and therapeutic needs. In essence, Phase One attempts to help the client recapture the feeling of childhood play (Emunah, 1994). Phase One can be seen to overlap some basic tenets of play therapy (e.g. Axline, 1955/1994; 1964; Freud, 1946/1994; Klein, 1948/1994), which is also seen as therapeutically useful with respect to its concentration on building interrelationships and individual strengths. However, Phase One is too indirect for brief therapy, and is used more as a building block for future work (Emunah, 1996). Therefore, we chose to use Phase One work as more of a springboard to the main therapeutic action, as opposed to a therapeutic process in and of itself.

Emunah's Phase Two, called *Scenework*, proceeds naturally from Dramatic Play, and incorporates the use of sustained improvisational dramatic scenes. This work is almost entirely of a fictional nature, and "involves playing roles other than those reflecting one's own life" (Emunah, 1994, p. 37). This is because of the largely distanced and projective nature of Phase Two, where the client experiences the paradox of the "me and not-me" (e.g., Landy, 2000, p. 59). Since the client can play roles seemingly unrelated to his or her life, they perceive themselves to be safely distanced, which results in greater risk

taking, since there is not necessarily any risk of self-disclosure. Thus, a client may, in role, express emotions and/or behaviours infrequently or never before expressed in their real lives. Eventually the client will begin to comment on these new emotions and/or behaviours, and will typically voice surprise at the expression. Furthermore, in Phase Two, the group members acting as the audience or ‘witnesses’ become more engaged and possibly express cathartic emotions in response to scenes, much like those released in response to a movie. The end of Phase Two is marked by the clients’ dissolution of safeguards, allowing “what is exposed [to] be *consciously* tolerated and integrated” (Emunah, 1994, p. 38). Therefore, Phase Two is used to help the client in expanding their role repertoire and in creating a sense of permission and possibility. However, like Phase One, Phase Two is also too indirect for brief therapy (Emunah, 1996), and we chose also to use this more as a building block for the main psychodramatic enactment of Phase Three.

During Phase Three, entitled *Role Play*, the improvisational enactments shift from being imaginary to depicting events and people in the clients’ real lives. This phase uses aspects of psychodrama and sociodrama to deal with the here-and-now in terms of situations, conflicts, problems, and relationships in the clients’ lives. In these enactments, the client can play both themselves and others in their lives. A fundamental aspect of Phase Three is the use of “rehearsal for life” (Emunah, 1994, p. 39). The work in Phase Three is predominantly behavioural, and, as a result, clients come to gain a deeper understanding of the patterns of the roles they play in everyday life. A typical

characteristic of Phase Three is instilling in clients the hope for possible change in the future (Emunah).

Phase Four of Emunah's Integrative Five Phase Model of drama therapy, subtitled *Culminating Enactment*, is characterized by the shift from here-and-now issues to an examination of deeper or 'core' client issues. The client has become more aware of their life role patterns in Phase Three, and now the work goes deeper, with the objective of achieving emotional catharsis, insight, and empathy and compassion (Emunah, 2000). The issues dealt with in Phase Four are predominantly those that have been revealed in the previous three phases. Sharing of personal issues, personal insight, and group trust and containment are intensified during the Culminating Enactment phase. Work done in Phase Four places emphasis upon psychodramatic scenes and techniques, and acts as a climactic point in the therapeutic process and in the development of the group (Emunah, 1994). However, since Phase Four involves deepening the level of catharsis, insight, and intimacy in the client, and also is largely dependent upon the emotional readiness of the group, it is thus beyond the realm of brief therapy (Emunah, 1996).

In the fifth and final phase, *Dramatic Ritual*, the clients are faced with closure, transition, and termination of therapy and the emotions surrounding this. Phase Five is primarily concerned with "facilitating the integration and assimilation of the therapeutic progress made in the preceding phases" (Emunah, 1994, p. 43). That is, through the ritual process, a developmental process in itself, the client learns to internalize the therapeutic process, and to extrapolate this into their everyday lives outside of the therapeutic space. By the end of the therapeutic process, there hasn't necessarily been a resolution of issues,

but the client may recognize the process, how it can be transferred over into everyday reality, and how to make this transition. The Dramatic Ritual allows the client to reflect upon his or her experiences, and acts as a frame for the entire therapeutic process. Phase Five inculcates the client with a sense of hope for the future and demonstrates how the therapeutic process can continue outside and beyond therapy (Emunah, 1994). However, since Phase Five is essentially a culmination of the other 4 phases, it was thus not applicable to the main intervention. It was, however, used to structure ending rituals, as well as to provide closure to the entire intervention.

This model was used to structure the intervention on microcosmic, or sessional, as well as on macrocosmic, or interventional, levels. As well, according to my suggestions above based on Grainger's work with people with depression (1990; 1991, cited in Dokter, 1996) we chose to incorporate a large verbal component into the intervention. Thus, the therapeutic focus would then alternate between cognitive, or language-based, and pre-cognitive, or emotional, structures. As Kymissis et al. (1996) state:

The adolescent is struggling around self-expression and peer interaction, the combination of art and group therapy would be particularly effective with this population. In groups where non-verbal and verbal techniques are combined, adolescents become involved sooner and their interaction can be greatly facilitated.

(p. 46)

This intervention was structured according to the suggestion of Emunah (1996) that Phase 3 is the most appropriate Phase for brief therapy. This is because, since Phase 3 gets directly to problematic issues without the use of metaphor (Phase 2), which would

require a longer intervention period, or without getting too intense (Phase 4), which would require a more cohesive group. This being only a 12 week intervention, we felt that this was the most appropriate phase to primarily work within, but also using Phase 1 and 2 as warm-ups to Phase 3, and using Phase 5 (closure) at the end of sessions and at the end of the intervention.

The planned intervention focused on the main curative factors of group therapy for adolescents, as outlined by Kymissis et al. (1996, based upon Yalom, 1970). The first curative factor, group cohesion, was focused on through the use of many dramatic and artistic activities. The intention was that through the act of playing and working together, the members of the group would learn to find a level of attraction for one another, making working together a more pleasant and productive experience. The importance of group cohesion in adolescent therapy takes precedence over other, more traditional rules of group therapy. For example, Yalom (1970) outlines specific rules for the group therapy contract, including the members refraining from social contact with one another outside of the group. However, as Riley (1999) states, “[a]n adolescent group that talks on the phone to each other, or plans to continue their association after group is terminated, *is a great success*” (pp. 77-78). Furthermore, Riley outlines criteria used for assessing the level of adolescent group cohesion: (a) whether there are enough members present to constitute a group; (b) if members come to group most of the time; (c) if the group talks to one another in the waiting room, which demonstrates that they are not afraid to be together; (d) if they continue to talk in therapy room, which displays that they have normalized the clinical environment; (e) if members start the art or drama right away,

which affirms that the therapy is comfortable; and (f) if the members acknowledge the therapists' presence, then they are not being rejected as an adult authority.

Interpersonal learning, the second curative factor outlined by Yalom (1970) was highly focused on through the use of verbal therapy. As well, we chose to emphasize the use of transparency, which involved the therapists being completely open with respect to their feelings about members of the group (e.g. Bruch, 1974). This was undertaken with the suggestion by Little (1986), who states that therapist transparency helps to further insight in the client. Through imitation, the members of the group would also learn this technique, providing a heightened level of insight about their effect upon others, which would thus provide an adaptive spiral of interpersonal learning.

The interpersonal learning process is similar to the third curative factor, recapitulating the primary family group, which was emphasized through the use of transparency, boundaries, and psychodrama. The group can act as a surrogate family, and can act as a microcosm for behaviour within the family group (e.g. Little, 1986). Through transparency and verbal interventions, the members can eventually achieve insight with respect to their maladaptive behaviours, which can then be fit within the therapeutic boundaries of the group. Attention is drawn to behaviours that stray from the rules or structure of the group, which can then be transformed into more adaptive ways of behaving. This process can be furthered through the use of psychodrama, which would have a heavy focus upon enacting familial relationships and experiences, and would provide more direct means of altering and rehearsing new behaviours with the family. Since a fundamental task of adolescent development is for youth to individuate and

successfully complete the process of separation from the family of origin (Riley, 1999), it was deemed important to place heavy emphasis upon familial relations.

The process of interpersonal learning and recapitulating the primary family group was also improved upon through the use of psychodramatic methods such as mirroring of behaviour (e.g. Karp et al., 1998; Starr, 1977). Furthermore, through verbal interventions and participating as auxiliaries in psychodramas, the aspect of universality, the fourth curative factor, would be emphasized. That is, through verbal discussion of problems, we intended to utilize the universality principle to stimulate and further discussion. Through discussion of the experiences of others in the group, it was hoped that each members' feelings of aloneness would be diminished. It was hoped that through universalizing or differentiating their plight, clients may experience a regeneration of self-esteem (Little, 1986). As well, through participating in the psychodramas of others, it was hoped that members would witness the experiences of others, which would also diminish the feeling of solitude. The final group factor that was to be emphasized, catharsis, was to be accomplished through the use of psychodrama, which has the ability to provide intense emotional release.

The specific overall goals of the group were as follows:

1. To build a sense of belongingness and community.
2. To decrease sense of isolation and solitude.
3. To build empathy for one another.
4. To provide a space to express emotions through drama and art.
5. To improve confidence in personal strengths.

6. To structure more adaptive patterns of thought.
7. To facilitate creative expression.
8. To work through life issues in a contained environment.

These goals were specifically designed to reduce depressive, anxious, suicidal, and negative behavioural symptoms, as well as to increase self-esteem and global level of functioning. The first goal, building a sense of belongingness and community, was designed in order to effect change through improving group cohesion. As I have already said, group cohesion is essential for providing an environment conducive to the healing process. As well, experiencing a sense of belongingness may be essential in improving self-esteem and in decreasing socially stimulated anxious symptoms. This goal is also similar to the second goal, decreasing the sense of isolation and solitude, which also addresses group cohesion and universality. Likewise, the third goal, building empathy for one another, will also contribute to group cohesion, as well as improve interpersonal learning and universality. The fourth goal deals with the creative expression of catharsis through the modalities of drama and art. The fifth goal, improving confidence in personal strengths, was specifically designed to improve self-esteem. The sixth goal, structuring more adaptive patterns of thought, involves the emphasis upon cognitive and verbal aspects. Through altering maladaptive thought patterns, it was intended that this would result in the desired change in symptoms. The seventh goal, facilitating creative expression, was designed with the fundamental premise of the creative arts therapies in mind – namely that creativity is essential for healing (e.g. Catttanach, 1996; Emunah, 1994; Jennings & Gersie, 1987; Johnson, 1982; Landy, 1986; Moon, 1998). The final

goal, to work through life issues in a contained environment, was designed in order to structure the focus of sessions, as well as to ensure the structure and safety necessary for adolescent therapy. We specifically designed the goals of the intervention to address the five primary curative factors in adolescent group therapy: (a) group cohesion, (b) interpersonal learning, (c) recapitulating the family group, (d) universality, and (e) catharsis. We have focused on these with the intention that through the participants achieving these factors, they will experience the intended effect upon depression, anxiety, suicidality, self-esteem, and conduct disorder symptoms and will experience a general increase in functioning.

In structuring and planning the integrated approach, we attempted to choose interventions that were productive and responsive specifically to the needs of depressed adolescents (Zagelbaum & Rubino, 1991). For example, much literature on working with adolescents emphasizes the need for structure (Jennings & Gersie, 1987; Riley, 1999; Tibbetts & Stone, 1990). Corder & Whiteside (1990) state that therapists use structured techniques in order to assist clients' ability to cope with high anxiety, prolonged silences, and ego-dystonic feelings. The affinity for structure in adolescents was demonstrated in a study conducted by Sandel & Johnson (1974), where adolescents participating in a combined drama and dance therapy approach reported greater satisfaction for the drama therapy intervention, due to the more differentiated task and role structures provided by drama therapy. It was found that articulation of a unique role provides adolescents with the autonomy and structure needed to protect selves from threats to identity.

Furthermore, Johnson & Eicher (1990) found that if roles or tasks are highly

structured, the adolescent's needs for autonomy and physical release were more precisely addressed. Thus, to account for this need, we incorporated the use of an opening and a closing ritual, to provide a set structure to each session. The security and safety provided by the ritual, which is required by adolescents in order to participate in the process, may also possibly help to facilitate a positive outcome. As well, it is important in working with adolescents to provide the space for them to express their issues and emotions if they so desire. Thus, we opened each session with a 'check-in' ritual, where a candle was passed around the circle. As each individual held the candle, it was their opportunity to hold the focus and attention of the group, and to express anything about their emotional or mental state that they wished. This ritual may, as well, address the universality principle, in that individuals were given an opportunity to hear the emotional states of others, which gave them allowance to express their own emotional states.

Each session began in Phase 1 or 2 (Emunah, 1994; 1996), which involved the use of a warm-up. This act of playing together worked to improve upon the overall level of group cohesion. As well, warm-ups often also acted as assessment tools to structure the focus of the session. Early sessions incorporated the use of introductory games, such as name games (e.g. Corder & Whiteside, 1990). These were also structured to be energizing, such as Take-the-Spot name games where individuals move to the places of the individuals' names they call, or cognitive, such as Name Alliteration, where individuals invent an alliterative adjective for their name, and also attempt to remember others'. Other warm-ups often focused upon emotional expression, which was a goal of the group. For example, one activity involved assigning a colour to their current emotional state.

Another activity involved sculpting another group member to embody their current emotional state, which also greatly increased group cohesion. Other emotion-based warm-up activities included the use of an emotional machine, and sound and movement circles, which involve the improvisational and projective use of sound and movement to express emotions (Emunah, 1994). As well, activation warm-ups, such as tag-like games, were used to counteract the fatigue often felt by the group, which is a symptom of depression (*DSM-IV-TR*, 2000).

A final warm-up exercise included in the intervention was trust falls (Emunah, 1994), which were utilized in order to assess and improve the overall level of trust and cohesion amongst group members. It was felt that this activity was essential to this process since, as Riley (1999) states, the primary goal in the establishment of an adolescent group is the establishment of trust. Trust falls “take the form of highly structured exercises designed to challenge our preconceived ideas, prejudices and assumptions about ourselves and others and provide opportunities for people to take risks and build trust” (Stephenson, 1993, p. 175). Using explicit rules, a client lets herself fall backwards and are caught by another group member. The inherent vulnerability felt by clients in this situation, coupled with the concrete support from others, helps to build trust and to contribute to group cohesion.

Following the warm-up phase, we often incorporated the use of art-based assessment activities that could also be used dramatically. Three main assessment activities were used over the course of the 12-week intervention, which were ordered according to the level of difficulty with respect to disclosure and expression. The first

assessment used, which was utilized early in the intervention, was the 6-Part Storymaking Assessment (Lahad, 1992). This assessment was used early in the intervention, since it is primarily metaphorical, which provides the safety necessary for adolescents to participate before group cohesion is achieved. In this assessment, members were asked to draw 6 pictures of designated subjects, which then told a complete story. The 6-Part Storymaking Assessment was conceptualised to assess the coping strategies of the individual. The sections and instructions were as follows:

1. The Protagonist; 'who or what is the story about?'
2. The Mission; 'what are they trying to accomplish?'
3. The Helper; 'who or what will help the protagonist accomplish their mission?'
4. The Obstacle; 'who or what is standing in their way?'
5. The Coping Method; 'how do they overcome the obstacle?'
6. The Ending; 'what happens next?'

Through producing these 6 drawings, the Lahad assessment gives insight as to specific life issues, as well as coping strategies for overcoming obstacles and difficulties. This story can then be utilized in the context of Phase 2, and can be dramatized in role play. Through enacting and embodying their stories, further personal insight can be provided.

The second assessment activity used was a variation of the Personal Shield, devised by Cattanaach (1994). Like the 6-Part Storymaking Assessment, the Personal Shield also involves 6 drawings, although not to tell a story. Members were asked to draw the outline of a shield, and to divide it into 6 sections. Each section incorporated a

drawing response to a question. The questions were as follows:

1. What is the best thing that has ever happened to you?
2. What is the best thing that has ever happened to your family?
3. What is the worst thing that has ever happened to you?
4. What do you want most from other people, not your family, but people your own age?
5. If you had all of the money in the world, what would you do with it?
6. What are three things that you would like people to say about you, whether or not they're true?

This activity is used to assess current emotional states, and also to provide an impetus for discussion and work for that session. As well, the activity emphasizes the universality factor, in that witnessing the shields of others can counteract feelings of aloneness. If significant stories are raised in the sharing of the shield, they can then be dramatized through role play.

The third assessment used, the Kinetic Family Drawing (Burns & Kaufman, 1972), involved the group members drawing a picture of them doing something with their family. This was used to help the researchers to understand the clients' perceptions of themselves and their familial relationships. The family drawing is done using movement, as it helps the adolescent to depict relationships, emotions and attitudes more effectively. From this picture, the intention is to infer psychopathology and family psychodynamics. The Kinetic Family Drawing uses family systems theory, which promotes the idea that the individual is a system in him or herself, which is within the family system, which in turn falls within the

community system, and so on. Thus, family systems theory expounds the concept that change in one system affects change in all other systems (Taylor, Kymissis, & Pressman, 1998). As well, the Kinetic Family Drawing is thought to reflect emotional disturbances faster than interviews (Burns & Kaufman, 1972), and has been shown to distinguish between low and high self esteem (Elin & Nucho, 1979). The Kinetic Family Drawing was originally conceptualised to measure actions, or rather movement or energy reflected in various figures; the style of drawing, which analysed how the figures are organized on the page, which was purported to indicate emotional disturbance; the use of symbols in the drawings; and the size of and distance between drawn figures. This study did not apply, however, these levels of analysis; instead, it was only used as an assessment for familial issues for use in session. The Kinetic Family Drawing, after being verbally processed, can then be brought into Phase 3, or psychodramatic, action.

Psychodrama was utilized as one primary tool for the main action phases in this intervention. The rationale for this use was that it is the most effective in brief therapy (Emunah, 1996), and that it assists in decreasing depression and anxiety, and in increasing self-esteem (Kellerman, 1987). Psychodrama involves the enactment of real life, which bridges the gap between real life and therapy. Through working in this method, clients were provided the opportunity to intentionally duplicate, replay, or preview their real lives in the therapeutic setting (Emunah, 1996). In addition, the psychodramatic process assists the adolescent in self-disclosure, a process that they may feel particularly uncomfortable with (Emunah, 1994). Furthermore, adolescent role play tends to involve themselves or their family, and even fictional scenes tend to be re-enactments of actual events or versions

of actual events (Johnson & Eicher, 1990). Therefore, since adolescents are best engaged by realistic enactments of things that pertain to their real lives, psychodrama would be the most appropriate intervention for adolescents. Psychodrama was also chosen as a primary method of working, since it involves the fluid oscillation between verbal discourse and dramatic processes (Eminah, 1996), which equates with our initial goals with respect to a method of working.

In terms of the specific psychodramatic interventions made, we used “the three-layered cake” (Karp et al., 1998, p. 207), which refers to the three techniques of doubling, role reversal and the mirror technique. The first technique, doubling, is referred to as the “heart of psychodrama” (Blatner, 1973, cited in Karp et al., p. 209).

The double is a helper (called an auxilliary) who sits or stands next to the client (called a protagonist) and takes on the same posture, mannerisms, indeed becomes the protagonist. A double speaks as “I”, trying to get in touch with the subconscious material. There are many forms of doubling including contrary doubling (where the double says the opposite to what the client is saying) but the technique is particularly valuable in providing a frightened, lonely, misunderstood client with a supportive, empathic witness who enters the person’s inner world and enables her to find a voice. I see this technique as providing . . . an advocate: a supportive witness, validating the person’s experience and enabling her to own that experience. The double may initially be able to voice the unspeakable. (Casson et al., 1995, p. 3)

The process of doubling, which requires significant sensitivity, empathy, and

understanding of countertransference (Karp et al.), is especially useful when working with depressed patients. People experiencing depression may have difficulty in communicating their needs, wishes, feelings, or thoughts, and thus a double can be used to assist the client in identifying and expressing an emotion. Through the double joining the client's mood, the origin of the mood is uncovered which helps to create a change in the patient's attitude toward the problem. In fact, the double method was found to significantly improve the rate and duration of verbal expressions of extremely withdrawn hospitalized patients (Goldstein, 1971). Moreover, doubling is also useful in that it can be used to help a client to feel understood, to interrupt hiding or avoidance techniques, to allow patients to experience catharsis, to expand the issues surrounding a problem, to open up communication with the therapist and group, to help the patient expose their feelings with respect to their issues, as well as being a useful method of searching for underlying causes of behaviour (Starr, 1977).

The second psychodramatic technique used, role reversal, is known as the "engine of psychodrama" (Karp et al., 1998, p. 211), and is an essential tool to understand the client's perception of his or her relationships. Role reversal involves the protagonist and an auxiliary exchanging places and roles. This process requires a strong ego, since the individual must possess an adequate self-perception in order to experience portraying another. Role reversal allows the opportunity to view a situation from outside of oneself, and specifically to view oneself from the perspective of another. Role reversal is used to gain information, to understand the role of the other, to heighten spontaneity, to develop a new role, and to clarify the projection of feelings into significant others (Karp et al.).

The third and final technique used, mirroring, is related to role reversal in that it involves an auxiliary taking the role of the protagonist. However, instead of the protagonist assuming the role of an auxiliary, as in role reversal, the protagonist sits out of the action to witness their behaviours and others' perceptions of them. This technique is useful for arousing a client and providing insight as to his or her maladaptive behaviour patterns. The auxiliary ego carefully re-enacts the maladaptive response or behaviour in a series of situations experienced by the patient and the group in order to offer insight to the protagonist (Starr, 1977).

A further activity used in the integrated drama and art therapy approach was the use of a group mural. This was used close to the end of the intervention, in order to assess the level of cohesion felt by the group. As well, group murals are useful for clients who are unwilling or are unable to communicate verbally. Furthermore, acceptance of the art in a group mural leads to self-acceptance. Finally, group murals are purported to assist in dispelling family myths, uncovering denied scapegoating, and providing distance from disturbing thoughts and feelings (Levick, 2001).

Closing activities were also an important portion of the therapeutic process. These were used to provide closure both to individual sessions, as well as the intervention as a whole. Each session ended with a structured closing ritual, which worked to further the structure needed by adolescents, as well as to provide the opportunity to reflect upon the session. This was done through the use of the Magic Box, which is a means of symbolically containing what has taken place in the session. An imaginary box is 'brought down' into the centre of the room from the ceiling, and members put in an unpleasant

element, feeling, experience, sensation, insight, fear, or wish that they would like to not take with them. Following this, they would then take out another, pleasant element from the box that they possessed. The box was then closed and stored safely in the ceiling (Emunah, 1994). Following the Magic Box, the group made use of a hand pulse, which involved the group holding hands in a circle and squeezing another's hand so that it travels as if an electrical pulse around the circle. This activity was designed to further and solidify any steps that the group had taken towards group cohesion.

With respect to closure activities for the entire intervention, we attempted to choose activities that support the integration and closure of the creative arts therapy intervention. For example, one closure activity used was the re-enactment of real-life scenes from the therapeutic process. That is, the clients and therapists would enact a significant event that he or she remembered occurring over the 12 sessions. This provided an opportunity for the clients to reflect upon the therapeutic process using a dramatic form, and to assimilate any therapeutic progress. As well, it provided the therapists an assessment tool of which events were significant to the clients in the process. Another closure activity used was that of gift giving (Weiner, 1997), where an individual 'gives' an imaginary gift to another. Clients were instructed to bestow each other group member with a present that they felt to be what the other needs most. This is an activity designed to solidify cohesiveness, in that the receiver feels cared for and heard by other members. In addition, only positive presents could be given, which increases empathy, compassion, and thoughtfulness on the part of the giver. As well, gift giving provides a degree of interpersonal learning, in that the receiver of the present gains insight as to how others'

perceive their needs.

In conclusion, the integrated drama and art therapy approach was designed using Emunah's Integrative Five Phase Model of drama therapy, focusing primarily on Phase Three, psychodramatic enactment. As well, a variety of dramatic and art-based activities were included to act as assessment tools, warm-ups, and closure to the therapeutic process.

Chapter 4 - Case Studies

Client 1 - Allison

History

Allison is a 15-year old female who lives with her parents. Presenting problems include depression, mild suicidal attempts, anxiety over parental issues, and panic attacks. Allison's family has a history of psychiatric disorders, including her paternal great uncle who was diagnosed with depression, her maternal aunt who had an anxiety disorder, and her mother's cousin who suffers from paranoid schizophrenia. Her mother, as well suffers from a substance abuse disorder, as well as clinical depression, for which she has used medication for the past 8 years. Allison has a history of suicidal attempts, and claims to have experienced depression, fatigue, and hopelessness since grade 4. She also suffers from occasional panic attacks between 1 and 5 times a month.

Allison claims to have friends that she can confide in, although she also expresses anxiety with respect to burdening them with her problems. Just prior to treatment, Allison broke up with an emotionally abusive boyfriend of 1 ½ year duration, and expresses little or no sadness over this, claiming that it was 'for the best'. Allison does very well at school, and is involved with school activities. However, her marks have recently fallen slightly, for which she expresses great disappointment. Despite her success at school, she describes school as 'awful', and claims that it is the primary source of her suicidal ideation. Allison changed schools just after treatment began, which seemed to improve her affect.

Allison's parents have recently reunited following a brief separation. Allison's

mother has been attending Alcoholics Anonymous for the past 2 years, battling a chronic abuse disorder, for which she expresses guilt and regret due to her inability to be emotionally available or provide appropriate role modelling for Allison. In addition, Allison faces great stressors with respect to parental conflict and separation, for which she acts as a mediator. Allison and her mother describe Allison's father as being emotionally closed.

At referral, Allison had been seen individually by a psychologist four times, but asserted that psychotherapy had no effect. Further, she is currently on Prozac, which she feels has not helped either. At the intake assessment, Allison had some superficial cutting on her left wrist, which was the latest in a history of suicidal attempts. Allison was originally referred to the emergency room for swallowing 16 ibuprofen pills, immediately after which she told her mother. She denies any particular trigger, but claims to be 'really tired of things' and that she is not able to endure her worries about school and friends any longer.

She reports being typically lethargic and melancholic, and reports that her mood is typically 'depressed but unemotional'. That is, she describes her mood as a "numbness at the back of her mind". She also reports an inability to cry. Allison reports some longstanding sleep onset insomnia, which is typically followed by overlong sleep periods that interfere with her daily activities. Moreover, she claims to have difficulty with concentration. However, despite her reports of alternating periods of eating large amounts and eating not at all, she reports no change in weight. She does, however, claim to feel sick to her stomach most of the time. She also asserts to have a high level of

anxiety about the future.

Therapeutic Process

Presentation.

Allison was a very charming and likeable young lady. She was perky, bright, and was frequently engaged in the sessional work. She was well liked by her fellow group members, and was instrumental in supporting the group process. She also set a positive example for the group in terms of dedication and attendance, sometimes travelling up to 6 hours a day, both ways, from school to attend the group. However, Allison tends to minimize or deny the existence of any problematic life issues. Instead, she tends to avoid dealing with her own issues through assuming the role of a junior therapist, which may have been the perpetuation of a role that Allison frequently adopts, that of playing the role of mediator between her parents. She rarely talked about herself or her own issues, instead concentrating upon the problems of others.

Formulation.

Allison's enthusiasm and openness with respect to the intervention was a positive influence on the other group members. For example, after session 2, Allison changed schools, claiming that she was unhappy at her previous school. However, Allison insisted upon continuing in the group, despite the fact that it now took her 3 hours to travel from her new school. This dedication to the group and to the study did not go unnoticed by the other group members, which ultimately may have contributed to a relatively high

attendance rate.

In fact, Allison displayed her agreeableness in many ways in the sessions, which frequently contributed to increasing the group cohesiveness. For example, in session 3, Allison expressed understanding and empathy for another group member who discussed his or her experience of depression. As well, in session 4, another group member was upset and crying but was reluctant to share, and Allison took over the role as ‘therapist’ and urged her to share, stating that one of the other group members may have experienced similar events. Early on in the intervention, Allison showed great potential for acting as an effective container for other group members, thereby helping to increase the level of group cohesion. However, it is possible that, in these cases, Allison was playing the role of the Doctor’s Assistant (Yalom, 1970), which involves a patient acting similarly to his or her idea of an ideal doctor and giving advice to other group members. This is done in order to gain respect and approval from the group and from the group leader(s), which may stimulate an improvement in self-esteem.

In fact, Allison’s tendency to be agreeable, to please others, to deny issues or problems, and to avoid confrontation became an issue in itself, and it became perhaps Allison’s most prevalent issues. In session 9, for instance, one group member was greatly upset by another group member monopolizing time in the sessions. The therapists asked Allison for her opinion on the subject, but, in an attempt to avoid confrontation or conflict, claimed that it did not bother her. Allison claimed instead that she was happy for the other member, since ‘she probably didn’t get it at home’.

Furthermore, Allison’s agreeableness was also expressed through her denial of any

current personal life problems or issues. For example, in session 9, Allison discussed her relationship and eventual break-up with an abusive ex-boyfriend. However, when this issue was used as a topic for psychodramatic work, Allison claimed that she no longer retained any anger towards him, since she understood that it was for the best. She further denied feeling any anger towards anyone. It is possible that this was an avoidance technique used by Allison to circumvent attempts to get her to explore her issues.

Another example of this tendency to avoid her issues came in session 10, when she was asked to draw two pictures of: (a) her doing an activity with her family, and (b) how she would like it to be different. For this activity, Allison chose to focus upon the fact that her family has financial difficulties. Although she brought this up as an issue that bothered her, she again avoided the issue through claiming that she felt 'fine' with respect to her family's financial situation. In this same session, Allison psychodramatically spoke with her parents about how she feels when they fight, but she resisted getting emotionally engaged with the enactment through claiming that it was no longer an issue in the home. This may be further evidence of Allison playing the role of the Doctor's Assistant, who typically resists admitting any personal weaknesses or needs (Yalom, 1970).

Allison's tendency to avoid dealing with her own issues may be due to a lack of self-esteem. In fact, many theorists expounding the underlying tenets of and manifestations of self-esteem assert that defensiveness is one facet of low self-esteem. For example, White (1959, 1963, cited in Mruk, 1999) discusses ego strength, or the individual's capacity to deal effectively with anxiety and the demands of reality, which is manifested either through mastery/competence or defensiveness/rigidity. The individual's

particular abilities, level of anxiety, and environmental influences culminate into a pattern of global or general self-esteem. Thus, the individual becomes resistant or defensive towards further factors that may further lower self-esteem. As well, Coopersmith (1967, cited in Mruk) asserts that people with low self-esteem are vulnerable to stress, and are thus more interested in defending against challenges than in solving them. This, in turn, results in further feelings of anxiety, inadequacy, and helplessness. Thus, Allison's tendency to avoid dealing with her issues may be directly related to her low self-esteem.

Allison's issue of having low self-esteem was apparent almost immediately in the group. In session 3, for example, when she was asked to write 3 words that she would most like others to say about her, she asserted that they would be 'original', 'brilliant', and 'talented'. Certainly, these words display a personal desire to be perceived in a positive way. Despite these personal descriptors, Allison's expression of low self-esteem continued throughout the sessions, such as in session 4 when she stated that she blamed herself when things went poorly. Also, in session 8, a group member described an incident when a stranger came up to her and told her she was ugly. Allison's response was that if the same situation had happened to her, she would be angry with herself for being ugly, rather than angry with the other person for insulting her.

In session 9, Allison directly asserted that she desired to raise her low self-esteem. She briefly discussed her past relationship with an abusive ex-boyfriend, Jim, and attributed her low self-esteem as the cause of her failure to leave him. We addressed Allison's low self-esteem issue by asking her, in session 10, to psychodramatically re-enact a scene where Jim was rude to her in the school hallway. However, Allison continued her

tendency to deny emotionality, and again claimed that Jim's actions did not bother her.

Her transformation of the issue into a non-issue, again, blocked any progress. However, it is also possible that the psychodramatic format may have been too threatening for Allison.

As well, during the psychodrama, Allison intimated that she would have liked Jim to show her affection, but that he was incapable of doing so. The therapists asked Allison to force Jim to hug her, to which she replied repeatedly that she could not and that she did not know how. One of the group leaders, as Jim, finally persuaded Allison to hug him, which may have provided a developmental need (e.g. Bowlby, 1959; Cowie, H, 1995; Smith, Cowie, & Blades, 1998). However, the fact that Allison continually claimed that she could not get Jim to hug her demonstrates her feelings of powerlessness. It is also possible that she felt unworthy of a hug, which may indicate a low self-esteem.

Although typically pleasing and agreeable, Allison was occasionally critical or confrontational with the group leaders. This may be due to her adoption of the Doctor's Assistant role, in which the patient may express anger towards the therapist(s) for having to eventually play the role of patient (Yalom, 1970). For example, in session 4, she attacked me over the use of large words, and then demanded to know if I had been beaten up as child. Allison persisted in her questioning, and got angry when I would not divulge this information. Moreover, in the final session, Allison gave me 'simplicity' as the gift that she felt that I most needed, and also told the therapists that she wanted us to be more 'authentic'. Along with evidence for playing the Doctor's Assistant, it is also possible that these incidents were personal projections; that is, she was accusing us of what she was herself demonstrating.

However, despite Allison's difficulties with becoming emotionally engaged in the therapeutic process, she made several claims as to positive progress following treatment. She claimed that her home environment improved in that it involved less tension, less quarrelling, and that her parents also understood her better. She claimed to have no problems making new friends at her new school, and that she now has close friends that she trusts and gets along with well. As well, her grades improved following the school change, and she asserted that she was calmer both at home and at school. Interestingly, she also asserted that she was now very interested in therapy as a possible future career path. Moreover, she claimed to have less anxiety about the future, to be less upset about her past romantic relationship, and that there were fewer ups and downs in her mood. However, taking into account her tendency to play the role of the Doctor's Assistant, it is possible that some of these claims were embellished in order to please the group leaders.

The experimenters made a number of observations that may be perceived to be valid positive progress with respect to Allison's therapeutic goals. For example, Allison changed schools between sessions 2 and 3, and claimed that her grades improved following this change. Interestingly, Allison attributed her improvements in grades to an increase in structure and organization. Taking into account that adolescents need structure in order to experience therapeutic progress (Jennings & Gersie, 1987; Riley, 1999; Tibbetts & Stone, 1990), this adds validity to her claim of improvement. In addition, as a result of her academic improvement, Allison reported an increase in self-esteem and self-confidence.

Allison also gained insight with respect to some of her motivations and behaviours.

As has been said, it is possible that her denial with respect to experiencing anger could be attributed to her depression and to her agreeableness; however, it is also possible that her claims hold some degree of validity. In session 9, a pivotal session for Allison, she engaged in a psychodrama where she confronted her own indifference and lack of emotion. Adopting the role of Indifference, I confronted her with the lack of benefits associated with denying emotional expression. As a result of this interaction, Allison came to the realization that her inability to express anger may have been directly caused by the intense anger expressed by her parents towards one another. Furthermore, she also gained insight with respect to the motivation behind her lack of emotion in general; namely, that she uses indifference as a defence mechanism to avoid experiencing intense emotions, such as those encountered during depressive episodes. Thus, the safety provided by the use of metaphor and distance in the psychodramatic enactment acted as an impetus for Allison to increase her self-awareness, as well as to be more open to accessing and experiencing emotions, and also to be more amenable to personal therapeutic change in general.

In addition, Allison displayed some improvement in her agreeableness and reluctance to engage in confrontation. In the final session, the group engaged in a group mural activity, where their task was to paint or draw as a group. During this activity, Allison engaged in a large boundary transgression, where she purposefully painted over another member's work. Moreover, the group member whom Allison transgressed was a member who continually stimulated negative emotions within the group. It is thus possible that Allison's boundary transgression was a true expression of her emotions felt towards the other group member. If this is indeed true, then this incident was especially

important in that it was contrary to Allison's claims that she neither feels nor expresses negative emotions towards others. In fact, Allison does experience negative emotions, but only expresses them passive aggressively; indeed, her boundary transgression may have highlighted this fact for her, and provided her with some degree of personal insight. This boundary transgression thus demonstrates an improvement in Allison's ability to express emotions, and to be less pleasing and more assertive of her own individuality. The safety provided by the therapeutic environment may have helped contribute to Allison's change in this area; otherwise, she may not have felt safe to express these emotions.

In general, Allison was able to normalize her issues through the interaction and support provided by the group, and also improved her self-esteem and self-confidence through taking the pseudo-therapist role. Furthermore, as was demonstrated during the group mural activity, Allison made some improvement towards accessing and expressing emotions more readily. The therapeutic frame provided enough safety and support to allow Allison the freedom to express emotions and issues previously inaccessible or anxiety-provoking, which further allowed her the possibility to increase her level of personal insight, emotional expression, and self-esteem. Finally, the opportunities to engage in psychodramatic enactments with respect to unresolved issues surrounding her ex-boyfriend, her parents, and her own emotions seemed to assist Allison in decreasing her depressive, anxious, and suicidal symptoms. However, Allison's desire to be the co-therapist rather than the client may be reflective of interpersonal connection and communication issues that Allison must continue to work upon.

Client 2 – Christine

History

Christine is a 17-year old female who lives with her parents, her brother, and her maternal grandparents. Presenting problems include depression, suicidality, and possible borderline features. Christine asserts that she is not aware of any mental illnesses in the family of origin, but claims that this may be due to her family's values, which disapprove of any public display of mental illnesses. Christine claims that her suicide attempts began at age 14, and that she makes frequent mild attempts.

Christine claims to have a few friends that she can confide in. She reports a number of past romantic relationships with both males and females, several of which ended under upsetting circumstances. She declares that she now has had a boyfriend for many months who lives in the United States. Her parents have expressed that they disapprove of her engaging in a romantic relationship, and because of this, she has been keeping the relationship a secret.

She attends college, and she has future plans to graduate from college and to go to graduate school. She gets very good grades in school, and stays involved in many hobbies and activities. For example, she is involved with several school clubs, as well as tutoring other students.

Christine reports that she tolerates a distant relationship with her parents, and that they are very strict and closed emotionally. As well, she reports that her parents place enormous pressure on her with respect to a variety of subjects, one of them including religion and occupation, and states that Christine is pressured by her mother to go into the

field in which she herself works. Christine reports having been close with her great grandmother, who unfortunately died when Christine was 13. She also claims to be close with her great aunt, who is currently residing in a hospital in another province. She claims to be close to her maternal grandmother, but that she does not confide in her.

Christine did not recount any past clinical interventions. She recently spoke with her school guidance counsellor; however, 1 month before her presentation to the emergency room, her guidance counsellor locked her in his office to dissuade her from making another suicide attempt. Due to this incident, she now says she mistrusts mental health professionals. However, she claims that she then made an attempt 2 to 3 days later.

When Christine was presented to the emergency room, she had attempted suicide 3 times in the previous month: taking pills, drowning, and attempting to jump in front of the subway. Christine's friends claim that she has low self-esteem, and also frequently attempts to hurt herself emotionally and physically. Christine reports significant disruptions in her sleep, claiming that she does not sleep 5 days out of the week. Christine also reports that her mood tends to be indifferent, and experiences neither happiness nor sadness. Instead, she reports that her mood tends to be situation dependent.

Therapeutic Process

Presentation.

Christine's choice of discussion topics frequently shocked others. She was confrontational, stubborn, and often attempted to engage the therapists in arguments. Christine would also frequently refuse to answer questions directly, but instead would only

drop hints with respect to larger issues. These behaviours were time consuming, and often led to the exclusion of others' issues, which stimulated negative reactions from other group members. One group member, for example, frequently expressed feeling irritation and frustration towards Christine, and others divulged that they tuned out when Christine would begin to speak. Generally, Christine was resistant to most interventions, and, as a result, the therapists were only able to build a rather superficial and tentative alliance with her.

Formulation.

Christine frequently used excessively violent or bloody images in her artwork and role plays. For example, in the first session, the group was asked to create a story using the 6-Part Storymaking Assessment (Lahad, 1992). Christine's story concerned a cow whose 'helper', a monster, hit the cow on the head and killed the cow. The cow then went to hell, met Satan, cut off Satan's head, and then committed suicide. The illustrations were remarkably bloody and violent in nature, and Christine's story triggered strong negative reactions in the other group members. When Christine presented her story to the group, she made overt links between the story and her real life, including claiming that the cow represented her, and that Satan was her ex-boyfriend.

Furthermore, after the story was created, we asked Christine to enact the story in a role play. In this role play, she chose to change elements of the story, and included a scene where the helper, named after a friend of Christine's, stabs and kills Satan. In this case, however, Christine chose to call Satan 'James', the name of her ex-boyfriend.

Taking into account the excessiveness of Christine's images, as well as the fact that she made an attempt to ground it in real-life persons, it is possible that Christine was taking a significant risk in attempting to express genuine feelings of betrayal by loved ones.

Another example of this was in session 7, when she was asked to draw a picture of her family doing something together. Christine drew a picture of her family engaging in a snowball fight, which may have signified progress, since, until that point, Christine refused to draw, enact, or discuss her parents in any way. However, also included in the picture were Santa Claus and Rudolph, and the picture depicted Rudolph having his nose violently ripped off. Thus, Christine's placement of fantastical characters in a family scene, coupled with violence against those characters, may suggest a strong defence mechanism with regards to her family. This picture may have depicted a real wish to engage in activities with her parents; however, it may have also stimulated anxiety in Christine, which may then have prompted the presence of fantastic figures and violence in an attempt to distance herself. It is also important to note that even the desired family activity, a snowball fight, connotes violence, and may signify Christine's anger towards her family.

However, although this picture included fictional characters, violence, and gore, it is possible to view this picture as representative of positive change in Christine. That is, through drawing this picture, Christine was able to metaphorically deal with her family, a subject that she had been avoidant of initially. As well, since this may have represented a genuine wish of Christine to participate in an activity with her family, this drawing also conveys progress for Christine with regards to being able to be authentic with the group. Moreover, since Christine used this drawing to express genuine feelings of anger towards

her parents, it further demonstrates her progress with respect to openness and level of comfort with the group.

Christine would also frequently use blunt, explicit, or deliberately offensive statements in the group. This tendency was apparent from the beginning of the first session, when she introduced herself as being 'crazy', despite the knowledge that other group members were there for similar reasons. In session 2, Christine expressed her anti-religion opinions, claiming that she would 'only go to church in a coffin'. Christine may have attempted to intentionally offend others as a manifestation of a communication pattern learned at home. It is possible that Christine, due to feelings of invisibility or being unheard, could only obtain any reaction from her family through utterances that elicit negative reactions.

Christine was also frequently unresponsive to others in the group. For example, in session 5, which was a rather heavy session, Christine refused to engage in the session or to even listen to others' disclosures, claiming to be too preoccupied with her recent Calculus exam. It is possible that this tactic may have been indicative of Christine's feelings of being unheard or of being unworthy of help; that is, she acted towards others in ways that paralleled how she felt.

As well, even though Christine came to the group to obtain help, Christine was continually resistant to participation during the group sessions. One example of this resistance was during the Kinetic Family Drawing activity in session 5, where Christine drew a picture of a Calculus graph instead of a picture of their family doing something together. However, although this exemplified Christine's resistance to the therapeutic

process, she was eventually able to use this drawing as a basis to discuss the lack of communication or connection at home with her parents, as well as the fact that she did not like to speak about her family. The fact that she was able to verbalize these issues also implied that she was progressing with respect to being able to open up to the group.

Another example of Christine's resistance occurred in her psychodrama in session 11, in which Christine refused to participate, as well as refusing to discuss her parents. Rather than forcing her to participate, the group members and leaders instead took the roles of Christine's family members, which seemed to be her most strained and damaging relationships, and spoke directly to her, while she passively observed. The enactment was intended to emphasize the fact that Christine's parents still love her, despite the fact that they are hard on her, and also that they need her help to communicate with her. Even though Christine continued to refuse to participate in the psychodrama, she still seemed to experience positive change. Specifically, Christine seemed to experience personal insight, as well as an increased emotional expression, evidenced by the emotion on her face during the enactment. As well, in future sessions, Christine gave hints as to a slowly improving relationship with her parents, such as incidents when she was open with them, or when they were less strict than she had initially expected. Whereas never explicitly discussed, it was felt by the researchers that it did indeed positively affect her parental relationship.

Christine's refusal to participate was occasionally upsetting or problem-inducing for other members of the group. For example, in several sessions, the group members were asked to sculpt another member in such a way as to embody how they were feeling. However, whenever Christine was asked to be the sculpture, she consistently refused to

exhibit her partner's desired facial expression, which caused the other group members to experience feelings of disappointment and frustration. It is possible that she may have used the safety of the group to act out in ways that were unaccepted in her strict home environment. However, it is also possible that such behaviours indicate a strong defence against co-operation, and that Christine engaged in similar behaviours at home.

Christine also demonstrated several testing behaviours in the group, which was exemplified in her conduct during Magic Box, the sessional closing activity. Rather than putting something in the 'box', such as an emotion, that she wished to leave there, and taking out something positive that she wished to take with her, Christine would instead take out and leave things that were confrontational or hostile towards the group leaders. For example, she extracted 'ignorance' in session 4, implying that she had no interest in personal insight or growth. Such choices may be indicative of Christine experiencing transference for the group leaders, displacing her anger at her parents onto us. Through expressing her hostility towards the therapists, she was able to safely express her feelings of anger towards her parents. It is also possible that Christine may have felt restricted and powerless at home, and engaged in such behaviours because she felt safe enough to rebel in ways that her parents would not allow.

Christine frequently tried to employ a 'chasing' tactic in her behaviour in session. She would drop subtle hints or clues as to larger issues that she thought would stimulate the interest of the group or its leaders. One example of this behaviour in Christine was in session 4 when she entered the session histrionically upset, refusing to participate in the activity that the rest of the group was engaging in at the time. The group then attempted

to embody and reflect back Christine's 'pain' several times; however, Christine consistently claimed that the enactment was incorrect, but yet still only hinted at the reason behind her intense emotionality. After extensive 'chasing', we finally discovered that her emotionality was a result of her friend asking her to have sex with her, which was indicative of a larger issue for Christine, specifically feeling betrayed by friends and loved ones. It is possible that Christine developed her chasing behaviours as a way of controlling the nature and amount of information revealed, in order to attain the attention and interest of others that she may not receive at home.

After some reflection, it can be seen that Christine's acting out behaviours, perhaps caused by her oppressive home life, may have been adopted in an attempt to raise her self-esteem. Christine has implied that her parents may not have offered her the warmth or acceptance necessary for Christine to develop a healthy level of self-esteem (Coopersmith, cited in Mruk, 1999). Christine may have attempted to raise her self-esteem through obtaining the attention from the group and group leaders that she did not receive from her parents.

A fundamental issue for Christine seemed to be the idea that help is unavailable, but that any attempts to do so may actually be hurtful. Related to this issue was Christine's obvious lack of trust for others. These two factors made working with Christine in a therapeutic environment very difficult, and often resulted in her engaging in resistant, aggressive, and testing behaviours. Christine created a defence barrier so that no one was able to become close with, and ultimately hurt, her. This issue was manifested in several ways during her process. From the first session, when she cast a group leader as

the evil villain in her story and beat him up, and created a sculpt with the two therapists strangling each other, Christine clearly displayed her resistance for the therapeutic frame. As well, in session 6, Christine said that she felt like a 'lab rat', in that she felt that the research project was more important than was her well-being. Christine claimed to be angry for several sessions afterwards, which also allowed her to distance herself, and to convince herself that yet again help is unavailable.

These types of occurrences were also discussed by Yalom (1970), who may have characterized Christine as a Help-Rejecting Complainer (HRC). The HRC repeatedly requests help, either through implicit or explicit means, from the group or the leaders by presenting problems and complaints; however, the HRC then rejects the help once assistance is offered. The HRC's behaviour typically leaves the group and the caregivers bored, irritated, frustrated, and confused, and may ultimately undermine the cohesiveness of the group. Yalom characterizes these patients as being conflicted in that they only feel significant if they play the role of a 'crisis-creator', but are also disdainful of dependency, due to their distrust of authority figures. The HRC presents problems in such a way to preclude effective help, thus denying her helplessness by trying to defeat the potential caregivers. Certainly, Christine displayed many of these qualities, and this may account for not only her contempt for the therapeutic frame, but also her reluctance to make efforts towards achieving positive change.

Despite Christine's reluctance to achieve or even claim experiencing any positive change, observations made by the researchers hinted at some improvement in Christine by the end of therapy. Certainly, Christine improved greatly with respect to her social

interaction skills. At the beginning of the study, Christine seemed to have few close friends and was reluctant to speak with others. Quite early on, however, Christine engaged in discussions in the hallway prior to sessions with other group members.

As the sessions progressed, Christine also seemed to experience an improvement as to her ability to give space to, be supportive of, or empathize for, others. This was especially important, since this seemed to be an aspect with which Christine seemed to particularly have difficulty. For example, in session 7, Christine was able to play a skilled and supportive auxiliary ego in another member's psychodrama. Not only did she do and say what she was asked, she was willing and able to improvise in a manner that was empathic and therapeutically sound for that other member. As well, in the final session, the group engaged in a group mural activity. During the activity, rather than reacting negatively when another member engaged in a boundary transgression, Christine instead accepted the transgression and used it to create a collaborative image. Moreover, Christine began to imitate other members' actions, which implies an improvement in her ability to be more agreeable to following others' leads.

Generally speaking, by the end of therapy, it was noted by the researchers that Christine seemed to hold less rigid boundaries and would 'let people in', both physically, as demonstrated by the group mural activity, as well as emotionally, as demonstrated through her increasing openness with discussing personal issues. She also seemed to be able to play more easily, which implied a lowering of defences. In addition, Christine appeared to retain less anger in her everyday interactions with others than she had initially. It was further felt by the researchers that, due to the cultivation of group cohesion and

through psychodramatic activities such as role reversal and adopting auxiliary ego roles, Christine exhibited an increased expression of empathy and compassion for others. Christine was also provided with the opportunity to safely enact, re-enact, or observe others enacting, her life events and to express previously withheld emotions, such as those towards her parents. As a result, the researchers felt that Christine may have also experienced an increase in her self-esteem, as well as a decrease in her depressive, anxious, and suicidal symptoms. However, Christine still retained difficulties with appropriate communication and behaviour patterns, with trust for others, and with emotional expression.

At the post-test assessment, Christine reported a number of positive improvements. For instance, she reported that although she still fights with her father often, her family was now more open to discussions. She also reported that her relationship with her brother was significantly improved. She stated that she still has good friends that she can confide in, and also that school was going very well. She claimed to still have a strong relationship with her boyfriend. However, Christine also reports that she experiences frequent ups and downs in her mood, and that she oscillates between being “tired, angry, upset, and happy”.

Client 3 – Victoria

History

Victoria is a 17-year old female who lives with her mother and her younger sister. Presenting problems include depression, auditory hallucinations, and possible attention

deficit disorder. She also reports being suicidal last year. Victoria's mother reports no psychiatric problems in her own family of origin, other than a nervous breakdown suffered by Victoria's paternal grandfather.

Victoria reports hearing voices for the past 3 years. She describes the voices as being both good and bad, and although she occasionally talks back, she has not experienced any command hallucinations to date. After a clinical assessment in 2001, the auditory hallucinations were not felt to be symptomatic of an actual psychotic disorder, but rather were used as a soothing technique. She demonstrates no other psychotic or schizophrenic symptoms. She was diagnosed with a learning disorder, and it was thought at that time that she also may also suffer from attention deficit disorder; however, this was not diagnosed, nor was it treated with medication. In a psychological assessment given in 1997, it was noted that she demonstrated a small vocabulary for her age, had a general lack of confidence, low thought flexibility, and had a limited and underdeveloped repertoire of coping strategies. Victoria was also given the Bender and the WISC tests, which showed that Victoria possessed a 2-year delay in sensorimotor development, and that she rated globally intellectually at a slow level, respectively. Moreover, her non-verbal IQ was rated as being at a significantly lower level than her verbal intelligence.

In the past, school peers have teased Victoria about her name, as well as other physical characteristics, which seems to have resulted in Victoria possessing low self-esteem. She claims to have friends and is very close to one boy, who was unfortunately transferred to another school. However, Victoria maintains that she argues with the majority of her friends and feels abandoned by them, and thus finds it difficult to confide in

most of them. She also declares that she would like to have a boyfriend, and finds it frustrating to be without one.

Victoria claims to have a difficult time at school. Due to her learning disability, she failed at least one grade, and does poorly in several subjects. Her grades were apparently very low last year when she experienced being suicidal.

She reports that she ran away from home 3 years ago in order to 'find herself'. She claims that her mother was over-protective and intrusive, and always wanted to know where and with whom she was going. Victoria's mother answered questions for Victoria during the intake assessment. Victoria appears to have substantial stressors at home, including a messy parental separation and consistent conflicts with her sister. Victoria's mother feels considerably stressed by the separation, and reports seeing a psychologist weekly for support. It was reported that Victoria's father appeared the happiest when he was at work. She also reports feeling very sad over the death of a baby brother years ago, although she did not disclose the cause of death.

Victoria reports that she gets along with her mother better since her parents' separation, but no longer speaks with her father, since he does not treat her well because she lives with her mother. She now makes claims of verbal abuse from her father, and asserts that she no longer wants to visit him.

She reports that stress and anxiety is causing problems with her sleep, and also reports non-constant mood swings. She reports experiencing depressive symptoms due to severe stressors at home, such as the separation of her parents, her sibling conflict, as well as at school, including being bullied, abandoned by her friends, and doing poorly

academically.

Therapeutic Process

Presentation.

Developmentally slower than the rest of the group, Victoria was faced with difficulties with respect to fitting in or identifying with the other group members or their issues. She spoke very slowly and rambled in her speech, which frequently encouraged such negative responses in the listener as irritation or 'tuning her out'. As well, despite being a group for depressed adolescent females, Victoria seemed to deny that she even experienced depression at all. However, despite Victoria's denial of her depression, she was referred for appropriate reasons. Although Victoria's speech and level of maturity made it difficult for her to achieve a sense of universality in the group, she was friendly, co-operative, and bonded easily. She always participated in sessions, and was also very committed to attending the group, only missing one session. Even though Victoria reported not actually experiencing clinical depression, she appeared to genuinely desire therapeutic assistance with her emotional issues. Furthermore, Victoria seemed to generally achieve some progress by the end of the study, especially in the areas of assertiveness and self-esteem.

Formulation.

The recurring issues for Victoria represented her difficulty in identifying with others and fitting into a group. Victoria was very slow in action and in speech; indeed, she

would typically take a very long time with her activities or drawings, and would usually be the last to finish. As well, Victoria had a very slow and rambling speech pattern, and she frequently spoke for long periods without bringing up any issues. Other group members reported occasionally experiencing irritation towards Victoria, and would even 'tune her out' as a result of Victoria's slow speech.

However, Victoria's characterization of her mother in psychodramas as well as statements made with respect to her mother implied that Victoria's mother was rather overprotective, domineering, and smothering. Victoria may thus have demonstrated less mature behaviours than did her peers as a result of this overbearing relationship. For instance, in the second session, Victoria attempted to identify and relate with another group member's ex-boyfriend difficulties through discussing her own ex-boyfriend. However, as her explanation progressed, it became clear to the group that her 'ex-boyfriend' experiences were of a developmentally lower level than those of the other girls in the group. As a result, the researchers noted a general change in other group members' attitudes towards Victoria, such as treating her with condescension or superiority.

Victoria also frequently exhibited elements of hopelessness and helplessness in her statements and actions. For example, in session 3, Victoria complained that she would not be able to come to sessions since her mother could not drive her. When asked why she could not take public transportation, Victoria seemed uncomfortable at the prospect. Although this complaint of helplessness stimulated some frustration and anger in the group, it was later discovered that Victoria's mother would not allow her to take public transportation, despite Victoria's desire to do so. This issue of her mother's over-

protectiveness was briefly worked on in the psychodramatic enactment, and, as a result, it appeared that other group members seemed to treat her more positively. That is, due to insight into Victoria's motivations, other group members listened more attentively to her, and gave her more space in the group.

Victoria frequently had difficulty in asserting her own opinions, ideas, or individuality. In fact, she would often use others' statements or ideas as her own. For example, she repeatedly echoed others' check-ins, but rarely discussed her own feelings, and even once claimed that she felt 'what everyone else said'. In another session, she sculpted another group member to embody how she felt that week, but then claimed to not know what emotions they represented. When others gave ideas as to what they thought it seemed to represent, Victoria simply agreed that these were her feelings. However, again, this tendency to echo others may have been due to a domineering mother who thought and acted for her daughter, which may have hindered Victoria's sense of self and autonomy.

It is possible that Victoria mimicked others in order to achieve a desired level of love, acceptance, and belongingness from the group. In fact, in session 9, Victoria openly admitted that she required another person to like her in order for her to like herself. Certainly, this search for acceptance and belongingness was also a frequent theme in Victoria's work. She frequently used variations of this theme for each session's Magic Box, and even her story created in the first session dealt with a heart looking for love. Unfortunately, it appeared that this behaviour, coupled with her lack of sense of self, had the opposite effect and instead further alienated her from the rest of the group. Some group activities were designed to assist Victoria in improving her individual autonomy and

individuality. For example, by utilising individual art activities, Victoria had no opportunity to copy or echo others' work. Instead, her artwork reflected ideas and issues that were unique to Victoria, thus accentuating her individuality and autonomy.

It became increasingly clear that Victoria retained a high level of hopelessness, despite her apparent denial of this fact in the pre- and post-test interviews. Victoria seemed to have little hope that she would fit in with the group, that she would amount to anything, or that she would ever experience happiness. These may be beliefs learned from her school environment, in which Victoria is constantly teased and bullied, despite her great desire to 'fit in', to be included, and to retain friends. Her hopelessness was firmly exemplified in session 9, during Victoria's personal psychodrama. A group leader concretised and embodied a burden on Victoria's shoulders by pushing down on her shoulders as she walked around. She was directed to throw off the burden, thus literally and metaphorically releasing herself. However, she refused to even attempt to remove the burden, claiming that she was incapable of doing so. Thus, despite the fact that Victoria openly claimed to not be clinically depressed, her lack of assertiveness and level of helplessness implied the opposite, that she was, in fact, depressed.

Despite Victoria's difficulties with achieving a level of universality, the element that she apparently desired most, she still seemed to experience significant levels of positive change. First of all, despite her difficulties with fitting in with the group, Victoria was occasionally successful in this endeavour. For instance, Victoria was able to relate to another group member's description of her experience of depression, and was also able to discuss it using terms and phrases not taken from others' statements. In addition, Victoria

may have felt more accepted in the group, as judged by her increasing level of disclosures.

That is, Victoria's issues and disclosures gradually increased in importance, such as divulging her feelings with respect to her parents' separation, the death of her baby brother, and her father's verbal abuse. Thus, due to the heavy nature of some of Victoria's disclosures, it can be perceived that Victoria came to feel accepted by the group.

Moreover, Victoria experienced a significant level of catharsis during the course of therapy. This was especially true during Victoria's psychodramatic enactments, which occurred in sessions 7 and 9. In session 7, for instance, Victoria had the opportunity to express her pent up anger towards her sister and her father. In addition, she used the enactment as a method to ask her father why he refused to demonstrate his love for her, or even to hug her. Through role reversal, she had the opportunity to portray her own father, and to answer these questions for herself. After the enactment, Victoria expressed experiencing a sense of catharsis. Further, this enactment allowed Victoria to directly address her issues surrounding her parents, and to possibly positively affect her self-esteem. As well, in session 9, she had the opportunity to directly address her own shortcomings, such as her 'short fuse'. This not only also appeared to be cathartic for her, but also provided Victoria with personal insight, self-awareness, and helped to increase her emotional expression. This, too, may have also positively affected her self-esteem.

Another way in which Victoria seemed to undergo positive change was through increasing her level of assertiveness. Victoria, as demonstrated by her inability or unwillingness to share her own thoughts, ideas, or statements, displayed significant

difficulty with personal assertiveness. However, Victoria seemed to gradually develop a higher level of assertiveness, which may have been a result of an improved self-image or increased self-esteem. In fact, her mother told the researchers that Victoria's level of assertiveness was improving at home. An example of her increased level of assertiveness was seen in her open expression of disapproval with respect to another group member monopolizing the session's focus. During that group member's absence in session 9, Victoria openly admitted her frustration and hostility for the other member. However, in session 11, Victoria demonstrated a significant improvement in assertiveness and confidence when she directly told the other group member of her dislike for her. This was a large step for Victoria, who frequently discussed how she could not tell others if she was upset with them. Although this may ultimately have been detrimental to the level of group cohesion, it may also have been due to Victoria feeling a high level of safety in the group, as well as Victoria feeling a greater level of self confidence.

This example also demonstrates how Victoria also experienced an improvement in her level of personal insight. When Victoria initially began to discuss her feelings of anger and frustration towards the monopolizing other member, she related the experience to an ex-friend who would tell Victoria that she talked about herself too much. As a result, not only was Victoria able to own her anger and express it in a useful and constructive manner, she also acquired a level of personal insight and self-awareness. That is, Victoria came to realize that her anger towards the other group member was, in actuality, anger at herself for taking up too much space, both in the group and with her friends.

A final way in which Victoria observably improved during the course of therapy

was in the area of individuality and autonomy. As has already been discussed, Victoria initially had difficulty with expressing her own unique experience, instead relying upon others' thoughts, feelings, opinions, and statements for self-expression. However, in the final session, the group engaged in a group mural activity, where they were required to paint or draw together on the same piece of paper. Even though the other two group members painted together, Victoria instead chose another art medium, pastels, and drew a rainbow in her own corner of the page, away from the others. In fact, the rainbow that Victoria produced was rather large, and took up a lot of space on the page, which may be representative of the self confidence that Victoria was now experiencing. This small example definitely demonstrates how Victoria was increasingly more willing to assert her own individuality.

Victoria was also relatively able to connect with others and was therefore also able to normalize her problem. In sessions, she had the opportunity to deal with issues surrounding her lack of friends and the effect that she has upon others. However, Victoria still requires much work with respect to her communication styles, her level of autonomy, as well as her level of dependency upon others. As well, Victoria still seemed to experience difficulty in achieving feelings of acceptance or of universality, which are significant issues for her.

Following treatment, Victoria reported that she continued to fight with her sister, but that she had strengthened her bond with her mother. Furthermore, she had discontinued all contact with her father, which she reported as being 'a good thing', and that it had helped her to improve her general mood. She claims to have a friend that she

can trust, but still feels like a bother to her other friends. School was reported by Victoria to be going very well, and that she has continued participating in her hobbies. She now also claims to have set more obtainable career goals of being a forensic analyst, a baker or chef, or enlisting in the army. However, she still retains no romantic relations, which she reports feeling sad about. She also reports eating less, having problems falling asleep, and still experiencing small mood swings.

Chapter 5 - Results

One aspect of the present study's hypothesis was that the integrated drama and art therapy intervention would decrease the overall level of depression in the participating subjects. The level of depression was measured using both a self-report questionnaire and a clinician-administered interview. These results are demonstrated in Tables 1 and 2. Table 1 demonstrates the pre- and post-test results of the Beck Depression Inventory (BDI). The changes were calculated with respect to the clinical status of the clients at the time of entry into the study (pre-test) and again 1 week following the termination of the intervention. Allison, Client 1, displayed an 88% reduction in symptoms, whereas Victoria, Client 3, demonstrated a 56% increase in symptoms. Christine, Client 2, displayed no change in depression as measured by the BDI.

Table 2 outlines the dichotomous and continuous outcome scores as measured by the Diagnostic Inventory Schedule for Children (DISC). The diagnosis for depression was calculated as corresponding with the *DSM-III-R* (1987), and had to fulfil at least 5 out of the 9 criteria. Clients were rated according to a dichotomous scale (depressed versus not depressed) and on a continuous scale with respect to the nine fundamental symptoms as outlined by the *DSM-III-R*. Client 1 demonstrated a complete turnaround with respect to depression, demonstrating a 100% reduction in symptoms. Client 3 as well, demonstrated a 100% reduction in symptoms, despite not rating as clinically depressed according to the dichotomous pre-test score. Specifically, Client 3 reported no significant distress following treatment with respect to weight gain or loss, fatigue, problems with concentration, or anhedonia, which describes the subjective level of pleasure or interest in

daily activities. Client 2, however, remained clinically depressed, and actually displayed a 33% increase in depressive symptoms. However, despite reporting increases in anhedonia, fatigue, and weight gain or loss, she also reported a decrease in depressed mood (Table 3).

Table 1 - Pre-test and Post-test Treatment Outcome Scores for Beck Depression Inventory

Client	Pre-test (Baseline)	Post-test	delta change (%)
1	49	6	43 (88)
2	23	23	0 (0)
3	9	14	-5 (-56)

Table 2 - Pre-test and Post-test Treatment Outcome Scores for DISC Depression

	Client	Pre-test (Baseline)	Post-test	Delta change (%)
Dx Depression				
Dichotomous Score	1	Yes	No	
	2	Yes	Yes	
	3	No	No	
Continuous* Score (0-9)	1	9.00	.00	9(100)
	2	6.00	8.00	-2(-25)
	3	4.00	.00	4(100)

**Note. Continuous score ≥ 5 symptoms = depression*

Table 3 - Breakdown of Presence of DSM-III-R Symptoms Before and After Intervention

	Depressed Mood		Anhedonia		Weight Dists.		Sleep Dists.		Motor Dists.		Fatigue		Guilt		Concentration Dists.		Suicidality	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
	Client 1
Client 2	.			.		.	.	.	.	.		.	.	.	.		.	.
Client 3			.		.						.				.

The effectiveness of the intervention was also examined with respect to its effect upon levels of suicidality in participants. The hypothesis of the study was such that the intervention would reduce overall levels of suicidality. Table 4 demonstrates the levels of suicidality before and after the intervention, as measured by the Spectrum of Suicidality Scale. Client 1 displayed an improvement in suicidality, and despite making mild attempts prior to the intervention, she scored as non-suicidal following the intervention. Client 2, however, reported more frequent suicidal ideations after the intervention than she did at pre-test. Client 3 rated as non-suicidal at both pre-test and post-test.

Table 4 - Pre-test and Post-test Treatment Outcome Scores for Suicidality Scale

Client	Pre-test (Baseline)	Post-test
1	4A	1
2	2A	2B
3	1	1

Note. Scores represent the following:

1=non-suicidal

2A=suicidal ideation, less often than once per 6 months

2B=suicidal ideation, more often than once per 6 months

3=suicidal threat

4A=mild attempt, associated with suicidal thoughts

4B=mild attempt, not associated with suicidal thoughts

5=serious attempt

Treatment effects for self-report measures of anxiety were also examined (Table 5). The study's hypothesis was that the drama and art therapy intervention would reduce the overall level of anxiety in participants. Following treatment, Client 1 reported an 84% decrease in anxious symptoms, displaying a post-test score that rates as clinically non-anxious. Clients 2 and 3, however, did not demonstrate a decrease in anxious symptoms, and Client 2 even reported a 4% increase.

Table 5 - Pre-test and Post-test Treatment Outcome Scores for Beck Anxiety Inventory

Client	Pretest (Baseline)	Posttest	Delta change (%)
1	38	6	32 (84)
2	24	25	-1 (-4)
3	35	35	0 (0)

A self-report measure of self-esteem was also utilized in determining the effectiveness of the drama and art therapy intervention. The hypothesis of the study was that self-esteem would be significantly improved as a result of participation in the drama and art therapy intervention. As shown in Table 6, all clients reported an increase in self-esteem. The reported increases were 52%, 26%, and 27%, respectively.

Table 6 - Pre-test and Post-test Treatment Outcome Scores for Rosenberg Self-Esteem Scale

Client	Pre-test (Baseline)	Post-test	Delta change (%)
1	12	25	13 (52)
2	17	23	6 (26)
3	19	26	7(27)

A further postulate of the study was that the intervention would be effective in

decreasing the overall level of conduct disorder. However, no clients rated during pre- or post-test as possessing conduct disorder (Table 7).

Table 7 – Pre-test and Post-test Treatment Outcome Scores for DISC Conduct Disorder

	Client	Pre-test (Baseline)	Post-test
Dx Conduct Disorder			
Dichotomous Score	1	No	No
	2	No	No
	3	No	No
Continuous* Score (0-3)	1	1	0
	2	1	1
	3	0	0

Note. Continuous score = 3 symptoms = dx conduct disorder

A final assessment used determined the clients' overall level of functioning, emphasizing the lowest level of functioning, as measured by the Children's Global Assessment Scale (CGAS). The hypothesis of the study was that participation in the intervention would improve clients' overall levels of functioning, and specifically would improve their lowest level of functioning. Results are shown in Table 8. Clients 1 and 3 both demonstrated improvement in overall functioning, reporting a 74% and an 18% increase, respectively. Client 2, however, reported a 42% decrease in her overall level of functioning.

Table 8 - Pre-test and Post-test Treatment Outcome Scores for CGAS

Client	Pre-test (Baseline)	Post-test	delta change (%)
1	24	90	66 (73)
2	61	43	-18 (-42)
3	46	56	10 (18)

Therefore, after analysis of the results, it can be seen that Client 1 demonstrated significant improvement as measured by all assessments. In contrast, Client 2 demonstrated a decrease in almost all measures, with the only exception being the BDI, where she demonstrated no change in depressive symptoms, and the RSE, where she reported an increase in self-esteem. However, after further investigation, it is also possible to see that, despite reporting an overall increase in symptoms as measured by the DISC, Client 2 experienced a decrease specifically in depressed mood. Client 3, however, experienced a wider range of results. For example, she reported an increase in depression on the BDI, but a decrease in depressive symptoms on the DISC. Likewise, she demonstrated no change in levels of anxiety, but reported an increase in self-esteem and global level of functioning. Finally, she reported experiencing no symptoms of suicidality or conduct disorder before or after the intervention.

Chapter 6 - Discussion

Intensive analysis of the above qualitative and quantitative data suggests some interesting implications. More specifically, if the quantitative results are scrutinized with respect to the qualitative data found on each client, light can be shed upon the confusing statistical results. Every assessment measure utilized in the study displays extensive improvements in Allison, Client 1. Not only did the BDI and the DISC demonstrate that depression levels improved by 88% and 100%, respectively, but her suicidality also displayed improvement from making frequent yet mild attempts to displaying no suicidality at all. Furthermore, her anxiety levels decreased 84%, her self-esteem increased 52%, and her overall level of functioning improved 74%. Thus, all measures used demonstrated significant positive change in Allison, although the extent of change is suspect. When analysed with respect to the qualitative data, it is possible that these drastic improvements may be explained by Allison's propensity to play the role of the Doctor's Assistant (Yalom, 1970), which involves the tendency to please others, especially authority figures, and to deny the existence of any problems. However, the improvements gleaned from the qualitative data support the quantitative data, and it can thus be seen that Allison did indeed experience significant positive change in several areas.

Contrarily, Client 2, Christine's quantitative results demonstrate several deteriorations. As can be seen from her results, she reported no change on the BDI, and also a gain of 3 new depression symptoms as measured by the DISC – anhedonia, weight disturbances, and fatigue. However, despite the negative change reported by Christine on the DISC, it is interesting to note that she also reported an improvement in depressed

mood. Thus, despite her claims that her state actually deteriorated, the primary symptom of depression, depressed mood, was no longer present following treatment. Furthermore, Christine's report of experiencing the three new symptoms as measured by the DISC is suspect in that, when these are compared with the post-test BDI, Christine reported only recently experiencing anhedonia, but not experiencing any change in weight disturbances or in fatigue. These differences may be due to the nature of the assessments; that is, the DISC is clinician-administered whereas the BDI is a self-report questionnaire.

Christine also reported other deteriorations, such as a slight increase in anxiety symptoms, more frequent suicidal ideations, and a considerable decrease in her global level of functioning. These declines in scores suggest that the intervention may have been more harmful than helpful. However, some of these results may be explained by inappropriate or incorrect scoring of the assessment tests. For example, although Christine presented for suicidality, she was rated at the pre-test of the Suicidality Scale as being '2A', or as having suicidal ideation 'less often than once' in the past month. She further claimed experiencing no suicidal ideation at the time of the pre-test on the BDI. It is possible that this discrepancy may be explained by the 2-month time lapse between her intake assessment and the administering of the pre-test. This may also be due to a defence, in that she may not have wanted to confess the extent of her emotional distress before the start of therapy. Further, is it possible that Christine was not suicidal in the month preceding the pre-test, in which case the time period being assessed should have been extended to the past 2 or 3 months. Nonetheless, the fact that Christine was suicidal implies that she should have been rated on the Suicidality Scale as being at least '2B', or

as having suicidal ideation 'more often than once' in the recent past; as well, she should have reported having suicidal ideation on the pre-test BDI. Taking this into account, Christine in fact did not experience an increase in her level of suicidality between the pre- and post-tests, but instead demonstrated no change. Likewise her CGAS score, which was rated at the pre-test as a 61. However, since Christine had experienced suicidality, she was thus scored too high on this scale, and should have been rated no higher than in the range of 41-50. Thus, in this case as well, Christine displayed little or no change in her global level of functioning, as opposed to a decrease. Therefore, Christine may not have experienced very little change in her condition at all between the pre- and post-tests. It can thus be seen that a significant limitation of the study was the inexperience of the research assistant used to scores the measures.

Furthermore, Christine's quantitative results may be further explained by her qualitative data. That is, Christine's propensity for playing the role of the Help-Rejecting Complainer (Yalom, 1970), may explain that perhaps her reported decreases in scores were not necessarily reflective of an actual corrosion in Christine's condition. Her difficulties with interpersonal relations, as well as her reluctance to accept or identify assistance may provide an explanation for Christine's lack of change or for her condition deterioration. Moreover, her post-test quantitative results may also be reflective of Christine not being ready to identify or accept positive change; that is, she reverted back to an established and familiar way of responding about her condition. As I have already said, Christine demonstrated several improvements in such areas as social interaction, level of comfort with emotional openness and divulging personal information, openness to

personal insight, being more supportive of others, rigidity of boundaries, level of comfort with play, openness to having new experiences, level of empathy and compassion for others, and amount of anger retained. However, it is entirely possible that Christine's condition deteriorated between the beginning and end of treatment. However, due to the short length of treatment, the ultimate effect of the intervention upon Christine is therefore inconclusive.

Victoria, Client 3, provides a puzzle for the analysis of data in this study, primarily because she did not rate as being clinically depressed in the pre-test assessment. According to the BDI, she only scored a 9, which is considered by Beck et al. (1961) to fall within the non-clinical range of depression, albeit at the upper range. Furthermore, on the DISC, she only scored positively on 4 out of 9 symptoms of depression, whilst 5 symptoms are required to be present in order to be diagnosed with clinical depression. However, here, again, the qualitative data plays an important role in the analysis of her condition. Despite her lack of clinically significant rating, Victoria presented to the emergency room as being clinically depressed, and was referred to this research due to these presenting complaints. Her resulting failure to report being clinically depressed on the measures may be due to the approximately 6-month time lapse between her intake assessment, and her referral and pre-test assessment. It is possible that Victoria simply did not feel as depressed by the time the study began as she did when initially assessed. However, it is also possible that her reporting of a lack of symptoms may be due to a tendency to de-emphasize the clinical significance of her depressive symptoms.

Furthermore, at the post-test, Victoria reported a 56% increase in depressive

symptoms as measured by the BDI, but a 100% decrease in depressive symptoms as measured by the DISC. This contrast may be due to fundamental differences in the measures, such as the DISC being a clinician-administered interview, as opposed to the self-report nature of the BDI. However, although Victoria displayed no change in her anxiety levels following treatment, she did report a decrease in her level of depression as measured by the DISC, as well as increases in her levels of self-esteem and global level of functioning, which may imply that the drama and art therapy intervention was, overall, a positive experience for Victoria.

Thus, it can be seen that the intervention achieved some degree of success in the treatment of the participants. Based on the DISC's continuous score of depression, two participants experienced a 100% decrease in depressive symptoms, and the third reported no longer experiencing a depressed mood. Although not as drastic, the BDI demonstrated improvement in one client, and no or insignificant changes in the other two members. Similarly both the Suicidality Scale and the BAI, which displayed improvement in one member, and no or slight change in the other two members. The CGAS, as well, demonstrated significant improvements in two participants, whereas the third participant was scored incorrectly and actually experienced little or no change. Finally, the Rosenberg Self-Esteem Scale (RSE) demonstrated that all patients significantly improved with respect to self-esteem. Despite the varied results seen on all other measures, the RSE displayed consistent positive results. Thus, it is possible that the integrated art therapy and drama therapy intervention used in this study may be particularly effective in assisting individuals to improve their self-esteem.

Based on this study, it is possible to see that the combined art and drama therapy intervention used in this study is an excellent addition to the variety of therapies used to treat depressed adolescents. On the most basic level, the group format enables the therapy to be more financially viable and to reach higher numbers of adolescents. As well, it provides a number of factors that have already been discussed, such as the peer grouping and social acceptance aspect that is deemed important by adolescents (Brooke, 1995; Riley, 1999), a sense of universality with respect to their circumstances or emotions, and personal insight gained from interpersonal learning (Yalom, 1970). This intervention also utilized Yalom's ideas of group cohesion which can contribute to a safe, supportive, and accepting environment, which then may result in the adolescent feeling more free to communicate his or her needs, wishes, and desires. Moreover, this intervention included aspects of positive reinforcement and feedback from both peers and authority figures, which has also been perceived to be effective in reducing negative symptoms and in raising self-esteem (Mruk, 1999; White, cited in Miell, 1995).

However, there are several factors that provide unique benefits not available to other forms of traditional group therapy. The use of creativity in the creative arts therapies added numerous benefits to the treatment of depressed individuals that are unavailable to more traditional forms of therapy. For example, both art therapy and drama therapy incorporate the use of distancing, which provides the adolescent a much-desired safety from directly addressing his or her problem. Through the use of artwork or enactment, the adolescent is free to express and work through his or her issues without the anxiety related to overt discussion. Thus, the adolescent may engage in a more voluntary

and genuine expression of emotions, which may further help the adolescent to resolve these emotions. This could be seen in this intervention, for example, through the use of the Mooli Lahad 6-Part Storymaking Assessment (1992). Christine used the safety of a distanced drawing to work through her feelings of betrayal from her ex-boyfriend, which she then carried over into enactment, where she felt more comfortable to ground the issue in reality.

This intervention also demonstrated that the creative arts as tools for healing are especially beneficial in that they rely heavily upon the use of projective measures and exercises, and therefore can access parts of the brain other than the language centres. Whereas verbal therapy uses only the frontal cortex (C. Caldwell, personal communication, April 29, 2002), the use of projective measures can access the more primitive, emotional centres of the brain (C. Caldwell, April 30, 2002). This employment of other brain areas can therefore layer the adolescent's therapeutic experience, allowing them to experience healing both cognitively and pre-cognitively. As well, because several exercises used were projective in nature, this allowed for a more effective means of lowering defences, allowing the adolescent to more freely explore their feelings around an issue, and providing personal insight and self-awareness. For example, in the first session, Victoria was asked to create a 6-Part Story (Lahad, 1992) about anything she wished. Her story involved the protagonist, a heart, whose mission was to search for love, belonging, and acceptance. Through using the art modality, she was able to access the emotions associated with these desires, which was furthered when she sculpted the other group members in a tableau emphasizing the main themes of the story. After cognitively

discussing the artwork, Victoria also came to realize that the heart's search paralleled her own, an emotional revelation that she may not have wished to, or been able to, express to strangers in the first session of a new group. Thus, the use of projective and distanced means provided the safety required by Victoria to be more open to others and to gain personal insight.

Furthermore, the use of symbols and images in the artwork and enactments provided the universality principle that is essential for adolescents in group therapy (Yalom, 1970). Each group member had the opportunity to identify with directly or indirectly expressed themes through witnessing the artwork and enactments of others. One example of this occurring in the current study was when Christine drew a calculus graph instead of a Kinetic Family Drawing. After discussing this picture, Christine admitted that it was difficult to communicate with her parents. The other two members identified with this theme, and communication with parents then became a significant theme that session. The benefit of symbol universality is not necessarily available to traditional group therapies, since they do not typically incorporate into the session the use of concrete, projective objects or embodiments created by the group member. Indeed, the utilization of visual matter provides a more concrete starting point for other group members to uncover common themes, images, or emotions.

The creative arts therapies are also particularly useful in that they are more accessible to a wider variety of populations than are some traditional verbal therapies. For instance, the creative arts therapies do not require verbal or direct communication or participation. Whereas traditional verbal therapies require the patient to verbally discuss

their issues, the creative arts therapies can be used with non-verbal or extremely resistant populations through the use of embodiment and art. These forms may be less threatening for resistant patients, or may maximize participation for those patients who have few or no verbal skills. This aspect was useful when working with Christine, who was frequently resistant to participating in activities during sessions. However, through the non-threatening use of artwork as well as allowing her to witness others portraying her family, Christine was still able to participate and achieve positive change from the intervention.

Furthermore, this particular intervention was developmental in design, which makes it accessible to anyone, regardless of therapeutic, artistic, or dramatic experience. Through starting with Phase 1 warm-up activities, each member was able to experience the work at the same level, and to progress through the stages together. Allison repeatedly remarked how she had participated in similar exercises in the past, whereas Christine had had no formal experience of dramatic activities. However, by allowing them to participate in easier activities, such as a sound and movement wave, they were able to progress to Phase 3 psychodramatic enactments at the same rate.

The use of drama in the intervention was included to maximize the emphasis placed upon social interaction in the group. Through asking the participants to engage in such activities as sculpting one another as an embodiment of their feelings or acting as auxiliary egos in others' psychodramas, it was hoped that the intervention would experience an improvement in social skills. As well, a greater emphasis was placed upon socially based activities in order to also improve levels of interpersonal empathy, interpersonal learning, group cohesiveness, and peer acceptance. For example, Christine

portrayed an auxiliary ego in Victoria's psychodrama, which resulted in Christine feeling more empathy for, and thus more acceptance of, Victoria and her circumstances. The effect of this enactment was an increased level of group cohesion, which may have ultimately contributed to increased levels of self-esteem in the participants (Miell, 1995). Thus, the use of activities specially designed to increase the level of social interaction gives the creative arts therapies an edge over that of more traditional group therapies.

The inclusion of specifically designed psychodramatic exercises into the intervention was done in order to maximize a number of possible benefits. According to Cowie (1995), an adolescent who suffers from depression or from low self-esteem tends to view herself as unlovable due to having endured harsh relationship experiences, including rejection and lack of comfort from caregivers when in distress. Thus, primary goals of the group were to increase emotional expression and to provide an opportunity to deal with problematic familial issues. Indeed, psychodrama is one method that emphasizes a cathartic expression of emotions, typically through reparative re-enactments or through enactments of unresolved issues (Starr, 1977). This experience of catharsis was certainly the case for each participant. For instance, both Victoria and Christine had the opportunity to express their feelings of anger and hostility towards their father and ex-boyfriend, respectively, in enactments. This was beneficial, since anger and hostility are basic feelings experienced by depressed individuals (Starr). Thus, whereas some traditional forms of verbal therapy may also emphasize emotional expression (e.g. Jennings, 1987; Yalom, 1970), the embodiment of the psychodramatic re-enactments enabled the participants to re-experience intense or negative emotions, and to thereby

work through them, rather than to simply verbally discuss them.

It was believed that through this safe but strong cathartic emotional expression provided by the psychodramatic enactment, the participants would experience an increased level of assertiveness (Leaman, 1983). This was certainly the case with Victoria, who began the sessions with a low level of assertiveness. Through a psychodramatic enactment, Victoria had the opportunity to assert strong emotions towards her father; following this enactment, Victoria became much more assertive, even directly confronting another group member with the strong negative emotions that the other member stimulated in Victoria. In this case, it is possible that the opportunity to enact and express strong emotions and desires, which is an opportunity not necessarily available in more traditional therapies, helped Victoria to achieve a greater level of assertiveness.

The combination of strong emotional expression and an increase of assertiveness through the manufacturing of creative work was hoped to contribute to the participants experiencing a feeling of empowerment. That is, through retaining control over their creative work, such as through the creation of individual art work, it is possible for the adolescents to experience a sense of mastery or control over their environment. Further, through the individual feeling as if they have greater control over their environment or situation, the individual may thus experience an improvement in his or her self-esteem (Brooke, 1995; Franklin, 1992; Miell, 1995). This, then, may be one factor contributing to the improvement in self-esteem, as measured by the RSE, in all participants in this study.

As well, art was included in the intervention in order to include not only creativity,

but also an aspect of accepted individuality. That is, through independent work within the group, such as individual drawings, each participant could create a product which would be her own, unaffected by the opinions, reactions, emotions, or statements of others. In the current group, each participant then had an opportunity to present or show her work, which was then accepted and validated by the group. This tangible evidence of worth, too, may contribute to the individual's sense of self-esteem (Miell, 1995; Storr, 1972), and thus may also have accounted for the RSE demonstrating a unanimous increase in self-esteem in the current study.

As well, the use of a combined drama and art therapy approach within the intervention can be seen to have several benefits above the use of a single creative arts therapies modality. For instance, the intervention was designed so that the art and the drama portions compliment and co-operated with one another, to the extent that the each exercise chosen for the intervention would incorporate both modalities. The intervention was further designed so that each modality would stimulate, or lead into, the other modality. For instance, both the 6-Part Storymaking Assessment (Lahad, 1992) and the Kinetic Family Drawing (Burns & Kaufman, 1972) used art and drawing as their fundamental basis. However, in both activities, after the drawing was complete, the story or themes found in the artwork were then explored dramatically. Thus, the dramatic action was motivated by the initial artwork, which enabled the participants to explore similar themes and issues at different levels and to express themselves through different means. It is also possible to incorporate the use of dramatic activities stimulating artwork, which would be useful with a longer intervention.

Furthermore, as has already been discussed, the use of multiple modalities in the intervention was also useful in that they each contributed to the healing process differently. Indeed, Zigelbaum & Rubino (1991) claim that each creative arts therapy heals in different ways. The dramatic portion of this intervention seemed to contribute more in terms of social interaction and emotional expression, whereas the art portion seemed to have more projective and autonomy-based benefits. As well, as pointed out by Potocek & Wilder (1989), the use of multiple modalities increases the overall level of safety in the group, since it provides more opportunities for the participants to feel comfortable with a modality. That is, if a participant does not feel comfortable in one modality, then they may still derive comfort from another. Certainly, this seemed to be the case with Christine, who, due to her feelings of being threatened, frequently refused to participate in the dramatic activities; however, she still seemed to feel comfortable in producing artwork. Together, I believe that this intervention was effective in that both modalities assisted to enhance various, and sometimes contrasting, elements, which may have been inaccessible through working with only one modality.

Some discrepant quantitative results may be due to several limitations of the study. As Mruk (1999) states, “[t]he change process, like much of human learning, is erratic. Improvement can be followed by a slight regression, which is in turn followed by an improvement. This process repeats itself until some stabilization of changed behaviour occurs” (p. 138). Based on this reasoning, it is entirely possible that the duration of therapy was not long enough to effectively bring about this behaviour stabilization, or at least to assess its existence. Thus, one significant limitation of the study was the short

treatment duration. It has been demonstrated that short term interventions tend to have limited effects and would benefit from follow up interventions or assessments (Walsh, 1990).

As well, due to the small sample size, it is premature to draw any conclusions based on this study. Similarly, the 40% attrition rate may have contributed some confounds into both the qualitative and quantitative data. Specifically, a male participant was originally included in the group for the first 6 sessions, who had a significant effect on the themes and issues dealt with in the early sessions. Thus, his presence, and possibly his gender, may have affected the three clients who did remain. Moreover, a fourth female walked out of the first session, which caused a strong reaction in some participants, and which brought up themes of being left or betrayed.

Further, there was no control group used, nor were any comparative therapies. Ideally, if the quantitative portion of this study were to be re-conducted, it should include comparisons between group and individual therapy treatment interventions, using representative samples that match subjects who are (a) depressed; (b) non-depressed, but diagnosed with other clinical mental disorders; and (c) normal, non-clinical subjects.

The quantitative measures used in the study also provided some limitations to the study. For instance, as has been said, the research assistant used to score the measures was inexperienced and newly trained, and had difficulties with the scoring. As well, if this study is to be re-conducted, it is suggested that it includes additional measures, such as those that measure variables other than those examined here, as well as those which are based on reports from family, friends, and third party objective observation of the

participants.

With respect to the qualitative portion, as well, the study possessed the limitation that it did not include checking with the participants. That is, the researchers did not include member checking; thus, the clients did not validate the hypothesized themes that emerged. Since the study was not originally formulated to include a qualitative portion, this aspect of the study was not as thorough as it may have been otherwise.

Despite these significant limitations, this study remains an excellent addition to the growing outcome literature on the effectiveness of the creative arts therapies for several reasons. First, it acts as a valid pilot study to be re-conducted in circumstances with more funding or resources. As well, it was a quick, cost-effective, group-based intervention combining two approaches thought to be particularly effective with this population. The intervention does not require the participation of the participants' families, which further decreases costs and resources, and increases the value of peer grouping, which is important for adolescents. The intervention may include a psycho-educational component, whereby participants may help their peers with information gleaned from the intervention. And finally, the intervention itself was particularly useful to contributing to the creative arts therapies outcome literature in that it is a specifically designed, replicable, objectively measured intervention. It is my hope that through further experimentation, this intervention can be further researched to refine its applicability to the population. Additionally, this research represents a preliminary outcome-based approach investigating the use of multi-modal creative arts therapies. Ultimately, research of this type may improve the standing of the validity of creative arts therapies in the mental health field.

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Appendix A Consent Form

As graduates completing a master's degree at Concordia University, we are doing a practicum placement in the creative arts therapies at the Montreal Children's Hospital, as part of the Emergency Room Follow-Up Team from September 2001 to April 2002. We will be offering creative arts therapies group sessions to help adolescents sort out difficulties they may be experiencing and to aid in improving their daily functioning, through the use of techniques that may included art, movement, story-telling, and improvisational role-playing, etc. These sessions will be offered on a weekly basis for a period of 12 weeks.

We are also conducting our research study with the purpose of examining the benefits of drama therapy and art therapy with adolescents.

I understand that:

1. Whether or not I participate in the research, I will receive the care recommended by the psychiatrist of the Emergency Room Follow-Up Team.
2. I will receive assessments at 2 different times: a 45- to 60-minute assessment before I begin the creative arts therapies sessions and a 45- to 60-minute assessment upon termination of the creative arts therapies group sessions.
3. These assessments will involve talking with a research assistant and filling out questionnaires.
4. I understand that participation in this program is not expected to bring any undesired effects.
5. I am free to refuse to answer any questions to which I object, and to withdraw from the research at any time without any consequences.
6. All information gathered during the assessments and sessions will be kept strictly confidential.

I also agree that:

- Any or all work produced may be photographed
- Any or all sessions may be videotaped
- Any or all information may be used for educational purposes
- Any or all information may be published

Should I have any questions or problems at any time, I can contact Ron Scott or Allan Rosales at:
(514) 934-4400 ext. 22210.

Having read and understood the above description,

I _____ agree to participate

Signature

Date

Signature of person obtaining consent

Date