Recovering the Lost Voice:
Exploring the Use of Role in Dramatherapy with Depressed Women

Alison Aylward

A Research Paper

In

The Department

Of

Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements
For the Degree of Master of Arts
Concordia University
Montreal, Quebec, Canada

August 2005

Your file Votre référence
ISBN: 0-494-10314-0
Our file Notre référence
ISBN: 0-494-10314-0

CONCORDIA UNIVERSITY

School of Graduate Studies

This is to certify that the research paper prepared

By: Alison Aylward

Entitled: Recovering the Lost Voice: Exploring the Use of Role in Dramatherapy with Depressed Women

and submitted in partial fulfillment of the requirements for the degree of

Master of Arts (Creative Arts Therapies, Drama Therapy Option)

complies with the regulation of the University and meets the accepted standards with respect to originality and quality.

Signed by the Research Advisor:

_____ _____Research Advisor

Approved by:

_____ _____

Graduate Programme Director

SEPTEMBER 13, 2005

ABSTRACT

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The following paper describes and summarizes my qualitative research in the form of group case study based upon the therapeutic process of four female participants. The primary question explored is: does the use of role in dramatherapy have efficacy for adult women suffering from depression? I have herein chosen to examine a feminist theoretical model which addresses women's inherently relational nature as it links with their susceptibility to this serious illness. Chapters One and Two comprise a review of the relevant literature with a heightened emphasis upon role theory. Chapters Three, Four and Five introduce my four participants and provide summaries of their therapeutic progressions through role, as well as a description of and rationale for employing Renee Emunah's Integrative Five Phase Model. Chapter Six presents an overview of both individual and group experiences of specific, role-related dramatherapy tools. Finally, Chapter Seven consists of a critical appraisal of the process and resultant findings.

ACKNOWLEDGEMENTS

I would like to thank my advisor, Yehudit Silverman, whose wisdom, insight and unfailing sense of humor have helped sustain my efforts both in the preparation of this paper and in my journey –both personal and academic-through the Master's program.

I also wish to convey my appreciation to a number of special spirits who guided me along the way: to Stephen Snow, for his passion and experience, to Joanabbey Sack for her sensitive heart, to Tobi Klein for her candour and knowledge and to Suzy Lister, for her grounding quality and her unflagging enthusiasm for all things research.

I owe a great deal to my circle of classmates, who each contributed to my experience with unwavering support, friendship and many a candlelit dinnerparty.

Love and thanks to Sherrin, Laurie, Annette and Shannon, four of my favorite 'voices' in the wilderness.

To Ann and Fintan Aylward I profess my abiding love and gratitude for far more than words could ever express.

To my husband, Christen Audet, your presence in my life makes me a better person, in this as in all my endeavors. Je t'aime.

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Nel mezzo del cammin di nostra vita
Mi ritrovai per una selva oscura,
Ché la diritta via era smarrita.

In the middle of the journey of our life
I found myself in a dark wood,
For I had lost the right path

(Dante)

Chapter One – Introduction

Many years ago I had the privilege of attending a women's retreat led by Judith Duerk, an author and therapist whose work I had long admired. During the course of this retreat, Judith guided the participants through a series of visualizations taken from her book, *Circle of Stones: Woman's Journey to Herself* (1990). Among the excerpts she shared with us, I was particularly moved by the following:

> I ask, What is asked of us? And the answer comes...To come, each one of us, to our own voice...our own feminine voice. It is an enigma, that when a woman first expresses herself, even if it is a matter for which she cares deeply, it may emerge in a false-masculine voice. It may state her matter factually, but without the shadings and overtones from her own life...without the nuance of her womanly feeling values. Or, if she is ill at ease, she may hand her script over to the animus and let him play the role for her, not out of her feelings, her relatedness and vulnerability, but out of an abstracted, polished, harder side of herself that feels a pressure to have all the answers, that has lost touch with softness, uncertainty, and weakness.
>
> What is asked of us? To find a voice....a voice to cry out...to make us all attend to our woundedness, our pain, our anguish, our needs...in ourselves, our children, our men...in nature, itself...that vast woundedness which has been so ignored, so denied...to attend that woundedness, and, at last, to honour it...the woundedness of us all...in hope and faith that it may heal. (p.64).

In the midst of preparing one of my final dramatherapy sessions for the process I describe in this paper, I discovered this text, buried and dusty beneath an avalanche of

books. Reading the above passage, in which Duerk (1990) not only calls upon women to reclaim their voices, but makes specific reference to the ideas of role and relatedness, I experienced a profound sensation at having come full circle in my own life. This thesis contains the stories of five women, my four magnificent research participants and myself, as we journeyed together through the darkness of their depressions in search of the "voice" within. In the safe container of the dramatic realm, discoveries were made, roles examined and relationships explored. Two circles of women spoke and listened, played and witnessed, and little by little moved towards new capacities for expression that were manifest both within and beyond the therapeutic frame.

Defining Depression

Based upon my review of the literature, relatively little has been written on the topic of women and depression both as seen in the broader sociocultural context and as viewed from a female perspective. I therefore have sought to present herein a basic overview of the pertinent writings leading up to the more current feminist theory I explored in my research. Still less is available on the subject of the creative arts therapies as vehicles for treating women's depression. I will therefore provide a brief review of each of these areas. Later in this chapter I will endeavor to integrate the insights gleaned from said literature to demonstrate what I believe to be the strengths and potential efficacy of dramatherapy for treating depressed women.

The proposal of a research study such as this necessitates the ascribing of parameters. Henceforth when I utilize the term depression I am referring to major, severe depression as defined by the DSM IV (APA, 2000). Though symptomology varies in nature and degree for each individual, elements necessary to warrant a formal diagnosis

include the following: an extremely depressed mood state with a minimum duration of two weeks, cognitive symptoms such as feelings of worthlessness, a marked disturbance in physical functions such as significant changes in sleep patterns, libido, weight and appetite and the presence of anhedonia. Other potential criteria for diagnosis include regularly-occurring, observable psychomotor retardation or agitation, noticeable fatigue, a diminished capacity for concentrating and formulating decisions and recurrent suicidal ideation and/or actual suicidal attempt (DSM IV). Additionally, depressive thought processes have been characterized as "particularly distinctive, consisting when severe or profound pessimism and 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, & Tauvon, 1998, p. 21). Experts have long deemed depression as one of the most pervasive mental illnesses in Western society, and one with the highest prevalence across the lifespan for those afflicted by it (Garber & McCauley, 2002; Karp et al.).

Women and Susceptibility to Depression: A Look at Special Risk Factors

Recent research concerning the epidemiology of depression has found a marked gender imbalance in the prevalence rates of severe depression amongst men and women (Stoppard & McMullen, 2003; Weissman & Olfson, 1995). Studies have determined that twice as many women as men suffer from depression and that this disparity commences with the first onset of the illness - as young as thirteen to fifteen years - and is maintained throughout the lifespan (Edwards, 2002; Solomon, 2001). The question deemed most salient by a plethora of researchers investigating gender differences in depression can be summarized as follows: does a woman's apparent vulnerability to depressive illness stem

from biological differences between the sexes or is it primarily determined by psychosocial differences and the varying patterns of expectations which dominant (i.e. male-oriented) cultural paradigms impose upon her (Kerman & Wiessman, 1985; Randour, 1987)? The following sections will provide an overview of the evidence for and research concerning these diverse perspectives.

I. Biological influences.

There is some evidence to support the biological perspective. In addition to all the types of depression experienced by men, women are often afflicted by gender-specific forms including premenstrual, postpartum and depressive symptoms associated with menopause. Though studies have found a correlation between mood change and a woman's fluctuating levels of the hormones estrogen and progesterone, the confounding variables of these hormones' complex interactions with other hormonal systems have rendered the results inconclusive (O'Connor, 1997). Some researchers have attributed women's greater susceptibility to the fact that men have been found to synthesize serotonin fifty percent more rapidly than women (Solomon, 2001).

Great controversy surrounds the concept of a premenstrual depressive state, but science suggests that already depressed women may find their condition exacerbated during this time. This has been variously attributed to a lowering of serotonin levels and to the fact that the related physical discomforts such as water retention may herald a drop in women's self-esteem regarding their outward appearance (O'Connor, 1997; Salmans, 1995; Solomon, 2001). O'Connor additionally proposes that the onset of menses confronts a women with forces she perceives to be beyond her control, imbuing her experience with a sense of powerlessness. This hypothesis can be viewed as closely

linked to some theorists' suggestion that women's vulnerability for depression is connected to their predilection for causal attributions beyond the self (Barlow and Durand, 2002; Edwards, 2002).

Other reproduction-related events, including infertility, oral contraceptive usage and childbirth have been associated with depression in women. Women just following birth have a considerably higher probability of experiencing depression than do other women, due either to hormonal influences or to the inevitable collapse that follows tremendous physical and emotional exertion (Salmans, 1995; Solomon, 2001). With entry into the menopausal phase, Rosenthal (2000) suggests that depressive symptomology can be viewed as linked to hormones, but is most likely more impacted by a woman's psychological fear of aging and to the stress of contending with physical changes occurring during this period.

II. Psychosocial factors.

Susan Nolen-Hoeksema (1990), a prominent writer in the field of women and depression, espouses the view that theories emphasizing the connection between women's reproductive biology and mental illness are both flawed and dangerous. In her seminal work, *Sex Differences in Depression* Nolen-Hoeksema (1990) asserts that highlighting the innate differences between genders may be distorted to support the notion of women as inferior beings. She advocates against emphasizing conventional findings regarding depression with female clients - such as that which holds that depression is due to a genetic predisposition- in order to better endow women with a sense of empowerment and the belief that they possess an innate capacity to contend with and mitigate their illness (1990). As the theory of *self-loss* I wish to explore focuses upon

the psychosocial risk factors predisposing women to depression, it is essential to take a closer look at the applicable literature in this area.

The most obvious common theme running through the writings I reviewed is that of women as disenfranchised, marginalized members of a primarily patriarchal society. A factor that many feel is likely to play an integral role in the higher incidence of depression among women is their frequent experience - approximately forty percent of women by age twenty-one- of some type of abuse, physical or sexual, during their formative years of development (O'Connor, 1997; Steinberg, 1999). The far-reaching effects of such victimization often include the internalization of a sense of powerlessness and passivity (O'Conner; Steinberg). The female predilection for internalizing negative emotions arising from such traumatic events renders them more vulnerable to the onset of a stress-induced depressive state. By way of contrast, research has demonstrated that males are more likely to externalize negative feelings, allowing them to manifest in the form of aggressive behavioral tendencies and/or self-medication via alcohol and drug consumption (O'Connor; Steinberg; Solomon, 2001).

Also prevalent in the literature is the idea that women's greater risk for developing depression is associated with the psychosocial predicament of feeling compelled to strive for an unattainable, culturally sanctified ideal of the 'feminine' which is comprised of physical, psychological and behavioral aspects. While boys, upon entering puberty, witness their bodies growing closer to the 'ideal' man (broad-shouldered, slim-hipped), girls experience the converse as normal maturation increasingly moves them away from the socially decreed 'ideal' body type of a prepubescent female (O'Connor, 1997). The resultant, dueling interplay of biological forces with the stereotypical concept of female

beauty (as propagated by mass media) creates in many women a sense of inadequacy and a growing dissatisfaction with self. This unfortunate duality continues to plague women as they are confronted with visible indications of aging that are at odds with society's attachment to youthfulness (Solomon, 2001).

Though I have not the space to devote to every conceivable contributing factor to women's depression, it bears mentioning that both adolescent and adult females ensconced in competitive school and work milieus may face additional stress due to double standards society holds for gender expectation. For example, both Steinberg (1999) and Edwards (2002) propose that academically-successful young women are more likely to experience conflictual emotions such as guilt rather than pride and heightened self-esteem in light of their achievements. This may be attributable to the implicit message that such success renders them less appealing in their gender role (Scott, 2003). Survey studies repeatedly suggest that substantially more women than men lack sufficient education and fiscal resources in adulthood, and that unequal pay, limited opportunities for advancement and sexual discrimination continue to be pervasive in male-dominated workplaces (Klerman & Weissman, 1985; Lerner, 1988; Rosenthal, 2000; Solomon, 2001).

Most recently-published writings assert that, while women's depression (like men's) results from the multifarious interaction of a host of factors, the different experience of women in relation to their world must be more indepthly examined (McMullen, 2003). One theory that strives to fill this theoretical void is that of *self-loss* (Jack, 1991) which will be addressed in a later section.

III. Women's development and vulnerability for depression.

A dominant premise in the feminist literature I have read on women and depression is a rejection of Erickson's (1956) view of the developmental stages a person undergoes on the path towards achieving 'maturity' and a coherent sense of self (Gilligan, 1982; Jack, 1991; Josselson, 1987). This refutation is based on the idea that Erickson's model, like many traditional paradigms, does not give credence to the inherent, fundamental nature of adult women as beings for whom interrelatedness is paramount (Gilligan, 1982). Erickson's (1956) psychosocial approach defines the path of identity formation during adolescence as intertwined with the individual's interactions with others. While he thus assigns to human relationships a critical role in the evolution of a person's sense of self, such interconnectedness is viewed as but a transient phase along the journey towards the individuation and autonomy of adulthood. In an effort to include feminine experience, Erickson (1956) additionally proposed that much of female identity is reliant upon her choice of mate, implying that, for women, intimacy may precede identity formation.

Feminist theorists find Erickson's view insufficient to encompass the richness and uniqueness of women's development (Miller, 1976; Josselson, 1987; Taylor, Gilligan, & Sullivan, 1996). Prominent among this chorus of voices is that of renowned author and researcher Carol Gilligan. In her groundbreaking work, *In a Different Voice,* Gilligan (1982) counters Erickson's ideas, stating that his model, like many that followed, is emergent from and therefore only representative of male experience. She is much more amenable to the ideas of Nancy Chodorow, written a decade after Erickson's. Chodorow (1978), speaking of female early development, posited the idea that women, due to being

mothered by someone of the same gender, form a different pattern of relationships that impedes them from ever attaining the same degree of separateness as men. Contrary to the belief that separation is the basis for maturation, Gilligan (1982) and Miller (1986) hold that in normative female development, girls experience interpersonal connections as crucial to their emerging identities. Both suggest that separation or disconnection from others can negatively affect women's psychological well being. They also assert, however, that it is a woman's way of being in relationship that most impacts her mental health state (Gilligan, 1982; Miller, 1986). This idea is central to my area of research and will be later expounded upon.

Studies conducted by Taylor, Gilligan and Sullivan (1996) reveal that prior to their entry into adolescence, girls exhibit a stronger sense of self and are better equipped to communicate their needs and perceptions. This affirmative sense of self may provide them with internal resilience against disconnection and a sense of falsity in their relations with others, thereby serving as a protective measure against depression.

In part due to cultural rites of passage, however, post-adolescent girls encounter a uniquely female crisis as they are conditioned to believe that to be in relationships entails conforming to the ideals of a male-dominated society. Within this context, the prototypical 'feminine' is equated with selflessness, and 'maturity' with independence and self-reliance (Taylor et al., 1996). The central dilemma for women thus becomes whether to surrender their true voices in order to establish and maintain relationships or to sacrifice the relationships they value at the altar of self-sufficiency (Gilligan, 1982). As a consequence of this crisis, the self-certainty evident in pre-adolescent females erodes,

replaced by self-doubt and the tendency to undermine the validity of one's own experience.

Feminist Theories Regarding Women and Depression

I. Women in relationships and depression.

Despite the prevalent view that interconnectedness is vital to women's lives, numerous theorists see women's focus upon the matrix of their relationships as an integral risk factor in their vulnerability to depression. Gilligan (1982) claims that women carry within them a perceived moral imperative to care for and accommodate the needs of others to the extent that this 'duty' sometimes supersedes self-fulfillment. Women's societal conditioning informs them, from a very early age, to adopt a more passive, sensitive stance towards others (Barlow & Durand, 2002). Men, by way of contrast, are taught to be self-initiating and assertive in their day-to-day functioning. The differences in these culturally designated sex roles, traceable back to distinctive messages in parental styles with male and female children, render women more prone to feelings of helplessness and role confusion (Bart, 1972; Klerman et al., 1985; McMullen, 2003).

O'Connor (1997) identifies such gender-specific roles as 'perfect mother' and 'ideal wife' as emotionally damaging because, in seeking to fulfill them, women are basing their sense of self-gratification and meaning on sources over which they exert little control. The relatively recent addition of the 'working' role in women's lives has done little to alleviate the situation as it has been found to be comparably stressful to the nurturing roles of the woman's domestic sphere (Solomon, 2001).

The aforementioned writers share a growing recognition of the importance of relatedness in women with depression and the necessity of finding some psychological

constructs with which to describe it. It is here that the ideas of theorists Harriet Lerner (1988) and Dana Crowley Jack (1991) prove helpful in providing a framework.

II. Women, self-loss and self-silencing.

Harriet Lerner (1988) relates women's vulnerability to depression to the loss emergent from their propensity to sacrifice the self in interpersonal relationships. Lerner proposes that women, "in attempting to navigate the delicate balance between the 'I' and the 'we'" (1988, p.201), often give up the former in service of the latter. For both Lerner and Jack (1991), depression results from this forfeiture of self and the concomitant drop in a woman's self-esteem. The former suggests that a woman's estrangement from 'self' commences in her family of origin and later manifests most blatantly in her romantic relationships (Lerner). Implicit in this view is the notion that a daughter who thwarts or undermines her personal growth in order to protect her bond with her parents is at risk of repeating the pattern in later life (Lerner).

Feminist theorist Dana Crowley Jack (1991) further addresses the challenges inherent in women's focus on relationships with her theory of *self- loss* and *self-silencing*. Her central premise is that women who find themselves unable to communicate effectively with significant figures in their lives are at danger of eventually lapsing into a disempowering state of silence. This loss of voice, she suggests, forms the basis of depression.

Jack (1991) suggests that the commonly held definition of 'self' as the "subjective organization of ongoing experience" (p. 3) differs for women and men, as do the nature of their depressive experiences. Within the patriarchal context enveloping women, the concept of 'self' is inextricably intertwined with ideals of separateness and autonomy.

From such a perspective, it follows that women's orientation towards relationship is often labeled as 'neurotic' or excessively needy. In a radical departure from this view, Jack (1991) embraces a *relational theory* of self, which holds that the 'self' is a deeply social experience that does not and cannot exist in isolation from others (Miller, 1986). For women then, the definitive goal of adulthood is the ability to attain a sense of human connectedness. Like Miller (1986), Jack (1991) believes that the female differentiation of self is characterized not by separateness, but rather by the assertion of her feelings of self-agency and competence *within* relationships.

According to relational theory, an arrest in development occurs when one is unable to remain connected while concurrently asserting a distinct sense of self (Miller, 1986). Based upon her studies of depressed female subjects, Jack (1991) extrapolates from said theory that women's depressive illness is precipitated not by the loss of relationship but by the recognition that they have lost their sense of self in the process of attempting to create intimacy. In an attempt to keep their significant relationships intact, women tend to self-negate by striving to embody the 'ideals' of womanhood in their intimate exchanges (Jack). Unable to convey their inner selves with authenticity, they become increasingly unable to sustain the convictions that constitute their identities (Jack). As the chasm between the inner, 'true self' and its outward presentation widens, women are apt to feel a sense of self-betrayal. The manifestation of this dissolution of identity can result in self-silencing, in which a woman abdicates her right to voice her own views and values in order to conform to what she feels is expected of her.

In her seminal works, *Silencing the Self, Women and Depression* (1991) and *Behind the Mask* (1999), Jack underscores the need for researchers to access and

attentively listen to women's inner experience. It is my view that dramatherapy offers multiple role-based tools by which such 'inner experience' can be accessed and depressed women's 'silenced' voices safely reclaimed, a subject I will discuss throughout this paper.

Dramatherapy, Depression and Connections to Feminist Theory

As can easily be inferred from the omission of the word 'women' in this section's title, I have found - after a considerably extensive search - relatively little literature on the subject of specifically female depression and the creative arts therapies. I did locate a number of articles however, on the broader topic of dramatherapy as it has been employed with mentally ill populations in general. It is my intention to incorporate this research while striving to highlight the aspects I feel could have the most impact in treating women with depression and that best correspond to the feminist theory of self-loss.

I. Dramatherapy, creativity and depression.

It has been demonstrated in the literature that depressed individuals can benefit from a dramatherapeutic intervention in myriad ways, not the least of which is its capacity to catalyze use of their creative energies. Such research is copasetic with the views of many major feminist authors, who underscore the overall importance of creative processes in a woman's voyage of self-discovery (Miller, 1986; Randour, 1987) and the emergence of her authentic self-expression (Eskridge, 1993; Forman, 1994).

Dramatherapist Malcolm (1997) voices a widely held opinion that an individual's creativity is essential to his/her sense of self-mastery, while the writings of Reinstein

(2002) suggest that the spontaneous, creative aspect of play can help clients recover some of the vivacity they have lost through the course of depressive illness.

II. Dramatherapy's efficacy for reclaiming the Self and exploring one's relationship to the Other.

The specific relational conflicts referred to in Jack's (1991) self-loss theory are mirrored in the works of several creative arts therapists. Many authors I read spoke of the efficacy of dramatherapy for restoring the 'core' or 'true' self that depression had served to repress or obscure in their clients (Emunah, 1983, 2000; McLuskie, 1983; Pearson, 1996; Syz, 1996). Rowan (1997) points out that dramatherapy can aid in developing the depressed individual's ability to access the requisite inner strength for coping with his/her sense of isolation. Emunah and Johnson (1983) and Birdfield (1998/99) underline the importance of dramatherapy's group context for allowing the depressed person the simultaneous experience of exploring the uniqueness of self while examining it in relation to others. Grainger (1990) similarly advocates the use of dramatherapy as a safe, contained vehicle by which a depressed individual can experiment with his/her self-image relative to the self/other boundary.

Interesting parallels exist between Jack (1991) and Lerner's (1988) ideas and those of several female dramatherapists. Syz (1996) supports the view of depression as a diminished sense of self in relationship, while Pearson (1996) asserts that dramatherapy offers the client opportunities to escape the 'false' self he/she has felt obliged to present to society. She further concludes that dramatherapy can facilitate a person's recovery and reclamation of the parts of self he/she has silenced. Another dramatherapist whose perspective struck me as very pertinent is Rawlinson (1996), who comments that

dramatherapy's use of the imaginal realm creates a space in which the depressed individual's inner truth can diverge from the often constricting 'truths' of his/her cultural milieu.

III. The advantage of dramatherapy's non-verbal processes for depressives.

Numerous authors reviewed stressed the utility of dramatherapy's non-verbal component (creative movement, embodiment, sculpting) in allowing their clients to transcend the boundaries of verbal and cognitive processing. For some, the very act of engaging the body is believed to counteract the psychological 'stuckness' of the depressed person (Casson, Meekums & Smith, 1995; Emunah, 1983; Rawlinson, 1996). Others found that their use of non-verbal dramatherapy devices proved beneficial both in helping depressed clients bypass the inevitable inadequacies of language to fully convey profound emotion (Rosen, 1981) and in addressing difficult personal material in an indirect, non-threatening way (McLuskie, 1983). Rawlinson (1996) also discovered that non-verbal techniques proved helpful for enabling clients to overcome the poor concentration and memory problems resulting from the cognitive effects of depression and the medications often employed in its treatment

IV. Dramatherapy, projective techniques, and depression.

Dramatherapy's use of projective techniques, in which the client externalizes inner material through a chosen form (Jones, 1996), has proven helpful in the treatment of depression in many accounts found in the literature (Gauthier, 2000; Malcolm, 1997). Allan Rosen (1977), one of the first dramatherapists to document the use of such devices with depressed populations, suggests that projective means offer valuable ways by which clients can see internal self-truths tangibly manifested. Dokter (1996) ascertained that

projective play with objects has efficacy for assessing a depressed person's perception of herself relative to significant figures in her sphere. Casson et al. (1995) make specific reference to the projective exercise commonly employed in both psychodrama and Gestalt therapies known as the 'empty chair technique'. The authors remark upon its value in enabling depressed female clients to directly communicate feelings towards others they would feel reluctant to articulate in a more traditional therapeutic setting.

V. Dramatherapy and the power of metaphor with depressed clients.

The use of metaphor, whether through simple imagery, physical enactment or interwoven in story and myth, has figured prominently in dramatherapy literature and appears compatible with the recent findings of feminist theorist McMullen (2003), elucidating women's heavy reliance upon symbolic language as a means for communicating their experiences of depression. In her case studies concerning women's depression and its relationship to loss, Dokter (1996) found that the use of metaphor through story-making and story-telling processes afforded her clients the necessary distance (i.e. sufficient removal from a purely affective state) through which to acknowledge their core issues. Writing from a Jungian perspective, Rawlinson (1996) observes that exploring female archetypes emergent from Greek and Roman mythology (particularly those with themes of loss and renewal) has proven helpful in her work with depressed women.

VI. The place of role in dramatherapy's interventions with depressed clients.

Perhaps the most pervasive concept in the dramatherapy literature I reviewed and that which became the fulcrum of my research process, concerns the use of role. Many authors appear influenced by the work of Robert Landy (2000), who views the individual

as a compendium of many, often conflicting roles. Landy (2000) maintains that his primary objectives in inviting clients to explore personal material through role are to aid them in the discovery and expansion of their role repertoires, attaining a greater degree of role flexibility and strengthening their ability to tolerate role ambivalence. The fact that role exploration takes place in a fictitious world of dramatic reality allows the client a necessarily distanced medium through which healing can occur (2000).

Landy's conceptualizations resonate with several of the authors I examined, who postulate that depressed individuals often feel confined by or trapped within limiting roles (i.e. the passive patient) and can derive substantial benefits from exploring role alternatives in the affirming, nonjudgmental atmosphere fostered by the dramatherapy process (Dokter, 1996; Emunah, 1983; Malcolm, 1997; McLuskie, 1983).

The concept of role exploration through dramatherapy processes appears to coalesce well with the relational theory of self- loss expounded upon by Jack (1991). Malcolm (1997), for instance, cites as an example the opportunity role-play presents for the client to don an assertive role without the associated trepidation of losing valued relationships. This illustration coalesces well with feminist relational theory in that female clients are permitted to explore role types that could be perceived as potential threats to their abilities to safeguard interpersonal connectedness.

In their work with a depressed female client, Casson et al. (1995) note the utility of doubling (in which another individual joins the protagonist to support her in conveying her feelings or perspective) and role reversal (in which the major participants in an interaction change roles) in role play as additional tools for affirming female clients' inner experiences. I would suggest that these techniques can be viewed as conduits

through which depressed women can derive support for the maintenance of internally-held truths and perspectives.

Such studies, though primarily qualitative in nature and therefore limited in their predictive findings, suggest the possibility of a link between dramatherapy's use of role as a vehicle for exploring the buried aspects of one's personality, and its potential for allowing depressed women to access and express the inner voices that constitute their healthy selves.

Summary

Upon consulting the relevant literature, feminist relational theories and Jack's (1991) concept of self-loss appear to offer helpful frameworks within which one can address the unique experience of female depression. Based on the supposition that depressed women can heal through a process of reclamation and affirmation of their inner experience, such theories seem highly compatible with the treatment techniques found in dramatherapy. As my study focuses upon the particular utility of *role* within the therapeutic process, Chapter Two necessarily extends my literature review to address its theoretical and methodological foundations in dramatherapy.

Chapter Two – Role Theory and Methods in Dramatherapy

An Introduction to Role

A salient characteristic of dramatherapy as a treatment modality for any population is its inclusivity or ability, as a therapeutic medium, to encompass diverse working models, conceptual elements and techniques. Through its many doors, gates and windows, clients can enter the dramatic process to garner new insights into personal experience, encounter and reflect upon new ways of contending with life challenges and discern new ways of functioning both in relation to self and other. Employing a variety of drama-based processes, dramatherapy prepares for and allows entry into a creative space, a fictional world that is separate from, yet simultaneously coexistent with everyday life or reality. Within this parallel, dramatic reality, the client is granted permission to safely explore alternative ways of being, acting and reacting, as normally taboo, often censored or denied personal material can be rendered accessible in a an accepting, non-threatening environment. Upon re-entry into the actual, one has the possibility to acknowledge and even integrate discoveries made in the fictive. It is thus in the interface between the fictive and actual realms that we witness the power of dramatherapy to elicit healing change.

I share with many theorists (Emunah, 1994; Jones, 1996; Landy, 1993) the underlying belief that an individual's journey through this creative modality can entail his or her much-needed movement towards self-actualization and empowerment and further, that one of the central mediums through which such change can be facilitated lies in the power of *role* and role exploration. In Section Two of this chapter, I will provide a brief

overview of some of the perspectives on role that have significantly impacted both its definition and mode of employment in the field of dramatherapy.

Theories and Ideas about Role

Though my focus in this paper lies primarily with the role theory and tools developed by Robert Landy (1990, 1991, 1993, 1996, 2000), divergent conceptualizations of the term both preface and inform his work and thus merit mention here.

Social scientists Mead (1934), Goffman (1961) and Sarbin (1968) have all explored the construct of role as it pertains to the individual's relationship to the social structure in which she is ensconced, or into which she desires entry. Mead's perspective holds that each person evolves as a function of others' responses to her. Role, in his view, is thus socially determined over the course of one's development, commencing with those roles first modeled for us by our primary caregivers. Furthermore, Mead suggests that the more willingly and completely a person adheres to society's role expectations, the easier her attempts to elevate her place within it (1934). Echoing Mead's ideas, Theodore Sarbin (1968) construes role as a "patterned sequence of learned actions of deeds performed by a person in an interactive situation" (p. 225). Such deeds and actions are the vehicles by which a person is permitted to engage with others in a given milieu.

For Erving Goffman (1961), human behaviors can be compared to those of a theatre performer who is reliant upon his capacity to adopt myriad, distinct roles that correspond to the expectations of his spectators. Not unlike the actor, individuals have the tendency to accommodate their actions and behaviors to meet the needs of family, friends, and others they encounter within the scope of everyday life.

Role: From Theatrical Construct to Therapeutic Device

Psychiatrist Jacob Moreno was among the first to situate the theatrical construct of role within a therapeutic milieu. Besides viewing role as a merely socially evoked phenomenon, Moreno proposed two other types of role, the somatic, which comprise bodily functions such as eating and sleeping, and the psychodramatic which constitutes one's "fantasy and internal life"(Jones, 1996, p.196). Within the therapeutic process, this latter type of role may serve as the medium through which we enter our unconscious from our everyday lives in order to formulate new semblances of order and meaning. It is likely to this sense of the term 'role' that Moreno refers when he states that, "roles do not emerge from the self, but the self may emerge from roles" (Moreno, 1946, p. 157).

The conceptualizations of role arrived at by Moreno and the above-mentioned authors have served to profoundly influence the ideas of more recent role theorists. Psychiatrist and psychodramatist Adam Blatner (2000), in his reflections on role theory and method in therapeutic practice, cites several advantages he perceives as intrinsic to their use with clients. Based as they are in image and action, roles offer a more tangible depiction of multifaceted behavior and benefit both client and therapist in that they "may be entertained in the mind more readily than most abstract concepts, especially psychological diagnoses"(Blatner, p.156). This point is by no means insignificant, as many of the subjects referred to in this paper express resentment and frustration with diagnostic labels by which they feel confused and societally stigmatized. Blatner also advocates the use of role work as it offers a means of viewing the complexity of an individual's personality a few aspects at a time, thereby lessening the potential for clients to feel overwhelmed by the process of attempting to view their qualities and behaviors as

a whole. Another advantage of utilizing role method lies with its temporal possibilities; one can choose to explore roles that are relevant to one's past, present and future, imagining and rehearsing for tomorrow's challenges and recalling –even attempting to repair- those of yesterday (Blatner).

Role in Dramatherapy

Author Phil Jones (1996) includes role among the nine core processes he outlines in his seminal text *Drama as Therapy: Theatre as Living* and offers the following distinction regarding the manner in which it is used:

> Within Dramatherapy, role is not 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. (p. 197)

According to Jones, the creation of role takes place not only when a client assumes a fictive persona, but also when he plays the role of self as contextualized in a different time or place. Additionally, the client can highlight a specific quality or aspect of self as the basis for role. This latter conception of role is perhaps most pertinent to my research as it coalesces well with the use of Robert Landy's (1996, 2003) Role Profile assessment tool, a core element used within the therapeutic process described in this paper.

I. Robert Landy: role theory and practice.

Dramatherapist Robert Landy is perhaps most renowned for his prolific work concerning role, which he has defined as a "basic unit of personality containing specific

qualities that provide uniqueness and coherence to that unit" (1993, p. 7). For Landy, role and story are the primary vehicles by which client and therapist gain entry to and explore issues within the therapeutic session (1993). He eloquently expresses the interrelatedness of the two, claiming that role is:

> the container of those qualities of the individual that need to be enacted in drama therapy. Story is the verbal or gestural text, most often improvised, that expresses the role, naming the container. The client as creator invents stories...as a means of revealing role. At the end of one's story,...one should be able to answer the question, Who am I? And the answer involves both and identification of individual roles I play and an integration among my many roles. (1990, p. 233)

The cornerstone then, of Landy's role theory, lies with the belief that each individual contains within her a plethora of roles that can potentially encompass the complete array of human experience.

In Personae and Performance: The Meaning of Role in Drama, Therapy, and Everyday Life, Landy (1993) expands upon a model in which the concept of an individual's 'self' is replaced with that of a system of interdependent personae which one takes on or plays out at different moments in one's life. The roles within this system derive from both our innate, biological make-up and the socio-cultural factors which inform our environment (Landy, 1993). The roles Landy labels as *primary* are those bestowed upon us at birth. *Secondary roles* constitute those we acquire. The roles or personae referred in this group involve a process of choice on behalf of the individual, and are adopted via an "external process of invitation and an internal process of identification with significant and generalized role models" (Landy, 1993, p. 39). His

third category, termed *tertiary roles,* comprises those which are played out. One's roles can be further arranged into a series of interconnected categories that include *cognitive*, *affective*, *spiritual* and *social.*

Secondary roles often mirror those portrayed within one's familial and cultural milieu and can, for this very reason, prove problematic. Dobrowolski (1995) raises the salient point that our role choice can be very much colored by "the consciousness with which we originally perceived it" (p.12). She offers by way of example the person who experiences the "mother" role as one fraught with abuse and neglect. It is not unlikely that said child could grow up harboring a limited conception of –and therefore limited ability to play- the maternal role (Dobrowolski).

Fortunately, Landy (1993, 1996) does not view the role system as a static entity that destines people to play and re-play dysfunctional roles. On the contrary, his theory depicts a role repertoire that is constantly in flux, growing and altering with a person's incessant culmination of new experience. Furthermore, a core assumption of Landy's theory is that roles can be worked with and modified through a therapeutic method aimed at restoring balance within the overall system (1993). Part of this healing process entails the client delving into and subsequently growing more cognizant of her role system. Armed with this knowledge, she can imbue her role choices with more insight and intention.

A central problem Landy (1993, 1996, 2000) seeks to address in utilizing role work therapeutically is that of *role ambivalence,* the emergence of conflicting, often confusing feelings a person may experience when engaged in the taking on or playing out of paradoxical roles. While he deems a certain amount of ambivalence both necessary

and healthy in order for the individual to fully embrace and explore the complexities of roles, excessive ambivalence can result in a heightened state of distress. This distress, and the confusion that is its common companion, can impede the individual in her quest to achieve sufficient mastery of a given role. The internal and external personal struggle denoted by the presence of role ambivalence is, however, viewed as requisite to the process:

> Without the struggle between conflicting roles, there would be no drama. The undramatic life is a fool's paradise. The dramatic life is one lived in paradox. And to live dramatically, one must cultivate a role system flexible enough to support and contain the struggle. (Landy, 1993, p. 169)

For Landy, the critical objective of work with role method in dramatherapy is attained when the client is capable of tolerating role ambivalence and can give credence to the inherent value of both the positive and negative roles in her system. The process by which these goals are achieved can be viewed as analogous to one of gradual disentanglement, wherein bits of the role system are extricated, examined and explored. Ultimately, the therapist hopes to help the client reconfigure her role system so that its composite parts are integrated in a way that allows balance between contradictory personae.

The role method proffered by Landy (1993) seeks to create viable, balanced role systems through the application of eight steps which include: "(1) invoking the role, (2) naming the role, (3) the playing/working through of the role, (4) exploring alternative qualities in subroles, (5) reflecting upon the role play... (6) relating the fictional role to everyday life, (7) integrating roles to create a functional role system, and (8) social

modeling..." (Landy, p. 46). The early stages of this method involve allowing the client to uncover, through a guided improvisational process, a specific role or roles which have need of attention. Subsequently, the role is examined to reveal its conflictual qualities through embodiment and exploratory role-play. Gaining insight into the ambivalent nature of our relationship with the role is followed by a burgeoning awareness of the ways in which we limit ourselves by accentuating certain roles or role aspects while disregarding others. It is hoped that through the later phases of the method, in which the client identifies with and differentiates herself from the enacted role, it can be successfully reintegrated into her role system.

II. Distancing and de-roling and their place in Landy's role method.

Entry into role marks "experience outside the usual framework by which the individual is known" (Jones, p. 203) and necessitates the creation of a dramatic reality. The dynamic tension resulting between the enacted, fictional self and the client's everyday identity contains an active relationship in which therapeutic needs can be perceived. The issue of entering and exiting the dramatic realm in which the client's role exploration occurs raises another critical concept, that of the therapeutic notion of *distance* as conceptualized by Landy (1991) and expounded upon in the work of Emunah (1994). Both employ the term with reference to the client's amount of affective involvement with or cognitive detachment from the issues and experiences that arise within the therapeutic frame.

In striving to elucidate a clear theory of distancing as it applies to the field of dramatherapy, Landy has adapted the ideas of renowned sociologist Thomas Scheff. Like Scheff, Landy views an individual's degree of emotional engagement with or removal

from material arising in the therapeutic process along a spectrum (Landy, 1984). At opposites end of this spectrum lie the extreme polarities of *underdistance* and *overdistance*. For Landy, the underdistanced client is one who confronted by person material, experiences an affective flood of repressed emotion. When expressed, this overabundance of emotion brings with it neither relief nor insight as the client is so engulfed as to be rendered incapable of cognitive reflection. The overdistanced client, in contrast, is one who has learned to block his ability to experience challenging emotions through cognitive control. When confronted with painful or uncomfortable personal issues, such a client responds with intellectual detachment and a disassociation from feelings. In the overdistanced state, the client tends to remain in the realm of the rational at the expense of emotional expression.

Like Scheff, Landy sees the central goal of the dramatherapy process as helping the client arrive at the mid-point of these extremes by achieving a state he terms *aesthetic distance* (Landy, 1984). At a place of aesthetic distance, an individual occupies a balanced psychic position in which, while enacting a therapeutic dilemma, he can access and experience emotions without the threat of becoming overwhelmed by them. It is at this sought-for middle point on the distancing spectrum that the client's state is characterized by "emotional expression that is clarifying and relieving rather than obscuring and overwhelming and that invites an engagement of the rational, reflective capacities" (Landy, 1996, p.367). Such inner equilibrium between extremes allows the client to move forward towards an understanding of his problematic material. In Landy's view, aesthetic distance is synonymous with *catharsis*. For him, catharsis does not refer to a mere purging of emotions; rather it implies a place of emotional and cognitive clarity

in which one experiences a "felt intelligence' with regards to one's issues (Landy, 1991, p.41).

I believe it essential that, while facilitating the client's healing exploration the therapist remains carefully attuned to her unique needs for lesser or greater emotional distance in the moment. Bearing in mind the emotional vulnerability of many in my research population, I tended to choose projective devices (see next section) and role games that offered increased distance at the outset of our therapeutic journey together. In one of his key articles, "The Dramatic Basis of Role Theory", Landy states:

> At the heart of all human experience- whether in ritual, spontaneous play, creative drama, improvisation, or theatrical activity of any kind, is the principle of impersonation, the ability of the person to take on a persona or role. The dramatic experience is one of paradox: I am me and not-me at the same time. It is one of engagement and separation: I take on a role and then I separate from it. (1991, p. 29)

Though the issues that emerge in role work are real, the role enactments are fictional rather than real life occurrences. The resulting tension between these acknowledged separated states of being permits therapeutic work with role to offer an intrinsically distanced medium through which healing processes can occur.

With regards to the issue of distance, the six-key dramatherapy assessment model developed by Susana Pendzik (2003) has proven helpful when choosing which role technique –whether for assessment or process- is most suitable with clients. Of great importance, Pendzik suggests, is the therapist's responsibility to observe the individual's capacity for movement between "ordinary (life) into dramatic reality and back" (p.94)

and the manner in which she effects this transition. This was an issue of some concern with many of my research subjects, for whom the concepts of 'self' and 'reality' were at times malleable. Like most methods, the use of role invites the client to play in a new, dramatically-embedded reality wherein the 'as if' quality of self-exploration is mutually understood and agreed upon. In the case of those of my subjects for whom distorted thinking and parallel 'realities' were already issues with which they were contending, the entry into this fictive realm, if not approached safely, could have served to enhance their inner confusion.

Additionally, such subjects, whose sensory and cognitive boundaries were sometimes quite fluid, could have experienced difficulty and disorientation upon trying to exit the role or character they had created. It is here that the practice of *deroling* proves fundamental in the dramatherapy process (Emunah, 1994; Landy, 1993). The client's necessary return from the imaginal realm back into his actual everyday life is characterized by a conscious effort on the part of the therapist to encourage the client to take distance. In practice, the deroling process can be viewed concretely in such processes as the taking off of a character mask or in the group's verbal examination of a session's outcomes following its 'action' phase.

Principal components of Landy's model of healing through role include role *type, quality, function* and *style*. He sees distancing in the dramatherapist's efforts to move the client towards an elucidation as to the quality of the role, as this process often calls for an extension or caricature of it. Such necessary amplification allows the client the opportunity to mock "that thing of great power that cannot so easily be approached" (1991, p.40).

Landy likewise views choice of style in role enactment as closely related to the use of distance in that varying styles of performance have different levels of emotional engagement inherent within them. By level of stylization he refers to the manner in which the role is performed in terms of it relationship to reality. Style falls into two primary categories, the presentational and the representational. A presentational style of role enactment is "abstract and symbolic, making no attempt at verisimilitude" (Landy, 1991, p.30). Such a style is deemed appropriate for use with an underdistanced client in that it tends to be more intellectual than emotional and brings forward universal as opposed to specifically personal truths. In contrast, the representational style is both more realistic and specific "leaning more on emotion that on cognition"(Landy, 1991, p.30). This style is appropriate when a client is overdistanced as it serves to elicit a deeper level of feeling. It thus follows for Landy that *psychodramatic* roles, with their basis in the actual life of the protagonist, are most suitable for those individuals who are too affectively removed in their role-playing. *Projective roles* such as those embodied in fictional characters, puppets and masks, are seen as more useful for clients who tend to merge too much with their characters (Landy, 1991, p.41). By playing with varying styles and types of role, the dramatherapist can help the client "achieve a balance of distance, an ability to act, without the fear of being swallowed up in the sea of their actions, and to simultaneously reflect, without the need to avoid the water at all costs" (Landy, 1991, p.41).

III. The Role Profile Assessment Instrument.

In light of the above-mentioned concerns, I chose Landy's (1996, 2003) *Role Profile Assessment* as a starting point that offered slightly more distance than asking subjects to embody a role. As I will demonstrate in Chapter Three of this paper, what began as a 'starting point' with which myself and my subjects could 'take stock of' what they perceived to be their primary roles in everyday life, evolved into the central device that formed the basis of much of our subsequent session work..

The genesis of Landy's Role Profile instrument emerged from his endeavors to identify and name the multitude of roles that human beings are capable of playing (Landy et al., 2003). Through an extensive perusal of over six hundred plays, Landy discerned a number of archetypal characters which commonly reappeared. One hundred and forty-six roles and subroles made up his original compilation, a number eventually reduced to ninety in what Landy labeled the Taxonomy of Roles (Landy, 1993). The taxonomy was utilized in various testing formats until its most recent manifestation as a card sort comprising seventy archetypal roles (Landy, 2000; 2003).

In the Role Profile assessment technique, subjects are given a deck of seventy role cards and asked to shuffle them. They are then instructed to distribute the cards across four categories, placing each card in the group that they feel most accurately describes how they perceive themselves in the current moment (Landy et. al, 2003). Headings of the four groups, as displayed on large cards, include the following: *I Am This, I Am Not This, I Am Not Sure If I Am This* and *I Want To Be This.* Subjects are asked to arrange the cards relatively quickly (i.e. without a lot of contemplation), and are free to ask any questions before commencing the process such as those concerning

definitions for terms.Upon completing the sorting and grouping task, the tester invites the subject to review her assortment and make any changes she deems necessary. The researcher then explores with the clients any associations they see between the roles and discusses various aspects of subject choices in each column.

In discussing the utility of Role Profiles, Landy et al. (2003) state that it "appears useful with [those] who are still experiencing roles and qualities for the first time. The act of delineating who one is (or is not) by sorting cards *is an apt metaphor for the [person] who is discovering her own identity as a human being*, and a keen way to begin the therapeutic journey." {italics mine} (p. 155). In Landy's view, this and other role-based devices provide "...tangible framework[s] in which to formulate diagnostic, treatment and valuative strategies and against which to evaluate new role phenomena." (Landy, 1996, p.115). As I will discuss in my description of the therapeutic process that is the basis of this paper, the Role Profile assessment instrument can be helpful in other capacities as well, not the least of which is its utility for catalyzing more in-depth role work.

Chapter Three: Methodology of the Research Study

Introduction

My intent in pursuing this research was to explore the use of dramatherapy techniques, specifically those which emphasize the investigation of role, as means of treating depressed women. To this end, my inquiry and its outcomes are herein presented as a descriptive group case study that depicts and reflects upon qualitative data gathered from a short-term dramatherapy process. I have also striven to determine whether or not the theories of self-loss and self-silencing, as posited by Jack (1991), provided helpful frameworks from which to interpret and examine many significant role issues that arose in the dramatherapy process.

Though the archetypal roles included in Landy's (1996) taxonomy were integral to the therapeutic method, they primarily served as important catalysts for other mediums of participants' self-exploration. Said mediums included projective techniques developed by Emunah (1994), Lahad (1992) and Sternberg (2000), as well as psychodramatic devices conceived in the work of Moreno (1959) and Blatner (2000).

Sources of Data

Types of data collected during this study include my case notes from observations made during and reflections after sessions, individual dossiers kept at the session site, initial assessment and post-treatment evaluation notes, client writings and artwork created within sessions, and photographic records of both client artwork and session materials such as charts, scripts etcetera. This data has been analyzed through both dramatherapy and feminist theoretical lenses. It includes not only my perspective and reflections but

also those generously shared with me by my participants, both throughout the therapeutic process and after its closure during debriefing and termination interviews conducted with each individual.

Participants

The four research participants described in this paper were clients who took part in two of the dramatherapy groups I conducted at my second-year practicum site, a community mental health facility which serves a population of adult clients with psychiatric disabilities. As I had the liberty to choose my client group, as well as those I invited to be participants in my research, I had a non-randomized sample. Participants initially arrived at the facility in a variety of ways, including through referrals from other mental health professionals and by word of mouth. My research sample comprises four women with whom I met weekly for two-hour group sessions over the course of approximately seven months between late October and mid-April, 2005.

The requisite characteristics I sought in selecting my participants were as follows: female; already given an official/probable diagnosis of depression by a recognized mental health clinician; either in a depressive state or in recent remission; ranging in age from thirty to sixty years; not presently suicidal (i.e. active, plan-oriented –this stipulation did not exclude passive, fleeting suicidal ideation); not evincing paranoid or delusional tendencies. It is important to note that it was not always possible to definitively assure that all of these criteria were met, as much of this information was elicited from the participant herself, and background dossiers were often incomplete or lacking sufficient detail. As well, depression's frequent comorbidity with anxiety and agoraphobia meant

that rates of absence and attrition at times proved challenging in terms of maintaining process continuity.

The four women whose therapeutic journeys are documented in this paper's case studies (Chapters Five and Six) were specifically chosen for a number of reasons. First of all, they represent two different dramatherapy groups: Participant One, Marianne, and Participant Two, Ruth were members of one group. Participants Three and Four, herein called Amanda and Claire respectively, were in the other. Though groups, by the very nature of the individuals comprising them, can never be called identical, it is critical to note that both sets of participants engaged in parallel processes in terms of the structural content and progression through various phases of evolution in the work.

Other factors in my deliberations stemmed from practical considerations such as the frequency and consistency with which members were able to attend sessions and whether or not most if not all chosen participants were present for and partook of the relevant exercises and process stages which constitute the basis of this paper. Certain clients whose initial diagnoses of depression were later amended to include possible schizo-affective, paranoid or borderline psychotic features no longer fit the requisite depressive description and were thereby deemed inappropriate for inclusion in this study. These participants, it must be noted, continued in the therapeutic process and received equitable treatment with other group members.

Among the suitable subjects remaining after the aforementioned issues were taken into account, I strove to choose four women who represented a range of age, socio-cultural background, religious affiliation, approaches and responses to the process, and most importantly, who presented with diverse challenges at the outset. While I

acknowledge that the term "range" is relative here given my sample size, I strove for this diversity because, as the reader shall shortly see, one of this process' most revelatory aspects lay in the universal themes it evoked.

It is also imperative to acknowledge that the processes of my four participants did not occur in a vacuum and cannot be thusly regarded. To clarify, though Marianne, Ruth, Amanda and Claire are those whose stories are explored in detail, their voices emerge from a sea of many participants' personal narratives whose journeys proved just as fascinating. These 'other' voices will necessarily be interspersed throughout sections of this study.

In the interest of protecting all participants' confidentiality, all names herein have been replaced with pseudonyms. Furthermore, some minor details have been altered in order to further assure that potentially identifying characteristics have been mitigated. All participant utterances in quotations have been quoted verbatim. In certain instances, parts of these statements have been italicized to faithfully indicate the speakers' own emphasis.

Chapter Four: The Therapeutic Process and Role

Wading into the Deeps: Emunah's Integrative Five Phase Model

The therapeutic approach employed in this research study was based upon Renee Emunah's Integrative Five Phase Model, as outlined in her 1994 work, *Acting for Real: Drama Therapy Process, Technique, and Performance.* Emunah's model offers an extremely comprehensive, pragmatic theory, which incorporates devices from a host of multidisciplinary sources including dramatic play, ritual, theatre, role play and psychodrama. The main treatment objectives are derived from a similarly eclectic array of sources, encompassing fundamental tenets of psychodynamic, cognitive-behavioral and humanistic psychotherapies. Said objectives include the following: allowing for the clients' expression and containment of emotion; encouraging an expansion of and tolerance towards their role-repertoires as put forth in the work of Landy (1993, 2000); fostering the evolution of their observing, reflective egos; strengthening self-esteem and facilitating the growth of interpersonal skills (Emunah, 1994).

Writer Ron Scott (2003) nicely encapsulates the model as one that, in its efforts to align to each client or client group's needs, "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" (p.61). I share with Emunah the view that the pace and progression of clients' movement from one phase to the next often emerges organically from the group, rather than following a rigid adherence to a preordained succession of treatment stages. This perspective is noteworthy for me because, in its implied intention to avoid superimposing specific clinical expectations on group members, Emunah's

model speaks to the clients' right to ownership of their own processes, and the varying levels of comfort and support requisite to different individual's ability to move safely forward.

Emunah's model highlights her underlying conviction that a potent relationship exists between the stage act and the life act (1994). The fundamental means of exploring this relationship is through the taking on and playing out of roles. Portraying the behaviors, and emotions inherent in one's roles through dramatic enactments offers the individual enormous benefits. The stage, a delineated fictional realm, allows clients the possibility of surpassing their usual limitations, both social and psychological. Her dramatherapy paradigm thus strives to grant clients "a sense of freedom from the constraints of everyday life and from engrained patterns" (Emunah, 2000).

The distance afforded by the dramatic container, Emunah maintains, permits the client emotional protection while simultaneously enabling her to garner important self-insights into her entrenched ways of being and acting in specific situations (2000). As the client's trust in and growth through the process progresses over time, the need for such protection diminishes and the associations she has made between the fictional enactments and her real life support her ability to engage in more direct work with real life material (1994). Emunah views the impact of role-play upon the individual as multi-faceted, affecting not only her self-awareness, but also her self-image and perception (2000). These changes are ultimately manifested in the final stages of the Five Phase Integrative Model (1994), which Emunah describes as follows: "When the time comes to discard roles and unravel layers of masks, the person is not the same as s/he was prior to these acting processes" (2000).

It is important to note that Emunah's model does not advocate clients' immersion in role and enactment at the start of the process. In her writings, she consistently stresses that, prior to engaging in such processes, individuals within a group must build the dramatic skills necessary to perform scenes with ease and authenticity (1994; 2000). The degree of authenticity with which an individual can enact a scene, Emunah suggests, corresponds to the extent to which she can be personally affected (2000). Moreover, Emunah's model holds that there is a distinct parallel between the development of trust, cohesion and dramatic aptitude in a group and its capacity to move towards progressively deeper, more profoundly personal healing work. Throughout this therapeutic journey, the concept of distance as a remedial tool figures prominently.

In *Acting for Real*, Emunah introduces the notion of cognitive/affective equilibrium as she shares her belief that, in contending with the intricacies and complexities of life, one "cannot afford to exist without a highly developed sense of empathy and perspective" (1994, p. xv). Like Robert Landy, she sees acting, the basis of most dramatherapy processes, as comprising the dual roles of participant and observer insofar as "we are emotionally engaged in the reality that is being portrayed, and at the same time we are witness to what is taking place" (1994, p. xvi) She further states that though the degree of emotional identification and cognitive distance vary within scenes and individuals, both factors are always present to some extent: "Even as we are 'caught up' in the action, we are detached enough to respond reflectively" (1994, p.xv).

Echoing Landy's ideas regarding the term, Emunah speaks of a necessary balance in our lives "between underdistancing (overly identifying to the point of mergence with others or becoming overwhelmed with feeling we cannot control) and overdistancing

(maintaining overly rigid boundaries or losing touch with our emotions) (1994, p. xvi). Indeed, the voyage of the client through the Five-Phase series can be viewed as following a distancing continuum in that the process begins therapeutic exploration from a rather distanced place in phases one and two, moves towards successively lesser distance in phases three and four, and strives, in the fifth and final stage, to return the client to a more distanced, balanced perspective of what has transpired in the four preceding stages. An apt analogy for Emunah's philosophy regarding this progression is found in the following quote:

> I don't like the shock of plunging from steaming hot to freezing cold water. I like wading in shallow waters, frolicking in waist-high water, and then swimming in the very deep waters – and the journey through the levels of depth. (Emunah, 1994, p.72)

In Phase One, *Dramatic Play*, clients enter into the imaginal realm contained in the playspace and begin to explore group themes "symbolically, creatively and collaboratively" (Emunah, 2000, p.73) from a considerably distanced stance. This stage focuses upon the gradual development of group cohesion, trust and playful interaction and serves as a critical foundation for the work to follow. Phase One generally invites clients to revisit the state of joyful permissiveness and spontaneity that characterize childhood play (Emunah, 1994). Though this initial phase is invaluable for allowing the therapist to garner clues as to the need-sets and issues of clients, in longer-term therapy such as that described in this study, it is used primarily as a catalyst for deeper, more core work undertaken in later phases.

In Phase Two, entitled *Scenework*, the group engages in improvisation and the playing of primarily fictional roles. As the roles differ from those the clients play in real life, this phase allows for greater role distance and less direct self-disclosure than the phases to follow. Phase Two marks a crucial step in the development of group unity, trust and improvisational capacity: clients thus become prepared to explore their personal material more directly in phases three and four (Emunah, 1994).

The entry into Phase Three, *Role Play*, marks a fundamental shift from the imaginary to the actual as the group begins to look at their real-life issues within the dramatic medium. The amount of distance between individuals and their personal material lessens and the potential for emotional extremes is greater. Though the scenes enacted in this phase are based on real life, "the fact that they are fictional enactments rather than real life occurrences is of critical significance in terms of therapeutic possibilities" (Emunah, 1994, p. 75). Emunah further states that, "the measure of distance from reality afforded by the drama stimulates the functioning of the self-observing ego" (p. 76), suggesting that the client is permitted to have emotional identification with the role and/or event, while avoiding complete immersion in affect by maintaining a degree of critical detachment. By pausing in the midst of and/or following scenes, the therapist may take advantage of the distance element to facilitate a thoughtful, collective examination of what has transpired (Emunah, 1994). This stage of the process, which Emunah refers to as that which uses "rehearsal for life" (p. 39), affords clients the opportunity to obtain insight into entrenched behavioral patterns and practice new responses to old problems within the fictional realm.

Moving into Phase Four, *Culminating Enactment*, clients enter into the least distanced stage of the process. It is here that the therapist begins to employ psychodramatic techniques as the focus of the group's exploration shifts from tangible, present-day issues to more profound, core material. Deeper, sometimes unconsciously-held personal matters rise to the surface and the therapeutic emphasis moves from the group to the individual. Deriving additionally from personal themes emergent during prior phases, the work done in this stage is evocative and enhanced by a heightened degree of risk-taking on the part of the client. In this least distanced phase, Emunah deems it critical that "the degree of self-exposure and emotional intensity be matched by the level of group cohesion and support" (Emunah, 2000, p.77). She sees the psychodramatic techniques utilized during this stage as invaluable, their primary attribute the way in which they integrate sensation, emotion and intellect in such a manner that clients cannot stay solely in the cognitive plane (Emunah, 1994). The gradual progression of the group from acting to *reenacting* "enables the therapist both to gauge and to develop the client's tolerance for emotionality and self-exposure"(Emunah, 2000, p.77) as she encounters material of heightened immediacy and potency. Possible outcomes of Phase Four include the experience of emotional *catharsis*, during which the client's long-buried feelings are granted expression, as well as a significant deepening of the group's capacity for *empathy* (Emunah, 2000).

The fifth and final stage, *Closure*, heralds a movement back to a less emotionally intense state: its objectives are termination of the group and transition from participation in the group process to reoccupying roles of everyday life. The very title of this phase denotes a 'closing up' of both the playspace and the therapeutic framework enveloping it.

In Phase Five, the therapist strives to move the clients towards a balanced cognitive-affective plane from which they can review the series of sessions and evaluate their progress, as well as express their feelings about the cessation of the group (Emunah, 2000). The chief aims at this juncture are concerned with "facilitating the integration and assimilation of the therapeutic progress made in the preceding phases" (Emunah, 1994, p. 43). In this way, it is hoped that clients will be able to carry insights and successes gleaned from the therapeutic process forward into their everyday lives, beyond the realm of the treatment milieu. The use of *dramatic ritualistic processes* are crucial to this final phase and "facilitate the review, encapsulation, and celebration of what has taken place" (Emunah, 1994, p. 22) over the course of the therapy. These rituals further provide vehicles by which the often intense, intricate mental and psychospiritual responses the therapy has elicited for clients can be acknowledged and contained (Emunah, 1994).

Rationale for Using the Five-Phase Integrative Model as a Framework

I chose to use Emunah's (1994) inclusive, clearly-delineated yet flexible model as a progressive framework in which to ensconce my overall treatment plan. The reasons underlying this decision were several. Beginning with any new group, one can never judge with complete certainty which avenues of treatment (free play, projective devices, psychodramatic techniques to name but a few), will most safely and effectively lead participants towards the attainment of both the group's objectives and the personal goals they have set for themselves. In this particular case, I also had to bear in mind the principal goal of my study which was to explore dramatherapy's use of role as a treatment modality for women living with depression. From my chosen feminist theoretical perspective, I wished to discern whether or not role exploration and modified

role methods could act as mediums through which these women might locate their authentic inner voices, long suppressed by societal conditioning and further obscured by the shadows of depressive illness. As discussed in the previous section, Emunah's Five Phase model emphasizes the taking on of role as the fulcrum of the therapeutic process. It thus appeared that this specific treatment format could effectively facilitate my participants' discovery and examination of the diverse roles constituting their taxonomies.

Of the many dramatherapy models I have thus far encountered, the Five Phase paradigm (Emunah, 1994) appears to most thoroughly encompass a broad diversity of therapeutic devices and techniques. I am also conceptually drawn to Emunah's proposed form. The inherent fluidity of movement it promotes within the progression of the various phases permits participants to go at their own pace: if a group is not ready to move forward, Emunah (1994) suggests that they can remain in the initial stage for the duration of the process and still have a rich healing experience. Her careful and consistent awareness of optimal distance is of immense importance for emotionally vulnerable populations, exemplified by women living with psychiatric illnesses.

One the basic premises underlying Emunah's paradigm, which incidentally aligns with my own treatment philosophy, is the importance of commencing the therapy in a manner which stresses a client's healthy parts and functioning capacities (1994). Such a positive starting point is crucial for participants such as mine, who have long self-identified with *the sick person*, *the victim* and other confining labels. For me, Emunah's viewpoint regarding this matter, speaks to a more all-encompassing benefit of her model: it enables clients to feel a heightened degree of personal ownership over their processes.

As many of my research participants tended –at least in the early sessions-to view themselves in passive roles (*patient, child, victim, slave* etcetera), this emphasis upon the 'active' self suggested a significant shift in attitude. The Five-Phase model also promotes *literal* activity in its inclusion of movement and physical expression. This component helped to counter the medication-induced or illness-related lethargy to which all of my participants were subject to varying degrees.

As I will describe in the next section, I also employed Emunah's model (1994) on what could be called a 'microcosmic' level, in that each session was loosely divided into a succession of stages. These included lighter, more distanced activity in the spontaneous and playful spirit of the warm up, through emphasis upon fostering trust and group cohesion, to work with core material and processing, and finally to closure.

Structure of a Typical Session

My intention in this section is to give the reader an understanding of the usual configuration of a dramatherapy session as formulated within the groups I refer to in this study. Due to this paper's necessarily limited scope and the immense diversity of session activities, I will not attempt to describe every technique and exercise employed in each stage of a session.

The two dramatherapy groups of which my four research participants were members, followed a fairly simple, cyclical format with a clearly delineated beginning, middle and end. We opened and closed each session with a ritual called *The Minute* which I offered to the group to try out and which they subsequently communally agreed to adopt for the duration of our process. During *The Minute* the group, seated in well-grounded postures (i.e. knee and shoulder widths aligned with feet planted solidly on the

floor) and eyes closed, silently observed the passing of sixty seconds. Though simple to describe, the ritual's purposes were several. It served as a plainly marked period during which participants could affect an emotional and physical transition between the often-harried time preceding their arrival at group and the actual commencement of the therapeutic work. It functioned as a framing device and helped participants focus their awareness upon both their personal state-of-mind and on the presence of others. Several group members began to gradually incorporate *The Minute* ritual into their everyday lives, sharing that they felt it granted them a moment to pause and have a personal check-in regarding how they were feeling during the course of a given day.

Following the opening ritual the group would enter into the *warm-up* phase, which in our sessions comprised both a physical component and an emotional check-in. The physical warm-up took many forms, such that we used a different exercise for almost every session. An example would be *The Anatomy Game,* during which members were invited to call out a part of the body that the group would proceed to stretch, shake or otherwise move, until each section was loosened up. Emotional check-ins often occurred through metaphor. *Emotional Forecast*, in which participants describe their current emotional state in the form of a weather report, is one example. When the group expressed a need for a verbal check-in, we made use of *The Talking Egg,* literally an egg made of smoothly-polished, solid wood that we would pass around our circle. I found the *Egg* remarkable for a number of reasons; firstly, it allowed the holder to invest any anxiety or inhibition she was experiencing into the physical act of holding its form in her hands; secondly, it acted as a concrete sign of one's ownership, even ephemerally, of the space and thus an indication that others were expected to listen; thirdly, the act of both

deciding when and if to take the *Egg* and when to pass it on were entirely the choice of the individual. She thus retained a sense of dignity and right around her voice, as opposed to feeling *compelled* to share.

The mid-section of each session was the time in which *core process* work took place. This was the main therapeutic activity and could consist of anything ranging from projective work with objects to full role enactments, depending entirely on both the objectives of the session and the phase in which it occurred.

The next stage of the session was *sharing.* This stage essentially provided a forum in which the core activity could be processed and reflected upon through verbal or non-verbal means. The latter could manifest in the form of a *Movement Circle* in which each individual conveyed her responses with a gesture.

The group then moved into *closure,* which denoted the end of all active dramatic work, and disengagement from the dramatic space or fictional realm that had been established (Jones, 1996). The de-roling process (as described in Chapter Two) was often an integral part of this stage. The group's sense of reconnection with one another (i.e. out of role) was fostered by exercises such as *Pass The Hand-Squeeze*, in which participants join hands with eyes closed and circulate a gentle squeeze, at times changing the speed or direction of the impulse. Closure additionally often included exercises that allowed group members to take stock of how the session had affected them.

In our groups, the closure stage was invariably followed by a return to the ritual *Minute*, once again allowing participants a brief, uncluttered 'space' through which to ease the transition from the intimacy of the therapy room to their everyday lives beyond its walls.

Chapter Five – Four Fabulous Women: The Case Studies

Participant 1 - Marianne

History and presentation.

Marianne is a female client in her early forties who resides with her teenage daughter. Both she and her daughter, who was recently diagnosed with a disability, have regular, but infrequent contact with the young woman's father. Despite this, Marianne characterized her relationship with her ex-partner as amiable. Marianne is currently in a committed, long-term relationship with a man and reports, "It is going well."

During our first meeting at intake, Marianne presented as very amiable and emanated a gentle quality She was soft-spoken but articulate, and very open in sharing her history and conveying her needs. She admitted to having experienced depressive episodes in the past, the most recent of which had occurred in the spring of the previous year. Though she described having been in a "very down" state during this period, she claims to have been in remission since. For this depressive episode, Marianne was treated with an antidepressant medication for the first time and asserts that she was obliged to cease taking it due to what she stated were "very adverse side-effects" which rendered her in a "zombie-like" state. She was also given a sleep-aid medication which she said similarly impinged upon her physical and cognitive functioning.

Marianne further described her bouts of depression as being cyclic in nature, occurring every couple of months over the last several years. When asked to expand upon the nature of her depressive episodes, she said she became uncharacteristically weepy, had agitated sleep patterns and felt "shut-down" and "isolated". Though she claimed never to have made a suicide attempt, Marianne admitted to having experienced passive

suicidal ideation while in past depressive phases. She depicted her depressive state of mind as comprising "negative thoughts" which led to a sense of diminished interest in her life and "not caring as much in general". She suggested that hormonal changes could be acting as a possible trigger for her depressive episodes, but that they were more likely attributable to the sense of mounting stress which visits her when she feels confronted with "too many demands".

Marianne shared that as a young adult she was a victim of sexual abuse. Furthermore, she stated that she had experienced physical and psychological abuse at the hands of her father and her ex-spouse. She claimed to have no substance dependencies and described herself as "an occasional drinker" whose "very limited" recreational drug use was no longer a part of her lifestyle.

Marianne reported that she was not currently feeling "down", but was feeling immense pressure from the many demands inherent in her everyday life, including the maintenance of two challenging jobs and the singular care of her daughter. She repeatedly expressed that the frenzied nature of her life left her insufficient time to stop and check in with her emotional and psychological well being. Part of her aim in seeking to join the dramatherapy group was thus to attempt to delineate a time for herself amidst her hectic schedule.

Marianne's stated objectives.

Marianne had participated in expressive arts therapies groups in the past, and strongly felt she had derived substantial benefit from the experiences. She was very calm and clear in stating her needs and goals for entering the dramatherapy group. Firstly, she wanted to profit from her current sense of "feeling good" by engaging in a process of

self-exploration. Secondly, she wished to practice asserting herself, expressing her "own needs" without fear of "how others would react". Thirdly, she was interested in looking at what she perceived as her issues with authority, specifically as they pertained to/related to her relationship with her father. In essence, she wished to "pause and pay attention" to what her "mind and body" were telling her. Finally, she stated her desire to work on "self-care and self-respect", to "listen to [her]self" and to be "comfortable in [her] own skin". She felt that a group context would allow for the sharing and releasing of emotions and issues in a mutually accepting environment.

Marianne's therapeutic journey through role.

"I need to learn to listen to myself, to my own story."

(Marianne, stated during our initial interview)

Marianne was, from the very beginning, perhaps one of the most dedicated clients I have ever had the pleasure of working with. She was fully engaged and committed to the process at all times. She was always early for sessions and did not miss a single one, even when it was a considerable challenge for her to attend. Perhaps due to her previous experience in groups (and no doubt in part to her personality), she had little hesitation diving into imaginative activities. In exercises such as projective *Emotional Expression with Fabric*, she easily entered a state of childlike play, laughing and running about.

In many respects then, Marianne could be regarded as having little difficulty taking risks in the creative realm. There was an underlying sense, however, that despite her warm support and respect for the other group members, she was somewhat wary during verbal processing. This reflected the theme of fearing others' reactions to her true thoughts, an issue around which she made considerable progress during the therapy.

In an early session, Marianne had a very significant realization around the theme of self-care and creating a space for her needs. During a projective exercise entitled *Emotional Spaces*, she sat in the space designated 'Love' very quietly, with tears running silently down her cheeks. She later shared with the group that she realized to what extent she had not been caring for and loving herself, despite her seemingly indefatigable ability to care for *others*.

Towards the end of therapy, Marianne reflected back upon this moment as her first, albeit subconscious, introduction to her roles and a common motif underlying them. She stated that her difficulty with prioritizing her own needs related to her long-held conception of the *mother* role as synonymous with being "a nurturer of everyone around [her]" at the expense of herself. She claimed to have learned this notion of *mother* from viewing the relationship dynamics between her own parents, in which her mother clearly occupied a subservient position to her father. Marianne further shared her view that her strong reaction in the 'Love' station of *Emotional Spaces* was linked to her *child* role, in the sense that she had "lost touch with the girl" within her. She explained that this inner 'girl' referred to a sense of being unfettered by responsibility and able to derive "joy from [her] everyday life". During our work with Role Profiles, Marianne's identification of *the overloaded person* as central to her compendium shed yet more light upon this early moment: she defined *the overloaded person* as one lacks fulfillment of her own needs.

Mid-way through the therapeutic process, Marianne revisited the role of *the overloaded person* while doing a projective exercise with story-making. Her narrative concerned a character that was in desperate need of liberation from a dark, confined space. The story had a happy ending, as the hero found a way to rid himself of the many

burdens pressing down upon him and ultimately gained his freedom. In later work with Role Profiles, she chose a multiplicity of roles; the group eventually decided to group this multitude of roles, *many* of which were stress-inducing, into a single, *new* archetype they chose to call *the overloaded person*.

Towards the final session of the process, Marianne engaged in an improvised, projective role-play with another group member, from which emerged an enormous outpouring of anger at her perception of the hypocrisy of society and the frustration she experiences in having to wear "a public face" that masks her "true feelings". Her voice rose and she became very animated, to the extent that the other group members witnessing were both surprised and proud. She shared that it was a powerful release to finally put this anger out in the open. In terms of role, Marianne's enactment allowed her to explore *the angry person* and *the self-silencer*, two facets of self that proved inextricably intertwined in her life. She expressed a common challenge to all four study participants; the conflict between a woman's need to have an outlet for frustration and rage and her desire to conceal such emotions, lest she be deemed "unladylike", "immature" or otherwise inappropriate in the eyes of society. Marianne's fears about appearing disparate from the "accepted standards" for womanly behaviour had led her to suppress her natural urge to overtly diverge from other peoples' points of view. In the process of so doing, she had accumulated even more anger which she had in large part directed at herself.

Marianne's integration of the above role-related insights she had made in the dramatherapy process was evident on several fronts. She began to clearly delineate and observe time for herself and the fulfillment of her own needs by enrolling in both a dance

class and a yoga course at a nearby community center. She decided to withdraw her membership from two of her many volunteer committees, stating that she felt she had "given a lot" and needed to prioritize "keeping [her] self sane". These actions spoke to Marianne's determination to counter her pattern of remaining entrenched in the role of *the overloaded person*

Perhaps the most touching aspect of Marianne's progress was the new understanding she said she had regarding her daughter. In our final session, she shared that, having uncovered her *angry person* role through the scene in which she had confronted her mother, she felt her best gift to her daughter would be the celebration "of ourselves, as women". By expanding her *own* role of *mother* to encompass one who "loves *herself,* as well as others", Marianne explained, she wished to model for her child a "healthier kind of woman".

Participant 2 - Ruth

History and presentation.

Ruth is a female client in her early forties who moved to Montreal fifteen years ago with her family, a husband and two teenage sons. She currently resides with her spouse and the younger son and evinces worry about her elder boy who is living overseas for a year. Though not presently working, Ruth has had sporadic employment teaching, a vocation she claims to enjoy. She describes her sons as "absolutely wonderful" and reports having close, at times overly-protective relationships with them. The nature of her martial rapport, she asserts, is often conflictual; at various junctures in our first one-on-one meeting, Ruth stated that her husband "is very critical of [her]" and consistently

caused her to engage in "self-doubt". Ruth also reported conflict with both of her parents, stating, "My mother is angry at me" and expressing that she fails to meet her father's expectations with regards to the fulfillment of her "duties as his daughter."

During our initial interview, Ruth presented as a mass of seeming contradictions. She was immaculately groomed and held herself with a modesty I can only describe as 'lady-like', smoothing the folds of her skirt carefully over her knees. At the same time, however, she appeared somewhat ill at ease and radiated intensity. She leaned forward on the edge of her chair and maintained strong eye contact with me, yet punctuated her verbal utterances with small, erratic gesticulations. Ruth's thought patterns seemed to lack organization; she often went off-topic onto loosely-related tangents that were clearly emotionally-charged for her. Also noteworthy was a marked disparity between the verbal content of some of her answers and the affect she displayed while conveying them. More specifically, Ruth frequently smiled and laughed while disclosing very heavy, difficult personal material. Despite this incongruity, she exhibited a strong intellect and proved immensely articulate as we spoke.

When asked questions pertaining to her mental health history, Ruth became quite agitated and her speech grew notably more rapid and pressured. She reported having been hospitalized against her volition at the age of twenty five for unspecified mental health issues. She expressed anger at both the person who had "had [her] committed" and at the therapeutic treatment she received while hospitalized and during her subsequent follow-up period. She asserted that she believed most psychologists and psychiatrists are "full of shit" and offer a "disease-oriented", "negative" model of treatment intervention. Ruth recounted only one "pretty good" one-year therapeutic experience and additionally

reported having undergone some marital therapy with her husband. She described their joint counseling as "beneficial but very insufficient".

Ruth's tone appeared defiant when answering my query as to which, if any, medical professionals were following her. She was "uncomfortable" with the subject and refused to disclose her doctor's name or contact information, stating firmly "I need to rely on myself". This latter announcement would later prove a very resonant issue for Ruth. She did offer, however that she has been given "multiple labels, more labels than you can imagine!" in terms of doctors' diagnoses. She then exclaimed "I hate labels!" and questioned their validity and purpose. She later asserted, "I *know* what's *wrong* with me. I *need* to know what's *right*" Ruth claims that she is not presently on any medications. However she noted that her mother, a Holocaust survivor, has been diagnosed with manic depression and follows a strict pharmaceutical regimen as part of her treatment.

Ruth then proceeded to describe a recent example of what she referred to as her "crisis times". During the previous summer, she characterized herself as having "lost it for a few months" due to multiple life stressors. These stressors, she said, included the following: a particularly difficult period in her marriage, during which her spouse became increasingly disparaging of her; her mother's voiced disapproval towards her; her father's ailing health; financial worries and fear about the political turmoil and violence in Israel. Ruth stressed that this latter issue was paramount among her concerns, as one of her sons was living there at the time. Moreover, she recounted a concurrent tragedy in which a woman to whom she was indirectly related was killed in a bomb attack

During this period, Ruth said her "whole world stopped": she was "excessively anxious about every little thing", unable to sleep and incapable of functioning in her day-to-day tasks. She claimed that when she received the news of her relative's death, she experienced a lot of guilt and self-condemnation for not "feeling really sad". She shared that she had not thought highly of the deceased, who she described as "not a good woman", but quickly followed this admission by asking me, "Am I some kind of terrible person? I mean, am I?" According to Ruth, she "begged for help" and finally saw a doctor who "dropped [her]" shortly thereafter. When describing how she handled her anxiety, she first asserted, "I managed", quickly following this statement with, "I didn't really manage."

Ruth expressed that, as an Orthodox Jew, the close attending to familial and religious duties were of primary importance to her. She described her faith in God as "crucial to [her] existence". She reported that many people, most notable among them her husband, find her "frustrating" and "too extreme". Ruth shared that when she informed her husband of her decision to try out the dramatherapy group, he replied, "No one likes you. No one ever likes you." Ruth accompanied this information with a bright-sounding laugh. She then stated that she wished she could find "kindred spirits like in Anne of Green Gables", who would be "sensitive" and "accept [her]" without criticizing her for the fact that she is "not perfect". She quietly added, "I don't believe in myself."

Ruth's stated objectives.

Ruth thought long and carefully before elucidating the therapeutic goals she wished to bring to the dramatherapy group. She expressed that we wished to "enhance" her everyday life by giving her something "to look forward to" and lending an element of

structure to her day. She related this goal to the facts that not only had her children grown older and hence become less demanding, she had also stopped working. She consequently felt "bored" and "socially isolated". Ruth went on to say that she wanted to explore "setting limits" and learning to "maintain boundaries" in her interpersonal interactions, particularly with regards to her family. She stressed that she felt the need to look at her issues around self-acceptance and her tendency towards "perfectionism in everything" she does.

Ruth's therapeutic journey through role.

"I've been thinking that sometimes, finding my own voice means telling all the *other* voices to shut up for a little while."

(Ruth, stated during processing of her Heroine role)

At the commencement of the dramatherapy, Ruth was quite wary and cautious in the group, carefully observing the other members' actions and behaviors. This was not surprising, given that she had disclosed in our assessment interview that she had "serious trust issues" in groups of people, having been a victim of bullying during much of her formative years. It soon became apparent in Ruth's work that a dominant theme concerned her frustration at feeling unable to voice her true (often very strong) opinions in various life contexts, including her views regarding her sons' upbringing and other conflict-laden subjects in her marriage. Several of the roles she later chose to include in her personal role profile were implicitly present even at this early stage, including the seemingly paradoxical duo of *victim* and *advocate,* and the role of *mother.*

Ruth gradually grew more at ease in the group as it became clear she was allowed to integrate and was not being judged by the others. She was very engaged in each

activity and segment of sessions, especially during sharing. When verbally processing or checking in, she sometimes required encouragement to stay with her emotions as opposed to trying to evade them by retreating to a place of cognitive analysis. At such times, Ruth's subject matter often concerned her high, even stringent expectations of the people occupying her personal sphere, including her sons' teachers, her father's hospital caregivers and an array of acquaintances. Such high expectations were not unlike those imposed upon her by her husband and her immediate family, as Ruth herself observed after several sessions. She stated that she played the role of *the perfectionist* in her life. Though this declaration was initially made with evident pride, her attitude towards the role altered notably over the course of therapy. After exploring *the perfectionist* role in a sociodramatic exercise entitled *The Hero and the Quest,* Ruth shared her realization that her "stuckness" in this role was a contributory factor to her ongoing "sense of being overwhelmed in [her] life". In her view, *the perfectionist* role was thus linked to her propensity for withdrawal into a depressed state as a response to mounting stress.

The incongruity of Ruth's outwardly manifested affect with the often-painful content she shared in group continued well past the midpoint of the session series. She would, for example, profess having been very hurt by an exchange with her husband, yet recount the details of the incident with loud laughter, managing to maintain a cheery demeanor throughout. The salient therapeutic question thus appeared to be: what is going on for this woman internally, and how can she find an outlet for its expression? It seemed that Ruth had learned to distance herself emotionally from the factual truths of her life, and had thereby lost the ability to join her feeling nuances with her spoken words. Ruth stated a plethora of instances in which she had "risked" voicing her emotional state and

needs to others, particularly to her husband, only to told she was behaving in a "stereotypical, weeping woman" fashion. She appeared to have internalized such undermining messages to such an extent that she had learned to repress her natural urges for emotional expression.

Ruth consistently asserted her amazement at the "creativity" of the other group members, often exclaiming, "But you're all so talented" and other similar compliments. She did not express a like sentiment towards herself. In stark contrast, she would often belittle and censure her own output in the group, particularly in more physicalized exercises such as movement games and embodiment work. As she had the opportunity to hone her dramatic skills through play and projective activity, Ruth's insecurity further dissipated, to the point that she could acknowledge and express satisfaction with her contributions to the group process.

For the first five months of therapy, Ruth attended regularly and invariably arrived early for sessions. A seminal event then occurred in late February in the form of her father's serious illness and subsequent hospitalization. During this time, she was experiencing enormous pressure to fulfill both her father's, and other family members' needs with virtually no support. The roles of *child/dutiful daughter* and *wife* came to the forefront as Ruth strove mightily to contend with the responsibilities of caring for her parents and her own family. She expressed that she often experienced the "sinking sensation" of "coming up short" relative to the expectations inherent in the *child* and *wife* roles throughout these difficult weeks. Ruth seemed to derive a great deal of inner strength from the group during this period, and also needed some additional one-on-one time with me.

Becoming overwhelmed by her circumstances, Ruth was absent from therapy for part of the month of March. She returned to a very warm welcome in late March and was able to process what had transpired and the core issues concerning her roles that had emerged for her. Through her involvement in several dramatherapy processes both preceding and following her absence from the group, Ruth arrived at crucial insights regarding the dangers inherent in her trying to do too much and to please everyone. These insights tangibly affected choices Ruth began to make in her real life, as she started to successfully implement boundary-setting in her significant relationships.

Participant 3 - Amanda

History and presentation.

Amanda is a female client in her early thirties who lives with her elderly grandmother in a two-bedroom apartment. She characterized their relationship as fraught with conflict and asserted that she wanted to "move out", but did not see any feasible alternative living arrangements.

In our first encounter during the initial intake session, Amanda presented as extremely meek and far younger that her stated age, both in terms of outward appearance and in her manner of social interaction with me. Her voice was barely audible and she averted her eyes for the majority of the interview. She appeared to be in a state of physical discomfort and notable lethargy. Her overall presence seemed imbued with a soft, diminutive quality that awakened in me an awareness of feeling protective towards her.

Amanda shared that she suffered from a series of very grave physical health problems for which she had been receiving medical treatment for most of her life. Due to both pulmonary and cardiac conditions, she stated that she was presently obliged to take myriad medications, the cumulative affect of which was a consistent lack of energy. Her heart troubles were so serious that she had, according to her doctors, already outlived her life expectancy rate of sixteen years and was on a transplant waitlist.

Despite these many challenges, Amanda had been working steadily at a job she enjoyed until just a few months prior to our meeting, at which time she stated that she was compelled to take sick leave. She expressed that the job had been a central source of "purpose" and "self-esteem", and that she thus felt its loss deeply.

Though she had not yet received an official diagnosis, Amanda self-described as "a lot, a lot less happy than [she] used to be" and manifested several classic symptoms indicative of depression. These included reported loss of appetite, insomina, lack of internal motivation, recurring negative cognitions, and feelings of "overwhelming guilt", "self-hatred" and "a lot of suicidal ideation". She shared that she tried to counter the onslaught of "bad feelings" by "escaping into T.V.". Though physically capable of light exercise, Amanda claimed that she experienced "trouble leaving the house" and disliked the prospect of being around "too many people". In light of what she was saying, I remarked that it must have been immensely taxing for her to have managed to come in for our interview. She responded that she had felt in need of our meeting "urgently", and that she "need[ed] help".

In addition to the above, there were numerous other situational factors to which she attributed her current distress. She claimed to be still engaged in the process of

grieving her father's death, which had occurred sixteen years previous. Though she described the man her mother subsequently remarried as an "okay guy" and portrayed her relationship with her mother as "alright", she also characterized the overall three-way rapport as "very conflictual at times" and indicated that said conflict stemmed from child/parent role and boundary issues. Additionally she reported having one brother residing in a different city and with whom she sometimes fought.

Amanda stated that she "may" have been the victim of sexual abuse and/or incest at a very young age, but claimed to be "fuzzy on this [topic]". When questioned as to emotional abuse, she reported that she and her grandmother are "mutually emotionally abusive", citing as examples "name-calling" and "shouting" behaviors.

When the requisite intake form had been completed, Amanda appeared very reluctant to leave and expressed her desire to furnish me with further information. She asserted that she currently had "no friends" and no "social support", despite sporadic efforts she had made to reach out to "former friends" by telephone. Her eyes filled with tears as she shared that "hardly anybody calls [her] back", claiming that they probably wanted to avoid contact with the "negative, pessimistic" person she felt she had become. Amanda stated that she sometimes contemplated suicide as a way of exacting "revenge" on these people, but claimed she dissuaded herself from the notion by focusing upon the hurt it would cause her mother. She wept openly as she expressed her fear that she'd never have a "romantic relationship". Amanda then proceeded to self-describe as a "lazy failure" who had a propensity for "grudges and jealousy." At the end of this torrent of self-denigration, she met my eyes fleetingly and said, "I guess I don't have any self-esteem".

Amanda's stated objectives.

Amanda's stated goals were very clear and simply expressed; she wished to add an element of structure in her day, augment her sense of motivation to "get up and rejoin life", and practice her skills in the realm of social interaction. We additionally agreed that introducing an element of joy back into Amanda's life would be a significant objective, though she did not appear optimistic regarding its viability. I informed Amanda that her acceptance as a candidate for group dramatherapy would be depend upon my ability to confer with her doctors in order to ascertain the physical safety of her participation. This issue did not prove an impediment to her joining the group, as her medical professionals foresaw no obstacles to her involvement other than the necessity of keeping all movement aspects light.

Amanda's therapeutic journey through role.

"I only feel 'myself' when I am *by* myself, and sometimes, not even then"

(Amanda, stated in Phase One while holding the Talking Egg)

Amanda was substantially younger than the other members of the group, and I initially harbored fears that she might be 'adopted' as the older women's communal 'daughter' figure and choose to remain safely ensconced in that role. Happily, this did not occur, and the other group members gave her the same space and respect they accorded one another. This immediate acceptance went a long way towards countering a fear that Amanda had previously expressed to me; that she would not 'belong', due to the very unique nature of her physical challenges. It also supported Amanda's desire, later clarified in her process of compiling her role inventory, to explore the antithetical roles of *friend* and *rejected one.*

Amanda was very invested in the group, attending regularly, though often a little late. In the early sessions, her loss of voice manifested quite literally: she was so soft-spoken that the others often prodded her to speak up. Though sweet and kind in her interactions, she at first held herself a bit apart. She listened with rapt attention when others spoke, and eventually grew more confident that she herself had the right to speak and be heard. She began to make and maintain eye contact with group members, shyly smile and even laugh aloud, all of which were markedly new behaviors. As Amanda became more actively and openly engaged in the group process, she began to distance herself from the role of *passive victim* that she had portrayed during our initial assessment interview.

During this period, Amanda spoke quietly, but with mounting frustration about her living arrangement with her grandmother and the boundary issues she had with both her mother and her stepfather. In so doing, she began to address three problematic roles that she later named in her role inventory, those of *daughter, step-daughter* and *granddaughter*. In a sculpt she created in which she used other group members as her 'clay' and positioned them, Amanda depicted her internal conflict as a young woman being literally torn in two directions. In the sharing process that ensued, she reflected that the tableau looked like a graphic picture of someone struggling for the right to live her own life while besieged by the stifling influences of others. The themes of needing autonomy from possibly overprotective parental figures and the search for her own voice pervaded a lot of her subsequent therapeutic work.

Amanda's growing confidence was tangibly manifested in her indepth work with Role Profiles. At this time, she came to acknowledge and voice her *angry person* role and

expressed that she felt both confined by and ashamed of it. This occurred during the mid-to-late-stages of the therapy, and the other group members began strongly validating how she had begun to come out of herself. They noted Amanda's new facility for articulating her issues and remarked upon their perceptions of her growing emotional strength. This affirmation had an enormous impact on Amanda, and her increased trust in the group led to her participation in a brief, culminating enactment in which she practiced asserting her needs, calmly and clearly, to her mother and stepfather.

In her day-to-day life, Amanda began implementing some of her newfound tools and role-related insights. For example, she was able to practice a more socially viable version of her *assertive person* role by calmly addressing some very justified concerns she had regarding her living situation with both her landlord and her current social worker.

Participant 4 -Claire

History and presentation.

Claire is a female client in her late fifties who lives with her husband of thirty one years. One of her first statements was, "He controls the finances", which proved a recurrent leitmotif throughout our interview. She had been a working professional in a field that "stimulated" her and which she "enjoyed a lot", until the atmosphere surrounding her business became "pressured" and she began to experience a sense of ongoing "duress" to meet job expectations. She had entered retirement the previous year. Claire has one grown son whom she "adores, absolutely loves".

In both the intake assessment and during the first few group sessions, Claire presented as very self-assured. She exhibited very definitive opinions and little

compunction about expressing them forthrightly. This included a certain degree of skepticism concerning therapeutic processes of many kinds, and the professionals who facilitated them. In years past she had participated in other creative arts therapy groups, one of which she deemed "enjoyable", the other in which she reported having had a "conflict with the therapist regarding [her] process". Additionally, she had "tried out" a women's group, but eventually found its "vicitimization" theme "too heavy". She claimed, however, to have garnered some insight into the dynamics of her marriage during this period.

Claire appeared quite nervous when questioned as to her mental health history. Though I told her was by no means obligated to answer questions that evoked discomfort or anxiety, she decided to share that she had experienced depression and had very recently been granted a diagnosis of same by her psychiatrist. She also stated that she believed her condition might have a seasonal component. . She reported that she was somewhat reluctantly taking her prescribed medications, specifically a mood stabilizer, an anti-depressant, a sleep sedative and a mild tranquilizer. She claimed that one of the multiple side effects she was currently experiencing was a sensation of being "more hyper" and "edgy" than usual.

Claire was very frank with me regarding her past history. Formerly alcohol-dependent, she claims to have been steadily sober for many years. She recounted that she had made a solitary suicide attempt just prior to "going on the wagon" which involved drinking while driving with the specific intent "to kill [her]self". She asserted that she was presently "not suicidal, but "having hopeless thoughts".

Claire stated that she had, at a very early age, been a victim of incest that occurred within her immediate family. She did not provide specific details of this experience, except to share that it somehow relates to her ongoing estrangement from her sister. She then asserted in a very firm tone of voice: "I've *pretended* to make peace with the person who did it". Claire described her mother as "psychologically abusive" and cited by way of example a childhood punishment in which she had been "made to kneel on hard salt" in the summer heat.

Impeccably groomed , Claire for the most part manifested outward composure during our interview, yet she experienced sudden, sporadic moments of weeping in sharing her story. These she quickly wiped away with apologies.

Claire's stated objectives.

In the initial session Claire's stated goals comprised the following; to have a positive, supportive experience in a group; to learn to accept life's inherent challenges with greater calmness and optimism; to explore a wider range of emotional expression in the context of others (ex. crying, laughing); to rediscover her authentic, "inner voice"; to learn some coping strategies for relaxation when confronted with stressful situations; to worry less about others' opinions of her; and, finally, to heighten self-esteem. She expressed that she found hearing other people's experiences helpful. One thing that particularly struck me was when Claire included her *husband's* opinions of what her goals should be: to learn to "dedramatize" her responses to things and to "learn to accept things as they are with a positive attitude". Concerning the quest to attain several of her objectives (ex. learning to laugh) she said quietly, "I cannot do this on my own", a

statement that appeared to starkly contrast with the woman who had earlier strode confidently into the interview room.

Throughout her therapeutic process, many of these objectives remained fairly consistent; though several became increasingly related to Claire's striving for greater balance and communication within her marriage. In the later stages of the dramatherapy , Claire's self-professed tendency towards perfectionism and unrealistic self-expectations became another prevalent theme, as did her desire to learn to articulate her personal needs.

Claire's therapeutic journey through role.

"I wear three hundred masks. They're very heavy."

(Claire, stated during a Role Profile session)

Though a little reticent at first, Claire quickly evinced a growing investment in the process and a deepening alliance with and trust in both her fellow group members and myself. She attended sessions with utmost regularity and punctuality and eagerly participated in all group exercises.

During verbal sharing segments that followed the group's emotional check-ins (usually through the distanced container of projective techniques), Claire had a tendency to diverge from her present issues to recount anecdotes. She thus often required – and always responded to- my gentle encouragement to re-enter the discussion's framework. She was attentive, respectful and empathic towards other group members. Despite an early stated reservation she held about often playing the role of *saviour for others*, Claire increasingly managed to focus on her own process and developed strategies (such as deep

breathing and self-touch) to protect herself during moments of intensity arising during other group members' processes.

Two primary role issues emerged in Claire's work within the group. The first was her realization that the stress and anxiety she was experiencing was being exacerbated by ongoing conflicts with her husband. Through Role Profile work, Claire discovered that she felt controlled and subservient in the role of *good wife*. A central source of tension concerned her husband's unilateral decision to take early retirement, sell their home, and move to another community where Claire foresaw she would feel emotionally bereft and rootless. Her lack of voice in these decisions clearly served to augment her growing resentment and led to her acknowledgment of her *angry person,* a role which she was gradually able to name and examine in brief, role-plays. She additionally enjoyed and found insights through fabric play and projective work with percussive music.

Claire's role revelations regarding her marital relationship seemed to have considerable impact in her actual life. By late January/early February she described her mood as markedly lighter and felt she was better able to calmly identify and convey her needs to her husband, as opposed to turning her frustration inward. She said this had catalyzed a new, healthy phase in their rapport, characterized by mutual listening and shared accountability for decisions. Claire said that the act of "reclaiming [her] perspective" and voicing it for her spouse was "very liberating" and expressed the hope that it would "get easier with practice".

The second central role issue for Claire derived from her receiving a diagnosis of bipolar II during the early-to-mid stages of therapy. Though she expressed relief at having a 'name' for her symptoms, she was also somewhat traumatized by the identified

role of *patient* and was initially resistant to taking the medication she was prescribed. This too she gradually worked through with the support and feedback of the group, most effectively through a *doctor/patient* role play in which the device of role reversal allowed her to access the sources of her inner anxiety around being the *patient.* Claire eventually reached what she described as a more "proactive", "empowered" perspective regarding her condition. She acknowledged the possible utility of medication and said she would continue treatment with her psychiatrist as long as she felt she could inhabit the *patient* role in an active, rather than passive manner.

Chapter Six – The Voyage Through Role: Interventions and Seminal Moments

Introduction

As described earlier in Chapter Four, the therapeutic process when following Emunah's (date) Five Phase Integrative Model rarely progresses along a linear path, clearly transitioning between stages. The same must be said for the process described in this study, as the groups and the individuals within them moved at different paces and arrived at unique insights regarding their roles at different moments. For the purposes of providing an overview of the growth and evolution within our succession of sessions, however, I will present it in a relatively sequential fashion. I encourage the reader to bear in mind that the following chronology, which matches each phase to a certain timeframe, does so in rough approximation only.

Furthermore, I feel it important to note that the following is a description of four *individuals* who did the therapy in a group context, rather than of the complete groups themselves. For this reason, each phase will receive but a brief perusal. Within each phase, however, I will highlight the primary, role-related and role-based interventions used and some of the seminal moments of my four research participants.

My underlying premise in designing the session series sought to link Jack's theory of depressed women's loss of their true inner voices (see *self-loss* and *self-silencing*, Chapter One) with the use of role-related techniques and role method. The feminist theory of women as inherently (and consistently) relational beings whose notion of self is jeopardized by inauthenticity *within* relationships is not dissimilar to the concept of discomfort with and repression of various *roles* within one's *repertoire.* Many if not most

of the roles found in Landy's taxonomy are those parts played out in connection to other people: *the victim, the mother, the witness, the lover* are but a few examples. Other roles can be seen as more intrapsychic in nature, such as *the lost one, the sinner* and *the person of faith*. Many roles are extremely open to individual interpretation, and can be dually regarded as either interpersonal or intrapersonal or both simultaneously.

It occurred to me that if a woman's loss of her sense of self, her 'voice', happens in the context of interconnectedness with others, then therapeutic work with role would seem an apt medium through which to explore *finding* it. It thus evolved that our group progression moved not only through the five phases of Emunah's model; concurrently, the work moved through a cycle that began and ended with an emphasis on the intrapsychic qualities and aspects of the participants, with an interpersonal focus constituting the core section. My hope was that the participants would start with a personal 'inventory' of sorts, progress towards exploring their interrelations with significant people in their lives, and end by taking stock of their own, inner resources with a celebratory acknowledgment of their innate capacities to heal themselves.

I. Laying the Foundations: Roles Begin to Emerge

The first phase of the therapeutic process took place throughout the month of October 2005. Our sessions were focused upon building group trust and cohesion and creating a safe space in which spontaneous, imaginative play could thrive. Most fundamentally, however, the techniques and activities employed during this period were intended to lay the foundation for the role work of later stages, by allowing clients to uncover roles and role-related issues through the safely distanced means of projection.

Projection, as employed within dramatic forms serves to "enable a client to create, discover and engage with external representations of inner conflicts" (Jones, 1996, p.132). An individual can project his personal material into and onto objects outside the self, whether through role, mask, puppet, play or numerous other means. Subsequently, a kind of dialogue arises between a client's inner material and its outward manifestations. Within this interplay of the actual and the dramatic, there lies the potential for the individual to develop a new relationship with the material, one which can be explored therapeutically to achieve insights and garner meaning (Jones, 1996). My primary interest in observing my participants' involvement in the projective methods of our early process was to begin identifying prominent and/or recurrent role motifs that arose within them.

Claire chooses Barbie.

An exercise the participants did during one of our first sessions together involved projective play with objects. I passed around an enormous *Magic Chest* filled to the brim with trinkets of different kinds, some of which were quite specific and concrete, others more abstract. Object examples include such items as an old watch, a lipstick holder, a stone, a feather, a toy airplane, an egg, a pager, a gun, a mask, a straw hat, a faded piece of lace, a locked box and a fake lock of blonde hair. Participants were invited to peruse the objects and, reasonably quickly, choose the one which –for whatever reason- 'spoke' to them in the moment. We then proceeded to go around the circle, each person (according to comfort level) sharing with the group the underlying reason, attraction, or symbolism of her choice.

In some cases, the participant only consciously perceived an object's significance at a later point in time. In most, however, the tiny associative threads between the chosen

object and the 'chooser' spoke volumes. Claire, whose later work with Landy's (1996, 2003) Role Profiles enabled her to examine her struggle to maintain a *perfect wife* and *mother* image, chose a miniature Barbie doll. She sighed deeply and said that although she felt an inner "resistance" towards her selection, she had made it because "That's how everyone sees me. This is who I've become."

Claire's choice of the Barbie doll illustrates the utility of projective play for evoking role possibilities early in the therapeutic process. In this particular instance, her object selection and comments regarding it served as mediums through which she could indirectly encounter and unveil an issue that would prove integral to her later role inventory work, which was her discomfort at feeling confined within an idealized feminine prototype.

During this exploratory therapeutic phase I did not press her further, but offered her the option of choosing a second item that she felt more at ease with. Claire's gloomy demeanor lifted and she dove back into the 'magic chest', pulling out two pieces of bright, golden hair held together with bows. She held them up to either side of her head as if sporting pigtails and said that she was looking forward to the idea of "being allowed" to explore "the little girl inside". This second object choice also introduced a role that Claire later identified and chose to examine, that of *the child.*

Ruth makes a phone call.

The exercise described above yielded an interesting role-related theme for Ruth. Just prior to this activity, she participated in a lengthy verbal check-in. The subject underlying her words was somewhat difficult to follow, given the fact that she appeared to leap from recounting specific life incidents to more global topics. What she strongly

conveyed however, was her belief that "society...has tried to repress [her] opinions", to "silence" her into a "false acquiescence". She referred to "the powers that be" that she struggles against in her life, which seemed to include a vast number of people. When her turn arrived during the 'magic chest' exercise, she chose a telephone, addressing the rest of the group apologetically with the following, "I talk too much. I know I talk too much." The room was quiet for a moment. Then another group member gently said, "Maybe that's because no one listens to you when you speak", to which several other women nodded grave assent.

Ruth's experience of the object play exercise suggested the underlying theme of speaking without being heard. This arose as a prominent motif in her later compilation of a personal role inventory. In the roles of *wife, mother* and *daughter*, Ruth shared that she had difficulty maintaining a clear sense of her own needs, a factor she deemed contributory to her depressions.

Claire finds the child inside.

Claire's projection through puppetry and subsequent revelations regarding the role of *self-nurturer* occurred during the course of another projective exercise I developed for the session's check-in, called *Emotional Spaces*. In keeping with the central objective of trying to name participants' current underlying themes and associated feelings, I had arranged the room such that our circle was surrounded by a number of 'stations', each representing a different mood state. The varying stations were designated with signs and each had a choice of artistic mediums with which participants could express themselves, as well as decorations appropriate to the atmosphere of each particular emotion represented.

Claire spent most of the designated time at the station labeled 'Playful/Childlike/Creative'. There upon a table, lay a dizzying array of bouncy balls, colored chalk, finger-paint, musical instruments, Play-Doh and puppets. Claire hovered around this station for some time, seemingly hesitant to approach it, then carefully perused every object. She picked up a soft, plush koala bear hand puppet and retreated with it to an unoccupied corner of the room where she tenderly stroked its fur and whispered to it. When the group reassembled in a circle to share their experiences, Claire asked me in a hushed, worried tone if she would have to return the koala puppet to its place on the table and appeared relieved when told she could continue to hold it.

After hearing everyone else speak, Claire shared that she had never been "permitted to be a little girl" and had never held a puppet in her life. One woman remarked at how gently Claire had cared for the bear. After taking a moment to reflect, Claire responded that in caring for the bear, she felt as though she was caring for herself "in a way I don't". She later proudly remarked that though at first nervous, she had taken "[her] own space" at the table, not worrying what the other group members were thinking of her. This, she announced, was a "big step".

Through the simple projective act of selecting and petting a plush puppet, Claire made implicit reference to several roles that concerned her in some way. The *child* role, first elicited during the *Magic Chest* exercise, reemerged. Additionally, the roles of *self-nurturer* and *self-denier* were subtly introduced.

The use of story.

The use of story as a projective tool in dramatherapy invites entry into a "symbolic framing relationship with reality" (Jones, 1996, p.173) wherein clients can

safely and spontaneously express ideas and concerns in a flexible manner, free from the censoring constraints of the everyday realm. The client's chosen settings, characters and narrative voice allow her to engage in new relationships with 'self' and 'other' (Jones, 1996). As therapeutic device, story also affords clients a measure of distance, as we enter its world armed with "...the trust and knowledge that we are able to return to the place of departure" (p.37). Furthermore, the connections the client makes, emotionally and/or intellectually, between the details of her narrative and her real life can facilitate personal insights. As with the other projective methods discussed in this section, my primary aim in using story with my group was to see if it helped elicit client material that would prove relevant to the roles they played.

Marianne Tells a Story.

The story making process provided a safe, sufficiently distanced medium in which Marianne could explore the apparent disparity between her sadness and her self-described "wonderful life". It also yielded thematic content that later showed itself to be closely linked with the role challenges she faced.

Marianne's story was told through a series of drawings that depicted the quest of a pair of scissors, named 'Clippy', to escape the confines of a lady's handbag. An enormous hand was shown stuffing many unidentified objects in on top of Clippy, who slowly but surely was forced to descend into the purse's depths. Clippy's sole companion was a small, animated can of essential oil, which sprayed the scissors, thereby easing his tension. Eventually, Clippy grew stronger and was able to move about forcibly until the handbag imprisoning him up-ended and he fell out, free at last.

As Marianne shared with the group the story she had created, she perceived several themes within it and remarked upon them aloud. The themes she discerned in "Get Me Out Of Here!" - her tale's apt title - included the following; the sense of being ignored, the sense of oppression by external forces, the desire for space and possible solitude, and the idea of needing release from tension. These story elements lent us clues concerning not only the nature of Marianne's current self-perception, but also an apparent contradiction that would prove crucial to her later process. Contrary to her stated wish to learn to better *meet* the plethora of demands made of her by people in her life, her story suggested a deep, unvoiced need to *lessen* these demands and to take better care of herself. Interestingly, at least a couple of Marianne's themes also pervaded other women's stories, and a profound feeling of camaraderie rose within the group.

II. Placing Roles in Context: Looking at the Matrix of Relationships

Phase Two of the therapeutic process occurred over a period of several weeks in November and December 2005. We continued with projective activities that were chosen for their capacity to act as building blocks for deepening the participants insight into their role issues. The participants also began honing their role-playing skills through such improvisational games as *Move, Freeze and Improvise*. In this exercise, pairs of group members moved through the space, making sure they had bodily contact at all times. When instructed to freeze, the participants had to stop and hold their positions relative to one another. They then had to create a likely –or at least 'imaginatively' plausible- scenario arising from the poses they were in. This and other, similar theatre games served as vehicles through which participants could hone and achieve greater ease with the dramatic skills requisite to doing later role enactments.

The Social Atom and role context.

The central projective technique that we used in this phase was the social atom, originally conceived by Moreno (Sternberg and Garcia, 2000) I included the social atom within my therapeutic design to further facilitate role exploration while beginning to integrate feminist relational theory into the group process. I believed it was essential for participants to be able to take a step back and view the network of relationships in which they were ensconced. In so doing, I surmised, they would be starting to lay the foundation for role work from yet a perspective that included role *context.* As Jack (1991) asserts, in her discussion of women and depression, the female self is a fundamentally social entity; it does not exist in isolation, but in a matrix of relationships with others. Like Gilligan (1982) and Chodorow (1978), Jack concurs that interpersonal intimacy is thus the profound organizer of female experience and the key to understanding the distinct characteristics of women's internal perspectives. As discussed in Chapter One's section on feminist theory concerning depression in women, interpersonal attachments and reliance upon them can be viewed as sources of strength. Indeed, healthy bonds with others can potentially act as 'psychological buffers', strengthening women's resilience in the face of depressive illness (Gilligan, 1982; Jack, 1991; Lerner, 1988). I felt that if participants could depict the type and quality of interpersonal connections in their lives, the emergent pictures might act as stepping-stones towards looking at the roles they played.

In essence, the social atom is a two dimensional drawing which depicts the nucleus of persons or entities to whom one is connected and by whom one is influenced. Such influence can be unidirectional or reciprocal in nature and can be denoted as being

positive, negative or both. Both the drawn version and the three-dimensional, sculpted modified version I employed with my participants, begin with a large circle on a piece of paper or cardboard. The basic concept is for the client to portray the significant people in her life, placing herself at the very center of the circle and drawing (or otherwise indicating) the *others* as small circles or other shapes, placed at various distances from the central figure. The degree to which the figures are placed in proximity to the client at the center echoes the extent to which the client feels closeness within that particular relationship. A number of refinements and details, such as arrows showing directionality and assorted shapes and sizes for differing genders etc. can be added. When the client feels that her social atom is complete, there may follow a period of discussion and processing with the other group members, or the client may wish to refrain from verbally presenting her creation. In this case, the group may be invited to spend some time witnessing the piece in silence.

Amanda's tangled web.

The following is a description of Amanda's final social atom as she chose to present and explain it to the group. A great deal of role-related insights occurred during our post-activity processing, most of which emerged from Amanda herself.

Amanda chose put a dense cluster of figures right at the center of the circle, leaving vast expanses of space between this group and a few lone figures on the outskirts. Watching this initial stage of her process, I thought she was perhaps afraid to really make use of the whole circle: this would metaphorically reflect her hesitancy to "take up space" in the group. Upon viewing her finished creation, however, Amanda suggested that her spatial configurations might hold a deeper significance regarding how she viewed the

matrix of her life. The figures in the center were placed so that most of them actually impinged upon the piece depicting Amanda herself, so that a cursory glance would yield nothing more than an amorphous mass of clay. She shared that the 'encroaching' relationships represented her mother and stepfather, and felt their placement possibly indicated underlying issues with maintaining and asserting her boundaries with them. She expressed that she felt "suffocated" by their "interference" in her attempts to move towards greater autonomy. At the same time, she admitted ambivalence around this issue, claiming that, as a chronically "sick person", she also relied upon their moral support.

The few figures placed very far away the central figure of Amanda were positioned such that they almost touched the circle's parameters. As the proximity with which each figure is placed from the center denotes degree of perceived emotional closeness, this spoke to me symbolically of Amanda's possible proclivity for extremes in relationships (i.e. either very close or very remote with no intermediary possibility). One of these figures represented her grandmother, with whom she shared her living space. Amanda stated that she felt it "a bit ironic" that she had placed her "roommate" so far from herself. "But that's what it *feels* like", she said, "We are right next to each other and we can't stand each other."

While most participants' social atoms were quite cluttered with figures denoting friends, family and associates, Amanda's creation was extremely sparse, with five family members. She sadly noted the lack of "good friends", saying that she had "lost all of them" because she had become "a burden, rather than a "buddy". In the midst of sharing, she decided to move the figure of her stepfather from its original position to the outer rim of her circle. The lines she drew between them were heavily scrawled, and showed this

relationship to be particularly conflictual. She pointed out the inclusion of a figure representing her deceased, biological father, which was the only rapport that she had positively connected.

Amanda's social atom introduced a number of roles which she chose to explore more indepthly in the subsequent stages of our therapeutic process. It clearly indicated areas of conflict in her role experience with *daughter, step-daughter* and *granddaughter*, and suggested the possibility of *the angry person* she wished to keep hidden from view. Furthermore, the *absence* of figures outside of her immediate family seemed significant in light of the extreme social isolation from which she was suffering. In her later work with role inventory, this sense of pervasive loneliness was reflected in her inclusion of *rejected one* and *good friend* as roles she found challenging.

III. Deeper Waters: The Creation of Role Taxonomies

The third phase of our process roughly corresponded to the months of January and February 2005 and is illustrated in this section and the next. The therapeutic focus began shifting from the more distanced and projective to activities that touched upon more personal material. Role-play during this stage, though moving towards core issues, stressed *fictional* enactments and tended to address commonly-emergent themes for the group, rather than specific events from individual participants' lives. Having laid the foundation for role exploration throughout our two earlier phases, we began to look more directly at role through the creation and processing of role inventories.

Role profiles: An overview of our process.

As discussed in Chapter Two, the use of Robert Landy's Role Profile Assessment (1996, 2003) marked an important moment in the therapy. I would like to reiterate

however, that the assessments were employed more for the participants to garner insight into their role repertoires than to allow me, as researcher/therapist, to make clinical evaluations. More importantly, Role Profiles offered the group a common language, a shared lexicon which they then were able to mould and shape to correspond to their own needs. These modifications included the group's discussion of roles they judged missing from Landy's taxonomy, yet crucial to describe their experiences. Additionally, the group felt it imperative to add a fifth role category to those included in Landy's model. We gradually moved from Landy's vocabulary to the creation of more personalized role inventories, using and creating role types that the women felt better encapsulated or named their ongoing experience. Many commonalities surfaced amongst the participants, often because, upon viewing the roles listed by other members, individuals would feel sufficiently emboldened to acknowledge such roles within their own lives. Dobrowolski (1995) eloquently expresses the benefit of role inventories, such as those compiled by my participants: "Archetypes offer context and meaning to the individual's life, and can, in fact, summon a voice that is stronger than our own" (p. 22).

Using Landy's Role Profiles Assessment device.

We began our work with role inventories using Landy's Role Profile exercise (1996, 2003) as it was originally designed. As the bulk of our role-naming process occurred in a modified fashion, I shall describe the participants' initial role allocations in brief, as illustrated by Marianne's role distribution. It is important to note that all participants were granted the time and space over the course of two sessions to do this exercise in a group context, but as with every activity, they were neither obliged to do so, nor were they compelled to share the results. This freedom of choice was fundamental for

those participants who might have felt they were exposing too much of themselves by performing the activity in a group forum. A few people chose to take a set of role cards home with them in order to do the Profile privately. The fact that every person later decided to share at least a portion of their inventories attested to the levels of trust and mutual acceptance which characterized the groups going into Phase Three of our process.

Marianne expressed eagerness to carry out the Role Profile with the support and witnessing of the other women. As per the procedure outlined in Chapter Two, she distributed the set of role cards, resulting in the lists that follow.

Beneath the heading **I Am** she placed: *average, heterosexual, adolescent, outcast, asexual, child, conservative, critic, coward, witness, visionary, survivor, simpleton, pessimist, warrior, wise, demon, wife, poor person, villain, sick, sinner, sister, lover, police, dreamer, clown, daughter, lost one, egotist, miser, judge, killer, hero, bigot, beast, bisexual, helper, mother, healer, avenger, artist, optimist, homosexual*

Beneath the heading **I Am Not** she placed: *homeless, orphan, husband, son, saint, innocent*

Beneath the heading**, I Am Not Sure If I Am** she placed: *adult, spiritual leader, rich person, magician, person of faith, atheist, radical, beauty, rebel, brother*

Beneath the heading **I Would Like To Be** she placed: *god, bully, elder*

Having thus categorized the majority of the roles to her stated satisfaction, she stood somewhat uncertainly holding seven remaining roles: suicide, *angry person, victim, zombie, father, worrier and slave*. I first asked Marianne to look over her handiwork and make any changes she deemed necessary. She stood, her gaze fixed on the **I Am** column and wondered aloud, "How can I be all these things?" Guided by this initial response, I

asked her to elaborate. She pointed out that this list contained a number of seeming contradictions, including *simpleton* and *wise person*, *coward* and *warrior/hero*, *optimist* and *pessimist,* and *killer* and *healer.* In essence, she answered her own question, stating, "But I *am* all these things. At least part of me is."

The group watched and waited several moments as Marianne contemplated further, then Ruth spoke up; "You are *not* a villain or a beast. You are *not* a killer. And I see beauty in you all the time!" I gently reminded Ruth that this was Marianne's process and thus reflected her own subjective experience and interpretation of the terms used to describe the roles. Marianne shared that she construed *beast* and *villain* to mean "primal parts of [her] self, parts that are usually hidden". She was less sure about her understanding of *the killer*, but offered that maybe the role was an element in her "depressed self" and was in a dual relationship with *the survivor.* She stated that her inclusion of four seemingly disparate "sexual" selves (*asexual, heterosexual, homosexual* and *bisexual*) "just belong there". She explained that she viewed the terms as confining, despite the fact that she was in a "happy, straight relationship". Though Marianne had selected *child, daughter* and *adolescent* for her **I Am** category, she I noted that she had also chosen to incorporate *mother* and *wife.* The latter terms often denote "some kind of adulthood", she said, but added, that inhabiting these roles was more akin to "taking on someone else's definition [of them]".

I next asked Marianne about her **I Would Like To Be** inventory, asking her how she saw the roles of *god* and *bully*. She hastily replied that she did not see herself as "some kind of deity". I once again lightly commented on her ownership of the process, underlining the fact that the exercise with Role Profiles was not concerned with judgment

and hence did not require justification. I stressed that the group members, both as individuals and as a collective, were looking at Landy's archetypes in the spirit of exploration. Marianne said she was glad to be reminded of this, and several of the other participants remarked upon the courage they perceived in her willingness to be "open" and "genuine" in sharing her process. She returned to the *god* role in her **I Would Like To Be** category, divulging that she believed a bit of the "divine" to be in everyone. She next considered the role of *bully,* located directly beneath *god.* She first said that she didn't understand why she'd placed *bully* in this category, stressing that she did not wish to "intimidate" or "be mean to" other people. She revisited her mental quandary regarding this role during the session's emotional check-out, claiming it disturbed her in ways she couldn't quite fathom. The group mulled over various significances the term *bully* held for them, a discussion that led many to recount incidents in which they had felt persecuted by other people. Marianne listened for a while. She then disclosed that though she didn't see herself in the role of the intimidator, she had "definitely *been* bullied". She gave a half-hearted laugh and added, "I guess that means I'm a 'victim' too." In light of the improvised scene Marianne would present in Phase Four, her inclusion of the *angry person, victim* and *father* in her "unplaced roles" category would appear to have had profound implications.

The evolution of Role Profiles through group process.

As the group processed the Role Profile (Landy, 1996, 2003) device, several participants voiced their dissatisfaction. Ruth suggested that it was lacking an essential category entitled **I Am This But I Do Not *Want* to Be,** a notion everyone supported. I found this interesting because although we had talked about dramatherapy's goals in

examining role systems, including the concept of learning to acknowledge and name those parts of ourselves we would rather ignore or disavow, most of the women professed a desire to *rid* themselves of roles they viewed negatively. Among the plethora of roles participants felt were missing or insufficiently indicated were the following: *dramatizer, martyr, confidante, whore, caregiver, self-denier, self-punisher, Barbie doll, servant, perfectionist,* and *self-nurturer*. The participants' perceptions of these roles will be elaborated upon later in my discussion of each woman's personal inventory.

Despite the fact that I took elaborate care to record each woman's suggestions, when the processing really got going it took on a momentum of its own. It consequently became difficult for me to discern which suggestions were attributable to which individual at all times. Rather than being disheartened by this, however, I viewed as evidence of a forum that emerged organically from within these circles of women.

Given the views she expressed regarding her ardent dislike of "labels", I was somewhat surprised to see Ruth very invested in our role inventory process. I asked her, at one point, how she felt about this exercise, based as it was upon the assignation of archetypal names to categories, and gleaned an important insight from her response; "Having the tools to look at how *I* would 'type' myself is completely different than having someone *else* do it *for* me" she stated firmly. Marianne echoed this opinion, sharing that, from her perspective, "it's being put in boxes by *other people* that drives me crazy...this process is more about my *own* stuff, you know, my *own* way of describing myself".

In keeping with the participants' voiced preference for ownership over the role method, I asked them to compile lists of parts they felt they were currently playing in

their lives, using any terminology they wished, including Landy's (1996, 2003). During the following session, each woman shared her list with the group, which we proceeded to divide into subcategories of **Roles that are Most Prevalent** and **Role/s that I Find Most Problematic**. Each woman's role compendium was written on a large piece of Bristol board hung on the wall, to allow both the individual and the group to take another 'step back' when viewing and reviewing their choices. When everyone's list had been shared, the group moved towards a two-part process in which participants defined or clarified their terms, and were at liberty to augment or change the lists if anything further had arisen for them in the sharing.

Marianne's Personalized Role Inventory.

Mariannes's list of **Top Current Roles** included *child, mother, employee* and *landlord.* After viewing her list on the board, she expressed frustration, stating that she hadn't "quite nailed it " and that "something important" was "missing". She asked for the group's help, given the fact that they had heard her speak about her life quite intimately for several months. Together, they created a new role entitled *the overloaded person,* which Marianne later defined as a person who does not "have enough time for freedom, for leisure, for self-care" and as one who "is lacking any kind of 'carefree quality' in her life". For **Most Prevalent Roles**, she chose *child* and *mother*, adding that her **Most Problematic Role** was *the overloaded person.*

During sharing, I reflected that this theme of bearing a lot of differing, demanding responsibilities was very akin to her stated goals in our initial interview. Marianne agreed, and further linked *the overloaded person* to her Six-Part Story (Lahad, 1992) created in Phase Two of the therapeutic process. Interestingly, it was during this

particular session that she openly disagreed with another group member who had expressed dissatisfaction with our inclusion of warm-ups each week. Said individual felt the group was "ready to dive right into the heart" of the process and that, given our limited remaining time together, she wanted "to get to the meat", or core segment, more rapidly. Marianne listened as these views were expressed and then stated that she felt the warm-up to be an "indispensable" step that allowed her to gradually move into the session's central exercise. She added that if she had "kept silent" without putting forth her own needs, she would have been "just going deeper into this overloaded role", by agreeing to "go faster than [she was] comfortable".

Marianne chose to explore her *child* role and its ramifications in an exercise entitled *Throw Down the Script*, described later in this chapter. In efforts to address the *overloaded* role, she began to make tangible changes in her everyday life, including daily self check-ins using the *Minute*, enrolling in a dance class, and lessening her responsibilities as a *landlord* and *employee*.

Ruth's Personalized Role Inventory.

For Ruth, the **Top Current Roles** included *child/daughter, healer, mother* and *advocate*, clarifying that the latter role primarily spoke to her ongoing care for her ailing father. She chose *child/daughter* for the **Most Prevalent** category, and *advocate* as her **Most Problematic Role**. During the sharing process, Ruth remarked that she felt "kind of sad" looking at her list, because she herself would have liked "to be on the receiving end" of the *healer* and *advocate* roles, as opposed to occupying the roles "for everyone else in [her] life".

In previous sessions, Ruth had often told the group about specific instances in which she had played the *advocate* role. For instance, she was very involved in a number of committees related to her sons' education and seemed to have little problem speaking forthrightly at meetings. Now, however, the role of *advocate* had grown more complex, as Ruth expressed that it was "very connected to [her] trying to be a good wife, sister and daughter" while feeling "very unsupported". When asked to expound upon this comment, she shared that her father's illness and hospitalization was "making [her] feel like a hostage". She stated that every time she tried to "take a moment for [her] self', her father would begin "laying a guilt trip" by telling her that he felt suicidal and "had nothing left to live for". Her one sibling refused to come from the nearby city where he lived, thereby abdicating any day-to-day responsibilities in their father's care. Additionally, Ruth said that her husband thought her mounting stress was "just female hysteria", "silly" and "crazy" and couldn't see or wouldn't acknowledge that she needed a respite.

For the very first time during the process, Ruth did not laugh while describing her duress. She put her head in her hands and cried, saying she was "embarrassed" to be "laying all this on you guys [the group]", to which several group members replied that such sharing without self-censor was why the group existed in the first place. Towards the end our time together, Ruth was also able to express, both verbally and through projective exercises, her anger about her treatment at the hands of both her father and her spouse. She remarked that this was "a big breakthrough" and that she felt "empowered" by being capable of accessing the "hidden emotions" underlying both her life roles and her depressions.

Claire's Personalized Role Inventory.

Claire cited *barber, cook, waitress, cleaning woman, organizer, Barbie* and *servant* as her **Current Top Roles**, with *cook* and *cleaning* woman as her **Most Prevalent** and *servant* as her **Most Problematic**.. She was very quiet for the sharing segment of the first role session, saying only, "I don't speak because I know all I will do is cry". In the following session, however, she was very open and eager to share her thoughts. She said that she had felt the need to cry, not just for herself, but "for all of us", because upon viewing the lists of roles together, it had struck her that "they were all for somebody else", a concept that made her "feel [her] heart break". She shared that all of her roles were inextricably linked to the duties she found herself having to "perform as a good wife" and posed the question "Where was *I* in all of this?" Claire also recalled her experience with the *Magic Chest* projective exercise, in which she had chosen a Barbie doll figurine.

Her amended role list included the following; *self-punisher, dramatizer of small things, one who puts others first at cost to herself* and *perfectionist.* When asked to explain her intended meaning for *self-punisher,* Claire replied that it was perhaps her "oldest role", beginning when she was four years of age. She defined it as "taking away my own enjoyment all the time". Another group member expressed curiosity as to how the role came into being. Claire had tears in her eyes as she shared that she was merely "following in [her] mother's footsteps". She gave as an example a past "betrayal" on the part of her husband. Instead of castigating him for the incident, Claire said that she had immediately given up her "nights out with 'the girls'", lest such a betrayal occur again.

Claire stated that she had been "brought up to be a martyr" and "to be very, very hard on [her] self". Among the lessons she had received and "internalized" were the following; "Nice girls don't cry....they don't get angry...they damn well do what they're told." It was of no small significance then, when Claire later shared what she designated her "new communication experiments" with her husband. In these exchanges, she began to state what she needed with greater calmness and clarity. She reported that her husband had expressed considerable shock to hear how unhappy she was at having to contend with all the household chores. He reminded her of the times when he had offered help, only to be met with her categorical refusals. This extended far back to their days of child rearing when Claire said she "wouldn't allow him to change [her] son's diapers". "I think" she mused, "this has to do with perfectionism as well", adding that she had not believed her husband was capable of doing such tasks "correctly".

One of the other group members remarked that Claire's role entitled *dramatizer of small things* seemed to be "more a judgment" of her experience as viewed from someone else's perspective. Claire shared that she felt "confused" about the role, and had included it because that was how her spouse described her when she became "upset". This role led into a fascinating discussion about which role terms the women felt were undermining and which they felt were truthful manifestations of their own self-perceptions.

Amanda's Personalized Role Inventory.

For her **Current Top Roles** list Amanda chose *friend, daughter, pessimist, worrier, sister* and *angry person*. She said her **Most Prevalent Roles** were *friend* and *daughter*, but then decided to qualify them to form *good friend* and *good daughter*. She cited *angry person* as her **Most Challenging Role**. Upon viewing the lists of the other

women, Amanda made a few further additions to her own, including *victim* and *sick person*. She changed *good friend* to *wants-to be-good friend.* In the following session, the latter role was yet again altered to *rejected friend.* Her updated role inventory now comprised, in addition to the original choices, *self-punisher, sister*, and explosive one.

During the sharing sections of two consecutive sessions, Amanda explained her process of selecting and refining these roles. She said that the *friend* role was very challenging to convey, "because it includes a lot of things", such as her feelings of loss about friends with whom she had once enjoyed close rapports, and her fear of being rebuffed in her efforts to rekindle relationships. She related her desire for companions to their notable absence in her social atom as described earlier in this chapter..

Amanda defined *self-punisher* in similar terms to Claire's, saying that it denoted her tendency to deny herself pleasurable things. She also, however, made a link between the role and her relationship to food, which she described as "not healthy". This was the first mention of food issues within the group, and a number of other women subsequently decided to include the role *self-punisher-with-food* in their compendiums.

Two remaining roles that Amanda felt inclined to explain in greater detail were *victim/sick person* and *angry/explosive person.* The first she said was meant quite literally given her physical health difficulties, but was also reflective of "a certain mindframe" she felt "stuck in". Many participants had expressed that a lot of their chosen roles were "passive" ones, in which they felt 'acted upon', rather than parts they actively engaged in. Amanda stated that she felt *sick person* was an example of a "passive-type role" insofar as it consisted of a "really negative attitude" that other people could "pick up on" and subsequently adopt towards her. This role served as the basis for her experience of the

Yes/No exercise described later in this chapter. Including the *angry/explosive* role, Amanda confessed, had made her feel "ashamed", but she said she was "really relieved" to see *angry person* contained in other women's lists. She connected her *angry person* with her verbally volatile relationships with her grandmother and stepfather. She said that although she "might appear very quiet", her behavior in these relationships included "a lot of yelling, name-calling...walking out, slamming doors". Though she would later practice expressing her anger in different ways with her significant others, another aspect of *the angry person* arose in the sharing, when a group member suggested that Amanda's rage might be a very understandable response to her serious health situation. Amanda returned to this idea in later sessions during the *Talking Egg* check in, and agreed that she was angered by "the hand [she'd] been dealt".

IV. Stepping into the Fictive Realm: Role-Plays

The use of sociodramatic devices.

Sociodramatic techniques and exercises coalesced well with the group's movement into both more structured role-playing forms and more 'here-and-now'-oriented enactments that derived from members' real life material. In addition, the fact that sociodrama emphasizes those roles and role aspects one shares with others meant that often, a single participant's journey through an exercise was imbued with the desires, needs and support of the entire group.

Many of sociodrama's underlying premises resonate deeply for me and coalesce with my personal perspective on group work. Its intent to build upon "the strengths that a person already has, rather than highlighting weaknesses and inadequacies" (Sternberg & Garcia, 2000, p. 53) mirrors my own desire to emphasize the client's innate resources for

healing and self-realization. Sociodrama evinces the fundamental truth that we have more commonalities as a collective than we do differences as individuals (2000), a concept I found integral to the dialectics within my group processes at this stage. Though its individual members shared the experience of mental illness, the diversity of unique challenges with which they were contending rendered the group make-ups far from homogenous. Our attempt to elucidate common goals was thus an intrinsic part of our journey together. The practical tools and methods of sociodrama proved invaluable for discerning, naming and focusing the communal role objectives of this very varied clientele.

The Heroine and the Quest

The Heroine and the Quest is a variation on sociodramatic role play which, due to its 'game'-like quality afforded my participants a comfortable degree of distance from the emotionally-laden themes we had begun to explore. I found it both surprising and encouraging that, in both of the groups discussed, the individuals who evinced the most timidity in Phases One and Two were those most eager to undertake the role of Heroine. In the *Quest,* there are essentially three categories of players. In addition to the Heroine, one participant takes on the role of Coach or Cheerleader, and several others adopt the roles of various obstacles or Dragons. The Quest is the objective the Heroine must strive to attain, and arises out of a communal group decision-making process. For sociodramatic purposes, the agreed-upon Quest must resonate with each of the group's composite members. The Quest (goal) and Dragons (impediments to goal) having been decided upon, the parts are distributed amongst the participants who proceed to arrange themselves in a straight line, each several feet apart. At one-end stands the Coach, whose

job is to call out encouragement to the Heroine, thereby helping her to contend with the various Dragons she who cross her path. The Heroine commences at the other end, encountering and addressing each of the Dragons, until she has made it through to the Coach and reached her objective.

In our particular process, the Quest and the Dragons were often related, implicitly or explicitly, to the role inventories we had assembled. For example, in both groups the theme and role of *the victim* was pervasive. From group processing around this role came a clearly defined Quest objective; to *release* oneself from the confines of *the victim.* The group then chose a list of Obstacles with which the Heroine would have to grapple in order to attain her freedom from being 'stuck' in this role, including her internal voices of Guilt, Denial, Self-Protection and Disapproval of Others.

Ruth slays some dragons.

The group in which Ruth was a participant chose the theme of *perfectionism* as the basis for their *Heroine and Quest* exercise. Coming up with a clear Quest statement took quite a bit of deliberation, as each individual had a different experience of how this theme had manifested in her life. Finally, common threads emerged from the rich tapestry of opinions and anecdotes. One predominant view was that fear of making the wrong decision tended to preclude making *any* decision, even when circumstances dictated that clear choices be made. In other words, many in the group relayed how their fears of doing the 'wrong' thing threw them into conditions of utter stasis. The ensuing barrage of self-criticisms did little to assuage these fears.

For Ruth, the role of *perfectionist* held vast significance. Not only had she consistently undermined her own ideas within the group up to this juncture, most

interpersonal relationships she had depicted were characterized by unfeasible expectations. Though she volunteered to embark upon the Quest in the Heroine role, she expressed anxiety that she wouldn't portray the *perfectionist* role well enough to satisfy the needs of the group.

The stated Quest was "to be capable of making a decision and to trust that it [would] be 'good enough'". The chosen Dragons included The Perfectionist/High Expectations Voice, The Self-Doubter for whom the phrase "I should" prefaced all choices, The Guilty One who feared being selfish and The One Who Fears Judgment and/or Rejection by Others.

The group members portraying the obstacles became very engaged in their attempts to thwart Ruth's task, adopting ferocious airs and menacing tones. Ruth set out very tentatively, approaching the first Dragon with a nervous laugh. She managed, with the Coach's encouragement, to calmly address both Perfectionism and Self-Doubt, stating firmly to the latter, "You can't dictate my life forever...I won't listen to you anymore". Arriving at Guilt, Ruth became quiet and appeared at a loss for words as the Dragon assailed her with accusations of her self-centeredness. She began to acquiesce to Guilt, even going as far as to provide examples of ways in which she was letting other people down. "Come on sister!" yelled the Coach, "Get a grip on yourself! Don't let her [Guilt] push you around!" Ruth drew herself up and took a series of deep breaths. She tried to exit the game, turning to me and saying 'I don't know if I can get rid of this one." Rather than call a halt to her progress, I suggested she allow Guilt to put a hand on her shoulder and move forward with her. This, I proposed, could signify that, despite the presence of some guilty feelings, she could still continue on with her journey.

Ruth seemed happy to follow this suggestion and stepped forward to meet The One Who Fears Judgment. This final Dragon began haranguing her with scenarios depicting Ruth's imminent exile from her family should she try and move forward. Guilt attempted to ally with Judgment, but Ruth resolutely pushed her back exclaiming, "I said you could come along, not take over!" This chastisement was greeted with a whoop of approval from the Coach. Appearing heartened by her success, Ruth placed her hands on the shoulders of the woman playing Judgment and gently pushed her aside. The group members broke into a spontaneous round of applause, congratulating her on having achieved the Quest. Ruth appeared bewildered at the powerful positive response from the group, but broke into a wide smile and took a formal curtsy. During the sharing that followed, several women thanked her for playing the Heroine. One commented that she had "held [her] breath the entire time", another that she thought Ruth was "a lot tougher than [she] looked".

Claire steps into another's shoes.

Another sociodramatic technique I used with participants was *role reversal*, in which the participants in an interaction exchange places. One purpose of this device is to allow the central player or protagonist the opportunity to gain insight into and empathize with the other person's viewpoint. As Blatner (2000) states, role reversal offers "a way of transcending the habitual limitations of egocentricity" (p. 250) in that it compels the players to adopt one another's perspectives. My primary interest in utilizing role reversal, however, stemmed from the fact that my review of the relevant literature included findings suggesting the technique's utility for affirming the inner experiences of depressed women (Casson et al., 1995).

Claire had admitted from the outset of the process that she experienced difficulty with the trust aspect of interpersonal relationships. Upon entry into a patient/doctor relationship with a new psychiatrist, this theme, as well as her discomfort in the role of *the sick person*, came to the fore. When she shared these issues with the group, several other participants voiced a similar ambivalence in the role of *patient*, claiming they too had experienced the sensation of "having no power" or being treated "like a child who has to do what she's told, no questions asked".

In order to explore these ideas, Claire and I entered into a brief role-play for the group. Initially, I took on the role of *the all-knowing doctor*, depicting him as she had described. In the role of *patient*, Claire clearly regarded me with suspicion and hostility. She sat opposite, viewing me with a wary expression and folded arms. When the doctor asked her questions, she conveyed great reluctance to answer. What little information she deigned to give was endowed with marked sarcasm.

We next reversed roles, with me playing the part of *the patient* and Claire that of *the psychiatrist.* Though she began with a highly stylized, exaggerated portrayal of *the doctor*, her character gradually shifted towards a softer, more realistic representation. In the group sharing that followed, Claire expressed that she had arrived at a few fundamental realizations. In the role of *the doctor* she said she had glimpsed, "for the first time" the "humanity" of the individual behind the position. "He is not God," she declared without cynicism, "And I am not a little girl." She said she had also had the opportunity to play "the *kind* of doctor [she] ideally wanted", one that met her needs.

We returned to the role-play at her request, assuming our original roles. This time around, Claire appeared much more confident, at ease enough in the realm of dramatic

reality to try out some more assertive stances with regards to her treatment. This proved important because it helped solidify her growing recognition that her perceived lack of *power* within the relationship was possibly linked with her inability to trust. Claire expressed her belief that she had to learn to trust her *own* capacity to help herself before she could trust others to help her. Many others in the group voiced similar thoughts about their own attitudes towards their professional care-givers. A few sessions thereafter, Claire reported a marked change in her rapport with her doctor. She told the group that she was "taking it day by day" and that, while still not entirely comfortable in her *patient* role, she was learning to adopt a more trusting stance.

Amanda talks back

At times during our process, the simplest of exercises yielded the most potent moments. Using a piece of stretchy fabric and a two line script consisting of the words "Yes" and "No", we examined another core theme that arose for the groups. The topic was the internal conflict between the active, optimistic attitude towards self-healing, and the passive, negative voice that told the individual she was beyond helping. Amanda became very animated during this discussion, and added that for her, changing roles from *passive patient* from whom little is expected to *functioning, well person* was a source of considerable anxiety.

We decided to play out the struggle between these two aspects by engaging in a tug of war with the fabric, each of us embodying and giving voice to one side of Amanda's inner dilemma. I began, stating, "Yes" and pulling the fabric towards me, to which Amanda countered "No" with an opposite pulling motion. We tossed these two lines back and forth for a few minutes, until I sensed that the momentum of the scene shifting.

Without explication, I suddenly usurped Amanda's 'negative voice', saying "No" and grabbing several inches of the fabric. Without missing a beat, she responded with "Yes" and added the line, "I want this". I in turn augmented my side of the dialogue with the line "No, this isn't yours".

With evidently mounting emotion, Amanda pulled harder on the material and said, "I *need* this " to which I responded, "You don't deserve it". "I do!" she said definitively, " I do deserve it!" Moments later she changed her lines once again, saying, "I *need* it! *Give it to me*!" I relinquished 'control' of the fabric and Amanda wrapped it around herself, weeping quietly. After de-roling thoroughly to take some emotional distance, the group processed this exercise, every woman sharing that she had been touched by the scene. One woman said she was certain Amanda, our quiet group member, would have "caved" under the pressure of having to maintain her side in our exchange. Another participant asked her what exactly she had been fighting for when she had said, "I need it". Was "it" meant literally, this member wished to know, or was "it" meant to be all encompassing in some way? Amanda responded that she was not entirely sure herself, but that perhaps she just wanted to "take some control back" and to "get back [her] life before [she] got sick".

IV. Leaps of Faith: Culminating Role Enactments

Phase Four, which Emunah (1994) calls *culminating enactment*, spanned the time period from late February to the end of March 2005. A deeper level of self-examination typified the group's process, as participants moved into the sharing of core personal material through enactments based upon their real lives. In this powerful segment of the journey, we made use of semi-directive improvisational scene work and some psychodramatic techniques. In all honesty, I had not fully anticipated that we would

arrive at this stage, as it entails a very heightened sense of intimacy within a group, as well as the emotional readiness of its members. Though I felt the seven months of our process might bring us 'to the cusp', it seemed quite a brief duration for such depth to occur. Yet occur it did, heralding a veritable tide of emotions and revelations.

Psychodramatic techniques.

As with those in sociodrama, psychodramatic devices are designed to facilitate an individual's exploration of role. Whereas sociodramatic work concerns itself with examining the collective aspects of roles, however, psychodramatic processes focus in on their private, individual, components (Sternberg & Garcia, 2000). While still occurring within the group context, the selection of one central figure, or *protagonist* denotes an individual role journey that is supported and witnessed by others. This type of work exemplifies the most emotionally intense, personally evocative aspects of role play, in which one's past "comes closer to the surface, and unconscious material becomes more accessible", lending light to "unresolved issues, recurrent themes, ongoing struggles" (Emunah, 1994, p. 41).

Marianne meets the Angry Person

One of the ways I chose to help catalyze culminating role enactments was to give pairs of participants partial scripts which acted as springboards for continuing, improvised dialogues around a central theme. Though the situation between Speaker A and Speaker B was left deliberately ambiguous, implicit in the lines was a conflict about one character not accepting the other and superimposing expectations that the other would have to change. The script was about eight lines long and was designed to allow

Speaker A to choose the direction the scene took. Observing the improvised dialogues proved extremely interesting. Many of the ensuing scenes created among the participant dyads became obviously emotionally fraught, as each player's projections of specific interpersonal conflicts emerged during the playing out of specific roles.

The following is the script we used in this exercise:

A: Why do I always feel like you're dissatisfied with me?

B: Don't be ridiculous. I'm satisfied with you. Completely.

A: No you're not. You want me to change.

B: I never said that.

A: You didn't have to *say* it. I can just tell.

B: Look, I care alot about you.

A: Then why can't you just take me as I am?
Why are you always wishing I would change?

B: What do you mean? What are you talking about exactly?

A: I'm talking about the fact that ...

B: .....

Marianne judged her improvised role-play in this exercise as the pivotal moment in her therapeutic process. In the role of Speaker A she engaged in a dialogue with her mother, in which she displayed more overt emotion than in any previous exercise. She told her mother she was "very, very angry" at her for allowing Marianne's father to "diminish" her. The participant playing the mother at first refused to listen. As Marianne pressed forwards with her view, Speaker B switched tactics, demanding that Marianne "back up" her accusations. Marianne inquired, "Why should I have to justify this? Why can't you just listen to me for once in your life?" She proceeded to explain to her mother

that, by setting such an example (i.e. of a subservient woman who repressed her true feelings and opinions), she had taught Marianne to do the same. This kind of "lesson", she stated, had led her to adopt the "misconception" that it was natural for her to let herself feel "controlled" by "systems and hierarchies" in which she found herself socially and professionally.

During the group processing of this role-play, Marianne expressed astonishment at "just how enraged" she was, a sentiment echoed by several other group members. She shared that she had been "absolutely sure" at the scene's beginning that she would be speaking to her father, but that the dialogue with her mother "just emerged naturally" as soon as she adopted the *daughter* role. Of her own accord, Marianne began relating the scene back to her work with role inventory. She shared that she saw a pattern in her life of societal "messaging" of "what is appropriate" in a woman, leading to emotions of "bottled rage" that turned inwards to form depression. She further stated that she found herself "depleted" from being in situations that required her to balance being "socially appropriate" with her desire to "speak [her] mind" and voice her "true opinions". At the same time, she added, she did not wish to be "too transparent" and felt that she had to "protect [her] self".

The group responded powerfully to Marianne's scene, particularly to the idea of not feeling permitted to acknowledge and voice anger as women. In the following session's check-in, Marianne shared that she had experienced a "great relief" at "letting this anger out". She said she felt "much more relaxed", as though she had "exorcised a demon". She reported that she had embarked upon a "simplification" process in her life, with the aim of reducing the stress load that she felt fuelled her anger. Moreover, she shared a

newfound belief that the role of *the angry person* did not have to be "negatively connotated. It can just....be another part of me". For Marianne, this meant that she could acknowledge and own the *angry* role as one among many facets within her personality. Having experienced how it felt to let her *angry person* have a voice without having "lightening strike [her] down" in the form of the mother's retaliation or rejection of her, she no longer felt the shame that had motivated her to try and suppress the role entirely. I also found it significant that Marianne's *daughter* and *angry person* roles emerged in the context of her relationship with her *mother*. Though she had often shared with the group the fact that she harbored resentment against her father, she had never made reference to similar sentiments regarding her mother. In the session following her enactment, Marianne said that she had spent a nice evening in her mother's company and that she had felt less friction between them. When another member asked whether she attributed this new level of interpersonal comfort to the role play, she said that she believed the two were connected.

Amanda holds her own: The enactment.

For another warm-up into enactment, I chose a piece of music whose lyrical content concerned the theme of acceptance and self-identity. The group had agreed upon this theme in a previous session after we had brainstormed around communal issues that had arisen from our process thus far. Participants were invited to close their eyes and attend carefully to the song as it played, allowing whatever associations or emotions it evoked to enter their consciousness.

The following are excerpted stanzas from our 'warm-up' song:

Here in the dark, I stand before you

Knowing this is my chance to show you my heart
This is the start, this is the start

I have so much to say and I'm hoping
That your arms are open
Don't turn away, I want you near me
But you have to hear me

Here's where I stand, here's who I am
Love me, but don't tell me who I have to be
Here's who I am, I'm what you see

You said I had to change and I was trying
But my heart was lying
I'm not a child any longer
I am stronger

Here's where I stand, here's who I am
Help me to move on but please don't tell me how
I'm on my way
I'm moving now

When the song had finished, I invited the group to think about and subsequently share an instance in their lives when they had felt they had not been accepted for their true selves. I then asked if anyone in the group was reminded of a similar situation in their lives that they would like to enact. Much to the surprise of everyone assembled, it was Amanda who spoke first, volunteering to portray the protagonist. In processing the role-play both during this session and in the two that followed, she conveyed a number of realizations she had arrived at concerning the roles of *daughter, stepdaughter, the passive sick person* and *the angry person.*

Amanda's enactment centered upon a three-way discussion between herself, her stepfather and her mother in the latter's home. The scene commenced with Mother expressing anxiety about Amanda's health and Stepfather giving her advice about many aspects of her life. Amanda tried to interrupt them to no avail, and sat back in her chair,

giving a frustrated sigh. The scene continued to unfold in this fashion for a few minutes, until a group member stood up to double for Amanda, saying loudly, "Shut up! Just shut up and listen to me!" Feeling supported, Amanda vigorously nodded her head and addressed her Mother and Stepfather, pleading for them to take note of what she was attempting to say. When her interjection appeared to have had little impact, she grew visibly angry and pounded her palm on the dinner table. Mother and Stepfather abruptly halted speaking. In the silence that ensued, Amanda expressed that, though she valued their support and believed it to be well intentioned, she felt that they were being "over-protective" and "too involved" in her daily life. Her Stepfather protested and began doling out more counsel. Amanda stood up and said, "You are not my father. You are not my father. You don't have this kind of say in my life." Shortly after this point, I froze the scene and Amanda stated that she felt good about what she had been able to say. The scene concluded with the three having a calm dialogue in which Mother and Stepfather showed a greater respect for Amanda's viewpoint.

Upon exiting the scene, Amanda had an air of triumph. During sharing, she expressed shock at the amount of anger she had felt towards her Stepfather in the scene. She stated that she thought that the "expectations" he had of her in the role of *stepdaughter* were more problematic than the role itself. She also shared that her role as *daughter* had become "muddy", explaining that she had ceased, in the past few years, to separate the *daughter* role she "mostly like[ed]" with the *stepdaughter* role she very much disliked.

In two subsequent sessions, Amanda continued to share her processing around the enactment with the group. She said that she had at first experienced guilty feelings about having expressed her *angry person* in front of other people, fearing they would "see [her] differently". She was able to "acknowledge [her] role as Stepdaughter", fortified with the

knowledge that this doesn't "mean [she has] to like it". She told us that she had begun to view her anger at her stepfather as "not completely fair", and suspected it was "easier to be really mad at him" than to acknowledge other possible sources for her frustration. Finally, Amanda said that she felt she had been successful in her recent efforts to renew the aspects of the *daughter* role she liked by spending more "girl time" with her mother. Though members of separate groups, this last was reminiscent of Marianne's evolving relationship in the role of *daughter*.

Chapter Seven – Discussion

A Look Back

> Most helpful of all for a woman to remember as she seeks her own voice, is that it will emerge only when she speaks form her own true nature and experience, only when she expresses what she cares most dearly about and is her own unique and individual truth. If she makes the mistake of identifying with the archetypal feminine and becomes intoxicated with its powerful energy, if she takes up its cause, she is likely to be devoured by it. Her task must be to ground herself in her own life and let its truth emerge. (Duerk, 1990, p. 66)

From "They say I am.." to "I am.."

In looking back over our process, I was struck by the different manner in which participants described themselves from beginning to end. In one of our early sessions, each group member was asked to name three qualities that she believed accurately portrayed her. Without exception, all of my research participants evinced considerable difficulty in the undertaking of this apparently straightforward task. Instead of starting their self-descriptive statements in the first person, employing "I am", the women displayed a predilection for telling the group how *other* people would depict them. For example, Marianne began two sentences with "My daughter thinks I'm", while Amanda prefaced each descriptor with the phrase "Everyone says I'm", then proceeded to say whether or not she deemed 'everyone's beliefs valid. Both Claire and Ruth described themselves primarily in the third person, as viewed through the eyes of their spouses. When I encouraged Ruth to begin her statements with 'I', she was at a loss, and then reverted back to using the "My husband tells me I'm" phrase.

I found the four women's reluctance and obvious discomfort with the first person very intriguing, given that our dramatherapy process was grounded in Jack's (1991) theory of depression as linked to the lost female voice. Simply to satisfy my own curiosity on the matter, I invited the participants to once again describe themselves during one of our final sessions together. The difference was remarkable; only once did an individual stray from the 'I' perspective, and that was to begin a statement with "We are" in order to pay tribute to the group as a whole. The participants themselves noted two things. Firstly, they observed that the statements were generally more positive than before, and contained much more detail. Secondly, they commented upon the lack of self-consciousness with which they were able to *say aloud* these affirmative descriptions. The evolution of self-perception and ownership exhibited by the self-descriptive exercise recalls the findings of Steinberg (1999), Edwards (2002) and Scott (2003) (see Chapter One, Section II), that women often exhibit the tendency to undermine their internal and external achievements lest they be viewed unappealing in their societally-designated gender roles.

A brief overview of the steps of role process.

The use of role warm up exercises such as the social atom and story-making provided helpful foundational devices that allowed participants to both discern underlying themes and role-related issues issues and to view themselves within the matrix of their current relationships. The projective nature of such methods permitted individuals to partake of this exploratory work with the heightened degree of distance requisite to the early stages of group process. Our compilation of role inventories granted the women a common, yet uniquely-constructed lexicon with which to express and process various

aspects of themselves. There was also a certain comfort to be derived from the numerous shared themes which arose as a result of this exercise. This universal aspect was of enormous benefit in helping participants counteract their individual senses of being isolated within their depressive experiences. Following the creation of role compendiums, I noted that participants began utilizing their 'role vocabularies' in weekly check-ins and check-outs. For me, this was indicative of the probability that work done in the therapeutic milieu was beginning to infiltrate the women's lives outside of therapy. In the final stages of our dramatherapy groups, each participant reported having had important moments of self-revelation due to her involvement in role enactments based in socio and psychodramatic processes.

Individual goal fulfillment.

The overall progress of my four participants over the course of the therapeutic process was substantial. Each individual exhibited an ongoing commitment to all stages of our journey through role exploration and all four women stated in retrospective interviews that they felt many of their stated therapeutic objectives at the outset had been met. For Marianne, these included confronting her fear of other people's disapproval, expanding her capacities for self-assertion and self-confidence in social interactions, and exploring past and ongoing issues concerning her parents. For Ruth, such goals comprised countering her sense of social isolation, examining her lack of self-acceptance and her reliance on others' approbation, and practicing setting personal boundaries with her family. Like Ruth and Marianne, Amanda wished to hone her social skills. Additionally, she wanted to rekindle her desire to actively participate in life and to explore how to set personal limits without giving way to hostile exchanges. Claire's

objectives were to explore emotional expression in the context of others, to rediscover her "own truth", to heighten self-esteem and to worry less about meeting other people's expectations.

Collective considerations of role work and inner voice reclamation.

Viewing the therapeutic process in retrospect, a number of links between the use of role work as conceived by dramatherapists such as Landy (1991, 1993, 1996, 2000, 2003) and Emunah (1994, 2000), and the theory of female loss of voice as posited by Jack (1991, 1999) can be discerned. As our journey unfolded, a clear relationship between the participants' unacknowledged, often conflictual role types often mirrored the unclaimed parts of themselves that they felt reluctant or unable to express openly in their lives and relationships.

Robert Landy's theory of role (1991, 1993, 1996, 200) holds that an individual's personality is comprised of a taxonomy of role types. He suggests that roles which appear 'missing' in one's life are in fact still present within one's inner role compendium, but have been neglected, ignored or denied. This phenomena results from a person's desire, subconsciously or consciously, to protect herself from the social and psychological consequences of allowing the role expression. One of the primary purposes of his role method (1991, 1993) is thus to help the client name, examine and ultimately achieve a greater capacity for tolerating her discomfort with and ambivalence towards problematic roles.

Likewise, feminist relational theory concerning the correspondence between depressed women and loss of voice (Lerner, 1988; Jack, 1991) holds that the 'voice' itself, is not absent within the afflicted woman. Rather, it is viewed as lying dormant,

awaiting release in the form of overt expression. As with role exploration, women must be surrounded in an atmosphere of emotional safety and nonjudgmental acceptance in their tentative forays towards reclaiming their voices because the pattern of suppressing their authentic self-truths has emerged as a means of self-protection. Because self-loss and self-silencing are believed to occur within the context of women's needs to attain and sustain connectedness in their significant relationships with others, it follows that they are protecting themselves from the painful emotions (i.e. grief, rejection, loneliness, lowered self-esteem) that the potential loss of these rapports would evoke.

I found it highly significant that all four of the women in this study, when they had achieved a sense of security that they could keep one another's positive regard and hence had the threat of interpersonal rejection removed, displayed little difficulty expressing their true opinions. This was the case even when their views were potentially provocative in terms of how they would be received by the rest of the group. The women rarely displayed wavering or ambivalence towards their own viewpoints, and consistently remarked upon a sense of relief that accompanied feeling safe to speak them aloud. For me, this pointed the way to a salient reality: it was not that the participants had *lost* the capacity to formulate their own opinions and feelings regarding various issues that was the fundamental challenge. Rather, they had lost the faith in their abilities to *share* their authentic perspectives with others without being marginalized, rejected or otherwise invalidated.

The above insight lends support for the notion that self-loss and self-silencing (Jack, 1991) is intricately intertwined with the women's need for secure, open interrelatedness. One illustrative example of this link can be seen in the case of Ruth.

While recounting her interactions in relationships beyond the scope of her family, Ruth evinced ease in expressing views that conveyed dissatisfied, frustrated and opposing opinions. For example, she was, by her own account, a highly vocal member of the parent/teacher committees at her sons' schools, and was unafraid of pointing out what she felt were problematic issues in the academic system. In her former job as second-language teacher, she had been active in both advocating for and concretely implementing changes in course curriculums. In both these public milieus, then, it appeared that Ruth felt sufficient confidence to voice her true perspective. Why then, did this same woman feel utterly incapable of communicating her needs to those in her 'significant others circle', including her husband and father? Looking at her quandary through the lenses of relational theory and self-silencing is helpful. The fact that Ruth had more intimate need of these relationships and placed more value upon them meant that she was thus more worried about jeopardizing them, which she often referred to as not wanting to "rock the boat".

The Angry Person role.

In looking at ways in which my participants' had engaged in self-silencing patterns (Jack, 1991), their acknowledgments and explorations of their *angry person* roles were perhaps the most pivotal, as this role type was related to a plethora of others they found problematic, including *daughter, child, wife* and *mother*. Each of the four women, at various points in the therapy, expressed marked anxiety regarding the *angry* role. For Claire, Marianne and Ruth, this anxiety stemmed from female role expectations they felt had been instilled in them as young children and was linked to their resentment at the manner in which the roles of *adult woman, wife* and *mother* had been modeled for them.

These three participants all made reference to the fact that, according to their early conditioning, for a woman to overtly convey anger was both a radical and unacceptable departure from the 'ideal feminine' as propagated the male-dominated culture surrounding them.

The way in which ambivalence towards the *angry* role manifested was different for each woman. Claire was cognitively aware of having anger-based emotions, but felt stuck in her attempts to convey them to her husband in way that respected and supported their relationship. Her stated desire to remain "faithful to [her]self" by acknowledging these feelings was in conflict with her fear of them "exploding" in the form of serious martial confrontations that would prove irrevocably damaging. Claire therefore adopted the role of *silenced one,* masking her anger and overcompensating for the related sense of guilt by throwing herself into the role of *good wife.* She also assayed to replace the *angry* role with that of *self-denier,* redirecting her frustration inward by denying herself pleasure.

For Ruth, the discovery of her *angry person* came as a surprise and gradually occurred over the course of several months of therapy. Like Claire, her internal desire to avoid dealing with her anger had compelled her to focus more on her sense of inadequacy in the role of *wife* and *one who takes care of others' needs.* This resulted in what Lerner (1988) and Jack (1991) call a 'forfeiture' of self, in which Ruth's unconscious decision to accommodate her husband and father at the expense of her own internal wants rendered her stressed, disoriented and seemingly detached when sharing painful material with the group.

Marianne's encounter with *the angry person* role, as described in Chapter Six, occurred during the culminating enactment in which she dialogued with her mother. Similar to Ruth, Marianne said she was somewhat "taken aback by the force" with which this role emerged. Though the angry person in this instance related directly to her *child, mother* and *daughter* roles, in the ensuing process she said that the chief source of her current frustration was connected with her sense that she had to "hide [her] true feelings", if to express them would mean to come into conflict with important people in her life. Not unlike Claire, Marianne felt that she had learned to suppress her internally-held views and feelings early in the course of her development. She summarized the engrained social message as follows: "A woman who strongly disagrees or sticks up for herself is always seen as a bitch, or aggressive, or both, but you don't often hear the same said about a man."

In the case of Amanda, her awareness of her *angry person* was colored by a penetrating sense of shame. Perhaps because she was a generation younger than the other three women, Amanda did not attribute her anger to having received early messaging about the necessity of silencing her opinions and feelings. Instead, she gradually identified the key source of her "rage" as closely connected with the conflict between her desire for independence as a young adult and her need for emotional and financial support from family members. Though Amanda could access the feelings associated with her *angry person,* they were so overwhelming that they often emerged through verbally-volatile confrontations with her grandmother, step-father and mother. Her struggle with this and associated roles of *daughter, step-daughter* and *granddaughter* was thus principally about finding safe ways to voice uncomfortable emotions so that she could

stay in the relationships that she deeply cherished, despite the complex dynamics characterizing them.

Transitioning between roles.

A final aspect of our role process that I would like to emphasize concerns the notion of *transitioning between* roles. While Landy's role method (1991, 1993, 1996, 2000) includes the concepts of role flexibility and fluidity, the theme of transition is not expressly addressed and was a major motif in the therapeutic journey described in this study. Moving between roles can be viewed as parallel to moving between relational contexts, as it is within these contexts that the varied parts of oneself are most called upon to emerge.

Our group process strongly emphasized that the participant women could have greater ownership over and ease with role transitions. One of the tangible ways in which we explored this was in a non-verbal activity we chose to entitle *An Average Week.* In this exercise each woman created a series of frozen sculpts, or poses, that illustrated the roles she played over the course of a typical seven-day period in her everyday life. The women were then asked to explore what it looked like were they to *move between* the poses in a fluid succession. The objective was to identify, using the vehicle of the physical body, where the areas of difficulty or awkwardness emerged in making transitions between roles.

Marianne, for instance, curled up on the floor to represent her *self-nurturer, self-listener* roles, and stood up very straight with her arms stretched out in opposing directions and a tense grimace on her countenance to show her *overloaded, public* role. In attempting to physically transition between the two role sculpts, however, she

encountered enormous difficulty and found herself almost tripping. As they processed this activity, the four women remarked upon how the metaphoric activity had obliged them to *slow down* and *accommodate* the physical requirements of their bodies as they shifted positions. This heralded a communal revelation about the care and importance with which they could invest their *actual* life role transitions.

Strengths and Limitations

This study had several inherent limitations. Firstly, owing to my small, non-randomized sample, my findings lack generalizability to a larger population of depressed women. Secondly, I have had to balance the subjective component of my research with some degree of objectivity, a challenge that is intertwined with the issue of limited replicability for those who may wish to verify my findings. Though my procedure included the use of specific, role-related dramatherapy tools, for example, such devices are highly malleable in terms of the manner in which they are used. Therefore, one cannot view them as 'standardized', in the conventional sense of the word. This study did not endeavor to arrive at causal connections between engagement in the proposed therapeutic process and the amelioration or deterioration of participants' mood states, nor did it attempt to quantitatively gauge the therapy's efficacy or lack thereof. Such objectives lacked feasibility, given the many extraneous factors inherent in both the research context and the lives of my participants which served as confounding variables. Many among my sample, for instance, were undergoing other, concomitant treatments and experiencing comorbidity with other mood disorders.

To my knowledge, no study examining the use of role in dramatherapy as a vehicle by which women with depression can potentially rediscover and integrate 'lost' and 'silenced' aspects of themselves has been done. Though my research methodology and design were restrictive in terms of generalizability and thus could not yield statistically supported, predictive findings, it has immense viability on myriad fronts. The relatively lengthy observation period afforded me by the duration of the therapy, in addition to the immense amount of data I was able to gather by virtue of limiting my focus to a few individuals, has hopefully allowed for an in-depth, detailed account of the process. Notable in this data is the quantity of participants' recorded words as it allows us access to the 'voices' this study seeks to depict.

Depression constitutes a state of being that clients often find hard to convey in everyday language. It thus, for many people, maintains an aura of 'otherness' that can contribute to increasing social isolation of the individual as she fears the unfortunate stigmatization society tends to bestow upon those identified as 'mentally ill'. It is my hope that the case studies described herein have proffered participants the chance to communicate their experience of depression in a unique way. This research could thereby enhance clinicians' and others' capacity to empathize with depressed individuals they encounter. Finally, I believe my study has feasibility as a springboard to further investigation into this area, perhaps in the quantitative realm of inquiry.

Potential Future Applications

From my involvement with and observations of the therapeutic journeys of these four women, I discern some support for the suggestion that role and role-related dramatherapy tools and processes can help women living with depression. Specifically,

and compatible with Jack's (1991) theories regarding women's mental health, such tools appear to have helped facilitate the efforts of my participants to identify parts of themselves they had lost touch with or repressed. In many instances, the insights derived from various points in our process were integrated to such an extent that participants reported related behavioral and cognitive changes which manifested in their everyday lives beyond the therapeutic frame. Though my treatment plan was necessarily flexible and evolving with the needs and affinities of my participants, the findings of this study could point the way towards a more structured, standardized treatment plan designed specifically for use with this population. Future research could include forays into a mixed qualitative and quantitative study, the results of which might lend support to the preliminary findings of this research. It would also be interesting to explore such research with male participants, in order to discern whether the theoretical ideas looked at in this paper have equal or different applicability.

The Last Word (s): Excerpts from Recovered Voices

> I see a finely wrought chain of tempered silver, delicate, yet strong, stretching back through time, reaching deep into the earth...A chain of women, each listening to each, being present to her as she waits for her self to be born, for her feeling values to come to form and to birth...Woman after woman after woman, being present, as each finds her voice.(Duerk, 1990, p.66)

Marianne's voice.

"Feeling safe for me is rare in a group, as in it never happens. I felt safe here with these other women."

"At first I had a really hard time *naming* things. The indirect approach really worked for me."

"I felt I could say anything, be myself. I am less afraid of expressing myself."

Ruth's voice.

"When I talk to my husband now, it's like 'Respect what I say. Hear me.'"

"I realize I don't have to ask permission, or get depressed. I can take a break if it's too much. I can give *myself* permission."

"I felt what it's like to feel safe to speak...no mask, no pretend. And I don't have to scream."

Amanda's voice.

"I want the opportunity to try out the skills I've been practicing in my relationship with my grandmother."

"By the end, I felt more deserving. I deserved to be here, to grow."

"The other people in the group say I've 'blossomed'. I think so too."

Claire's voice.

"I really loved the Talking Egg. We didn't censor ourselves."

"I've been rethinking the roles I've been playing in my marriage. I lost touch with some of my own needs. And I wasn't communicating them. I am rediscovering love."

"So many of my roles were for someone else. I looked at my list and I felt numb. I had totally lost my voice....who I am."

"I speak from the heart now. I learned that here."

E quindi uscimmo a riveder le stele.

And so we came forth, and once again beheld the stars

(Dante)

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Appendix A

CONSENT FORM

Authorization for use of materials for inclusion in the research paper for the completion of the below-named dramatherapy student's Master's Degree in the Creative Arts Therapies. Such materials include, photos of my art work, video recordings and related case material derived from drama therapy sessions in which I have participated.

I, the undersigned _____

have had the opportunity to read and ask questions regarding the attached document entitled ***Consent Information,*** and understand its contents.

I hereby authorize_____

to take any:

	YES	*NO*
Photographs	____	____
(e.g. of art/projective work)		
Video Recordings	____	____
Case Material		
(e.g. of process/progress notes)	____	____

that the therapist deems appropriate, and to utilize and publish them for educational purposes (specifically, for inclusion in her Master's research paper), provided that reasonable precautions be taken to conserve confidentiality.

However, I make the following restrictions:

_____

_____

_____ _____

Signature of Participant Date

_____ _____

Signature of Witness *Date*

If at any time you have questions regarding this research study, please contact:
Supervisor: Yehudit Silverman at (514) 848 2424 (ext.# 4231).

Appendix B

CONSENT INFORMATION

Drama Therapy Student: *Alison Aylward*
Concordia University, Montreal, PQ
Supervisor: *Yehudit Silverman*, DTR, RDT
Assistant Professor
Dept. of Creative Art Therapies

Background Information:

One of the ways drama therapy students learn how to be drama therapists is to write a research paper that includes case material and sometimes examples of art work produced by clients during dramatherapy sessions. The purpose of doing this is to help them, as well as other students and drama therapists who read the research paper, to increase their knowledge and skill in giving drama therapy services to a variety of persons with diverse problems and life challenges. The long-term goal is to be better able to help individuals who enter therapy with drama therapists in the future.

Permission:

As a student in the Master's in Creative Arts Therapies Program at Concordia University, I am requesting your permission to write about/make reference to your drama therapy sessions and to utilize photographs of your art work for inclusion in my research paper. I am also asking you for permission to consult your clientele file (at LaSalle) for a period of one year (or until I have completed my research paper). ***Please see below segment regarding confidentiality.*** One copy of the research paper will be bound and kept in the Concordia University Library, and another in the Program's Resource Room. This paper or parts thereof may also be presented in educational settings or published for educational purposes in the future.

Confidentiality:

Because this information is of a personal nature, it is understood that your confidentiality will be respected in every way possible. **Neither your name, the name of the setting where your drama therapy took place, nor *any* other identifying information will appear in the research paper.** Confidentiality will be maintained in the presentation of your art work as well; your identity will not be revealed.

Advantages and Disadvantages to Your Consent:

To my knowledge, this permission will not cause you any personal inconveniences or advantages. Whether or not you give your consent will have no affect on your involvement in drama therapy or any other aspect of your treatment. You may consent to all or just some of the requests on the accompanying consent form. As well, you may withdraw your consent at any time before the research paper is completed with no consequences, and without giving any explanation. To do this, or if you have any questions, you may contact my supervisor, Yehudit Silverman, at phone number (514) 848 2424 (extension # 4231).

If at any time you have questions regarding your rights as a research participant, you may call Adela Reid, Compliance Officer, in the Office of Research, GM-1000, Concordia University, Montreal, Quebec, H3G 1M8 Phone: 514-848-7481 Email: adela.reid@concordia.ca

Appendix C

LETTER OF THANKS TO STUDY PARTICIPANTS

Tuesday, July 12, 2005

Dear Participants;

I am writing to thank you for your participation in my final year research project, a paper in which I describe the dramatherapy tools and techniques that proved beneficial in our therapeutic processes together. The writing and submission of this paper to my department are my final steps in achieving the completion of my M.A. in Creative Arts Therapies, and the insights gleaned from my work with each of you have proved invaluable.

One of the ways drama therapy students learn how to be drama therapists is to write such a research paper that includes case material and sometimes examples of art work produced by clients during dramatherapy sessions. The purpose of doing this is to help them, as well as other students and drama therapists who read the research paper, to increase their knowledge and skill in giving drama therapy services to a variety of persons with diverse problems and life challenges. The long-term goal is to be better able to help individuals who enter therapy with drama therapists in the future.

As I shared with each of you in our prior verbal exchanges, the specific area my paper explores is the way in which examining one's life using work with roles (both real and fictional) can potentially evoke healthy growth and positive change for women. I relate this topic to the feminist theory of Dana Crowley Jack, who suggests that much of women's depressive experience arises from having lost touch with and confidence in their own inner voices. Jack's theory holds that a woman, in order to accommodate the needs of other people in her life, tends to often unknowingly begin silencing the inner voice that represents her authentic sense of self. In essence, my paper proposes the possibility that dramatherapy may help restore this sense of self.

As a student in the Master's in Creative Arts Therapies Program at Concordia University, I thank you for granting me your permission to; write about/make reference to your drama therapy sessions, utilize photographs of your art work for inclusion in my research paper and consult your clientele file until I have completed my research paper. **Because this information is of a personal nature, it is understood that your confidentiality will be respected in every way possible. Neither your name, the name of the setting where your drama therapy took place, nor *any* other identifying information will appear in the research paper. Confidentiality will be maintained in the presentation of your artwork as well; your identity will not be revealed.**

One copy of the research paper will be bound and kept in the Concordia University Library, and another in the Program's Resource Room. These copies should be available in the late Fall/05-Winter/06 season. This paper or parts thereof may also be presented in educational settings or published for educational purposes in the future.

During our meetings you were each given an information sheet, much of which is reiterated in this letter. If you have any other questions, you may contact my supervisor, Yehudit Silverman, at phone number (514) 848 2424 (extension # 4231). You may also e-mail me at the following: alisound7@hotmail.com. Finally, I wish to extend my best wishes to each of you for the future!

Sincere Regards,

Alison Aylward, M.F.A., M.A. (pending)

Appendix D

ROLES CONTAINED IN ROBERT LANDY'S TAXONOMY

ADOLESCENT
ADULT
ANGRY PERSON
ARTIST
ASEXUAL
ATHEIST
AVENGER
AVERAGE PERSON
BEAST
BEAUTY
BIGOT
BULLY
CHILD
CLOWN
CONSERVATIVE
COWARD
CRITIC
DAUGHTER
DEMON
DREAMER
EGOTIST
ELDER
GOD
HEALER
HELPER
HERO
HOMELESS PERSON
HOMOSEXUAL
INNOCENT
JUDGE
KILLER
MAGICIAN
MISER
MOTHER
OPTIMIST
ORPHAN
OUTCAST
PERSON OF FAITH
PESSIMIST
POLICE
POOR PERSON
RADICAL
REBEL
RICH PERSON
SAINT
SICK PERSON
SIMPLETON
SINNER
SISTER
SLAVE
SPIRITUAL LEADER
SUICIDAL PERSON
SURVIVOR
VICTIM
VILLAIN
WARRIOR
WIFE
WISE PERSON
WITNESS
ZOMBIE