

Spring 5-18-2019

# Role Method with Patients with Obsessive Compulsive Disorder: Development of a Method

Megan Marchant

Lesley University, mmarcha2@lesley.edu

Follow this and additional works at: [https://digitalcommons.lesley.edu/expressive\\_theses](https://digitalcommons.lesley.edu/expressive_theses)

Part of the [Social and Behavioral Sciences Commons](#)

---

## Recommended Citation

Marchant, Megan, "Role Method with Patients with Obsessive Compulsive Disorder: Development of a Method" (2019). *Expressive Therapies Capstone Theses*. 111.

[https://digitalcommons.lesley.edu/expressive\\_theses/111](https://digitalcommons.lesley.edu/expressive_theses/111)

This Thesis is brought to you for free and open access by the Graduate School of Arts and Social Sciences (GSASS) at DigitalCommons@Lesley. It has been accepted for inclusion in Expressive Therapies Capstone Theses by an authorized administrator of DigitalCommons@Lesley. For more information, please contact [digitalcommons@lesley.edu](mailto:digitalcommons@lesley.edu).

Role Method with Patients with Obsessive Compulsive Disorder:

Development of a Method

Capstone Thesis

Lesley University

May 10<sup>th</sup>, 2019

Megan Marchant

Drama Therapy

Christine Mayor

## ROLE METHOD AND OCD

### Abstract

Little has been written about the treatment of obsessive-compulsive disorder (OCD) using drama therapy. Therefore, I explore the adaptation of role theory and role method (Landy, 1993; Landy, 2001; Landy, 2008; & Landy, 2009) with an individual patient in an inpatient hospital setting who is diagnosed with OCD. Through our sessions, which occurred twice a week for three weeks, I was able to see the rigidity and inflexibility which is present in patients with OCD. In my application of an adapted role method, my patient was able to more deeply explore the “OCD role,” as well as start making steps to allow for more flexibility and spontaneity. I propose that integrating drama therapy, specifically role method, into OCD treatment has the potential to target specific symptoms of OCD and work to untangle the varying complexities of this disorder. I conclude with practice and research recommendations.

## ROLE METHOD AND OCD

### Role Method with Patients with Obsessive Compulsive Disorder:

#### Development of a Method

#### **Introduction**

The purpose of this thesis is to develop an adapted version of role method appropriate for individuals with Obsessive Compulsive Disorder (OCD) and to report on the learnings from implementing this intervention with a client. Obsessive Compulsive Disorder, as defined in the Diagnostic Statistical Manual or DSM-5 (2013) is “characterized by the presence of obsessions and/or compulsions” (p. 235). OCD can manifest in many people with little regard to gender, sex, age, ethnicity, and many others and has a lifetime prevalence of around two percent (Kessler, Chiu, Demler, Merikangas, & Walters).

Further discussion of existing research on the current treatment options for OCD, as well as the challenges these patients face, will be found below in my literature review. However, it is important to note that patients with OCD exhibit deficits in cognitive functioning as well as a cognitive rigidity which result in the presence of obsessions and/or compulsions. Therefore, it is my belief that the rigidity present in these patients results in a rigidity in other aspects of their lives, including identity.

David Tolin (2009) discusses the three main treatment methods for obsessive compulsive disorder; Exposure and Response Prevention (ERP), Cognitive Behavioral Therapy (CBT), and Acceptance and Commitment Therapy (ACT). For the purposes of this thesis, I will be focusing on CBT and ACT however all three can be relevant to the inclusion of role method in treatment. Cognitive Behavioral Therapy (CBT) focuses mainly on psychoeducation around OCD and ways in which the patient can re-frame cognitive distortions (Tolin, 2009). According to Twohig

## ROLE METHOD AND OCD

(2009), Acceptance and Commitment Therapy (ACT) focuses on “altering patients' tendency to treat thoughts as literal and to avoid them, and increasing the experience of meaningful, values-based actions” (p. 25). Both of CBT and ACT encourage the patients to expose themselves to stimuli that may be anxiety provoking and not to avoid them. Exposure, combined with psychoeducational and values-based actions, provides a treatment that is seen in many of the world's top OCD hospitals and treatment centers.

Despite the research discussed above, there is little in the clinical treatment literature which describes how to help OCD patients classify these rigid roles, bring them out into the play space, imagine new ones, or practice working with them. To this end, there is also limited research on using drama therapy to work with people diagnosed with OCD (Verluys, 2017; Cohen, Delaroche, Flament & Mazet, 2014). Therefore, this thesis focuses on adapting role method to an OCD population in an adult inpatient facility which focuses solely on OCD treatment.

I have been an intern at an institute focusing on individuals diagnosed with OCD since August. Working here has allowed me the unique opportunity to explore drama therapy in a hospital setting. The literature I have read and what I have experienced has indicated to me this gap in treatment; a gap that I believe an adapted version of role method could fill. Robert Landy (2009), one of the main founders of role theory and role method, defines the theory as “discrete patterns of behavior that suggest a particular way of thinking, feeling or acting. Role is one name for these patterns” (p. 67). He goes on to state that, “role is not necessarily a fixed entity, but one that is capable of change according to the changing life circumstances of the individual role player” (p. 67).

## ROLE METHOD AND OCD

The inclusion of the arts is also missing from existing OCD treatment, specifically drama therapy and role method. I believe that by implementing role method into the treatment for OCD, not only will clients begin to see a shift in their ability to embody more than one role and can begin to allow more flexibility and spontaneity in their lives, but it could potentially be used to aid in understanding the unique challenges patients face. I can see the benefit in integrating role method into the existing CBT and ACT treatments as well. Experimenting with ways of incorporating drama therapy techniques, like role theory and role method specifically, may enhance existing CBT and ACT treatment. Developing appropriate adaptations to existing role method techniques and developing recommendations for future research and practice are all things that I would like to gain insight and knowledge about through this thesis.

### **Literature Review**

#### **Obsessive Compulsive Disorder**

**Definition and symptoms.** Obsessive Compulsive Disorder (OCD) is characterized by the presence of either obsessions or compulsions (or both). According to the Diagnostic Statistical Manual or DSM-5 (2013), obsessions are defined by “recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted and that in most individuals cause marked anxiety or distress” (Tolin & Springer, 2018, p. 455) It is important to note that these obsessions are often so intense that patients try and suppress or neutralize them by performing compulsions. Compulsions are defined as “repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rigid rules” (p. 456).

## ROLE METHOD AND OCD

While the specific obsessions and compulsions vary depending on the person, there are a few common themes including contamination obsessions, symmetry, morbid thoughts, and harm to self and others. Patients with OCD often have difficulty with psychological flexibility and spontaneity as well (Twohig et al. 2014). Mathes, Van Kirk, and Elias (2015) describe OCD as “an insidious disorder that can take many forms, resulting in high levels of impairment, as evidenced by the World Health Organization identifying OCD as one of the top ten most disabling disorders” (p. 285).

**Main challenges.** There are many challenges that people with OCD face, including difficulties interpersonally as well as interpersonally. Many people report a strain in or loss of relationships because of the need for constant reassurance (Cerqueira, Torres, Torresan, Negreiros, & Vitorino, 2008). Tolin and Springer (2018) report:

35% with current OCD reported severe impairment in home management tasks; 21% reported severe impairment at work; 47% reported severe impairment in relationships; and 34% reported severe impairment in social life...nearly two thirds of those with OCD reported severe impairment in at least one domain of functioning, and more than three quarters reported at least moderate impairment in at least one domain. (p. 458)

Abramowitz and Arch (2014) discuss the ongoing challenges people with OCD face including “compulsive rituals (overt and mental), avoidance, and other safety-seeking or neutralizing behaviors” (p. 20).

Patients with OCD exhibit deficits in cognitive functioning (Berkhout, Dekker, Ruiter, Sternheim, & Van Der Burgh, 2014). As Berkhout et al., 2014 writes, “Executive functions regulate the more complex cognitive processes in the brain such as planning, decision making,

## ROLE METHOD AND OCD

organizing, response inhibition and flexibility of cognitive strategies” (p. 573). Cognitive flexibility is often a goal for patients with OCD, successfully evidenced by their inability to cease performing the same compulsions repeatedly regardless of the knowledge that it will not lessen the anxiety. Cognitive rigidity goes hand in hand with difficulties in cognitive functioning. In patients with OCD, the obsessions, which are difficult to separate from, result in a fixed mindset or rigidity (Diamond, Meiran, Nemets, & Toder, 2011).

Further, there is research that indicates an overlap between OCD and body dysmorphic disorder (BDD). OCD and BDD are both characterized by recurrent and intrusive thoughts that cause the person to feel distressed. They are both associated with deliberate, repetitive behaviors that alleviate distress and are thereby negatively reinforced (Hodgson & Rachman, 1972; Phillips, Gunderson, Mallya, McElroy, & Carter, 1998). Both disorders further appear to be characterized by hyperactivity in orbitofrontal-subcortical neural circuits (Feusner, Townsend, Bystritsky, & Bookheimer, 2007; Saxena & Rauch, 2000), which may be associated with obsessive thoughts and compulsive behaviors. These two disorders might therefore be grouped together as compulsive Obsessive Compulsive and Related Disorders.

In addition, patients with OCD often exhibit other comorbid diagnoses. According to Tolin and Springer (2018), “The most common comorbid conditions were anxiety disorders (76%), particularly social phobia (44%) and specific phobia (43%). Mood disorders were also common (63%), particularly major depressive disorder (41%)” (p. 458). A small number of patients were also diagnosed with a substance use disorder (Tolin & Springer, 2018).

**Current treatment.** As noted above, common current treatment options for OCD include cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), and exposure and response prevention (ERP). CBT (previously referred to as Cognitive Therapy or CT) begins

## ROLE METHOD AND OCD

with educating the patient about OCD and identifying symptoms like maladaptive thoughts and beliefs. Another aspect of CBT is instructing the patient to engage in behaviors that are scary which they would normally avoid, and to work towards stopping their attempt to control internal events (Tolin, 2008, p. 41). Mathes et al. (2015) state,

Individuals with OCD often believe they are responsible for their thoughts as being overly important. These maladaptive beliefs, coupled with the experience of intrusive thoughts, lead to increased anxiety and a consequential urge to engage in compulsions to reduce that anxiety. However, compulsions negatively reinforce the anxiety and obsessive belief, thereby maintaining the OCD cycle. (p. 285)

CBT, then, focuses on disrupting this cycle by “targeting the maladaptive thoughts, emotions, and behaviors that contribute to the onset and exacerbation of symptoms” (Mathes et al., 2015, p. 285).

Acceptance and commitment therapy (ACT) fits under the umbrella of CBT and is structured within functional contextualism. Functional contextualism, in its most basic form, is the idea that a behavior may occur that would indicate one thing when taken out of context; however, there are often more than one way to view the behavior and the various reasons why a patient would exhibit that behavior (Harris, 2009). The goal of functional contextualism, according to Harris (2009) is “to predict and influence behavior, accurately and effectively, using empirically- supported principles” (p. 38). This is important in ACT because it aids patients in creating more awareness of their particular behaviors and to notice how it functions in the “context” of their lives. In order to understand the relationship between ACT and functional contextualism, it is helpful to think of the varying parts of ACT as floors in a large home (Harris, 2009). Functional contextualism is the foundation, meaning that everything is built upon it. On

## ROLE METHOD AND OCD

the ground floor would be Applied Behavioral Analysis (ABA), the second floor would be Relational Frame Theory (RFT), and finally the top floor would consist of ACT. It is important to note that a therapist can use ACT without having extensive knowledge regarding the other theories and frameworks. However, it is helpful to know them and a therapist can provide a more well rounded approach to treatment when they all work together.

Bluett, Twohig, and Morrison (2014) wrote an article describing the importance of ACT based treatment specific to OCD. ACT requires patients to practice psychological flexibility, a trait that is difficult for many afflicted with OCD. Twohig (2012) wrote an article describing the basics of ACT and state that “ACT directly aims to increase psychological flexibility, and it does this through the following six psychological processes of change: acceptance, defusion, being present, self as context, values, and behavioral commitments” (p. 501-502). He goes on to describe the therapeutic stance for this treatment. He describes this approach as experientially oriented by giving the example:

We are trying to help clients take language less literally through conversation we are trying to loosen the grip of rules but in the process teaching the rule that rules cannot be trusted; and, finally, to clarify one’s values but also hold those values lightly as they are likely to shift over time. (Twohig, 2012, p. 504)

Tolin (2008) responds to the introduction of ACT as a means of treatment for OCD by examining the main tenets as psychoeducation, self-monitoring, instruction to decrease avoidant and compulsive behavior, instruction to stop attempting to control internal events, encourage new ways of thinking, and deliberately doing things that are scary and avoided.

## ROLE METHOD AND OCD

Exposure and response prevention (ERP) is another behavioral model of treatment for patients with OCD. Himle and Franklin (2009) argue that ERP,

Is based on the assumption that if an individual is systematically exposed to stimuli that elicit obsessional thoughts and associated anxiety, and is prevented from escaping or otherwise neutralizing the anxiety (ritual prevention), the anxiety will diminish over time through the process of extinction and the person will be better able to function in his/her daily life. (p. 30)

Mathes et al. (2015) define ERP, writing “ERP asks individuals to be “exposed” to the stimuli that cause fear and anxiety and to consequently “prevent a response” that would otherwise neutralize their anxiety and reinforce their obsessive thoughts” (p. 285). Cottraux, Olatunji, Powers, Rosenfield, Smits, and Tart (2013) discuss the efficacy of behavioral therapy versus cognitive therapy for OCD. They state that:

Behavior therapy (BT) that focuses on exposure and response prevention (ERP) is the psychological treatment of choice for OCD...The behavioral treatment derived from this theory involves gradual prolonged exposure to fear-eliciting stimuli or situations combined with instructions to abstain from compulsive behavior. (p. 415)

The overarching goal for ERP is to help patients learn that anxiety can flow in and out of consciousness and by participating in ERP they are learning to habituate to those fears over time.

**Limitations to current treatment.** While there are many effective ways to treat OCD, as described above, research is still ongoing to prove the best approach for treatment. For example, in Twohig et al.’s (2009) investigation into the processes of change in these treatments, the results indicated that, while there was some change in the level of severity in OCD symptoms

## ROLE METHOD AND OCD

post treatment, more research needs to be done. Hollon, Magiati, and Ponniah (2013) reported on the efficacy of treatments for OCD and stated that while ERP and CBT were effective in treating those patients, there was incredible variability present. For example, in regards to ERP they state “Some studies conducted sessions on an almost daily basis with in-session (therapist supervised) and homework ERP, while other studies conducted sessions only once or twice per week and used ERP only for homework” (p. 209). Given the amount of variability, it is difficult to say with certainty that these therapies are effectively treating OCD.

I believe that, while it is important for the patient to have the knowledge needed and certain behavioral tools like those presented in CBT and ERP, there is still a vital piece that is missing and that is the acts of embodiment, flexibility, and the ability to be spontaneous. By practicing those, in addition to CBT, ERP, and ACT, treatment might be better well rounded. By utilizing an adaptation of Landy’s role method, patients can practice embodying various roles, learning ways in which they can be more flexible, and re-learning how to play; all things that OCD has taken control over.

**Drama therapy and obsessive-compulsive disorder.** As of now, there are only two articles that discuss the benefits of using drama therapy with the OCD population (Cohen, Delaroche, Flament, & Mazet, 2014; Versluys, 2017). The first is a research article by Versluys (2017), documenting adults with OCD and their level of playfulness. Her hypothesis was that adults who had an anxiety disorder like OCD had a lower level of playfulness overall. She states the aim of the study is “To measure if playfulness in adults with an AD or OCD is different from playfulness in adults without an AD or OCD” (Versluys, 2017, p. 120) She goes on to discuss follow up questions if there is a difference in playfulness:

## ROLE METHOD AND OCD

Is the difference seen in playfulness as a whole or does playfulness differ in specific components as well as being divided in the measurement instruments? Could demographic factors (education, gender, age, household) account for the differences in playfulness? Does playfulness differ in specific subcategories of AD and of OCD, when categorized by the DSM-5 by fear/distress-dimensions and by anxiety sensitivity dimensions? (p.120)

She assessed playfulness by using three self-report questionnaires. The Young Adult Playfulness Scale (YAPS) is for adults aged 18-30 and consists of fifteen items that determine the characteristics of playful people. The Older-Adult Playfulness Scale (OAPS) is for older adults with a minimum age of 65. This questionnaire is similar to YAPS in that it also includes fifteen items that determine the characteristics of playful people. Finally, the Adult Playfulness Trait Scale (APTS) consists of nineteen items determining the representation of statements of the participants. Her sample includes two groups: the first group were comprised of 34 adults aged 18 and up with AD or OCD as their primary diagnosis. Group two (the control group) consisted of 34 adults without an AD or OCD diagnosis.

After gathering the participants surveys and matching them by age, education level, and gender, the results indicated that there is a statistically significant correlation between level of playfulness and a diagnosis of an AD or OCD. This work suggests that, because there is a correlation between the level of playfulness and those with OCD, that the inclusion of drama therapy interventions like role method could be used to positively impact the lives of those with OCD.

The second is a clinical case, reporting an individual psychodrama for a patient with “treatment resistant” OCD, written by Cohen et al. (2014). This case illustrated six months of

## ROLE METHOD AND OCD

sessions for an adolescent patient, Jay, with “treatment resistant” OCD. Jay, who was referred to a child and adolescent psychiatric outpatient clinic, began treatment with a Serotonin Reuptake Inhibitor (SRI) and family support because of severe OCD symptoms. By month four, Jay was able to enter a day treatment program for adolescents with psychiatric problems. There she participated in individual psychotherapy (IP). They noted in the study that it was difficult to report 6 months of psychodramatic sessions, however they highlighted three main periods of treatment, each one with definitive content and meaning (Cohen et al. 2014). In the beginning, Jay chose regular scenes from her life that correlated to her obsessive thoughts. It seemed as though the reason behind this was an attempt to dominate Jay’s fears. The second area of work contained scenes that were related to her specific family dynamic. The last period gave Jay the space to voice her fears about sexuality. An example of this was when she enrolled the therapist as her dog.

She always gave the dog role to the same therapist, who became a fantasmatic partner, exhibiting both hilarious and anxious feelings. When her fear of sexuality was recognized and pointed as such by Jay herself, she felt more secure and willing to start an individual psychodynamic psychotherapy, which allowed her to pursue the therapeutic process engaged during the psychodrama treatment. (p. 21)

In a few months, her OCD symptoms went from severe to mild. She was able to leave the day program the following year. Two years following treatment, Jay was able to attend a regular education school and was set to finish high school by eighteen.

Although it is difficult to say with certainty that IP combined with an SRI was the cause of Jay’s decrease in OCD symptoms, according to Cohen et al. (2014),

## ROLE METHOD AND OCD

The present report highlights that original psychotherapeutic approaches, such as IP, may be useful to help juvenile patients with “treatment resistant” OCD. Although it is not possible to generalize our findings in the absence of case series or more systematic studies, it is possible to raise their potential interest in the field of juvenile OCD. (p. 21)

They conclude by saying “IP should be considered as a psychotherapeutic option in cases of treatment resistant OCD. It can trigger symptom improvement, as well as enhance acceptance or efficacy of more classical treatment approaches” (p. 21).

This study is important because it shows a form of expressive therapies and its effective treatment for patients with OCD. While it is not exactly what I am aiming for, the inclusion of the arts appears really important here in terms of treating OCD. It should be noted that while this case offers important information for further studies that link the expressive therapies with treatment of OCD, findings from a single case study cannot be generalized to a broader OCD population. Further, because this case study centers on the treatment of an adolescent, there may be important developmental differences when working with adults, who are the focus of this capstone.

There are also several articles that combine role theory and role method with other populations, which are helpful to review here. Medical clowning has been used in children’s hospitals to uplift patients and provide a brief reprieve from the stress of their daily lives (Goshen, Grinberg, Kowalsky, & Pendzik, 2012). This article sought out to challenge the idea of humor as the main reason for the impact medical clowning has by using Landy’s role method. The role of the clown can be linked to “Landy’s taxonomy of roles, the fool belongs to the *cognitive domain* and presents two *subtypes*: the trickster and the existential clown” (Goshen et al., 2012, p. 43). While working within role as a clown can be helpful in hospital settings, role

## ROLE METHOD AND OCD

method has also applied to working with patients who have an eating disorder (Schneider & Wood, 2015). Many patients with an eating disorder, according to Landy (2008) are “role locked”. This means that those patients often feel as though they are their eating disorder, while also not wanting to only be seen in that way (Schneider & Wood, 2015). Drama therapists working within role, then, would aide the patient in exploring what the role of eating disorder looks like and working with them to expand their role repertoire to see what other roles they have available to them. While Schneider and Wood (2015) only provide a case illustration of this method, they find that using drama therapy allowed for integration and processing, while also helping keep the patient attuned to her body. This, in turn, allowed her the opportunity to heal both in herself and in her relationships.

Role method has also been used in Taiwan at the National Taiwan University of Arts. Chang (2017) discusses studying under Landy at New York University and working with him again in Taiwan in developing and executing a therapeutic theatre production. Through the productions, Chang learned about the therapeutic benefits to implementing a theatre production using rule method. He stated several things that he learned, including,

The process of invoking the role may constitute a warm-up phase of a therapeutic theatre production process. Emergent roles provide distance from oneself and make it easier for clients to become comfortable with the notion of performance. (Chang, 2017, p. 72).

He also discusses the benefit of using role method to keep the production structured and organized, which allowed the students to stay in the mindset of the play. Another notable finding was the use of steps six to eight of the method and how it provided closure as well as emotional clarifications.

## ROLE METHOD AND OCD

One of the most popular cases by those studying role theory is that of “Derek,” whom Landy used in his exploration of role in the film *Three Approaches to Drama Therapy* (2005) and written about later in *The Couch and the Stage* (Landy, 2008). Derek agreed to participate in several drama therapy sessions, including role theory/role method (Landy, 2008). In the transcript of the session, Landy assesses Derek using the Tell-A-Story (TAS) method in addition to exploring the roles that came up in the assessment using a range of exercises including the empty chair. By expressing his story, Derek appears to be connected with the work and expressed a feeling of catharsis and healing. This is a great example of the positive effects of using role method with the adult population. While no known studies or articles have applied role theory or method to populations diagnosed with OCD, it is my argument that Landy’s work would enhance existing OCD treatment methods.

**Role Method.** Many drama therapists believe that role theory was solely created by Robert Landy; however, he found his inspiration from Jacob Moreno. In fact, it can be argued that role theory dates back even before Moreno. Landy (2001) states that, “It was developed by a number of theorists and practitioners who believed that the dramatic metaphor of life as theatre and people as actors could be applied to an analysis of social and cultural life and inner psychological processes” (p. 65). He further argues that, “[Moreno] created a role method of treatment even though his intention was to create both a theory and a practice” (p. 65). Role theory, according to Landy (2001), “embraces the theatricum mundi metaphor of life as stage and people as actors and is based on the assumption that human beings live a double existence” (p. 103). Landy (2001) believed that everyone had various roles that they played out during the course of their lives, writing “Role theory begins with the concept of role...role is a personality construct, representing specific qualities of a person, rather than the totality” (p. 104).

## ROLE METHOD AND OCD

Williams (2017) draws on Landy's exploration of role by saying "the individual is not conceptualized as one whole self, but rather a compilation of roles" (p. 134). She further states that everyone has a role system, which is a wide variety of different roles that we play at differing points in our life. While Landy expanded on role theory as it pertains to drama therapists, he also created an application with which to use the theory and aptly named it role method. As Landy (2001) explained, "The role method of drama therapy extends naturally from role theory as clients create effective roles and stories within which to explore their dilemmas" (p. 111). Williams (2017) states, "Landy's role method is the means by which integration between role and [counter role] can be achieved, thus bringing the role system to a state of balance" (p. 134).

There are many small parts that make up Landy's role method with the main three being role, counter role, and guide. When a client begins drama therapy, Landy (2001) assumes that "at least one role the client needs to play in life is either unavailable, poorly developed or inappropriately aligned with other roles or other people in their roles" (p. 68). The role, then, is made up of different parts of the patient. The counter role or CR, according to Landy is "the figure that lurks on the other side of the role, the antagonist" (p. 68). The CR does not have to be the exact opposite of the role. In fact, Landy (2001) makes it clear that the CR is often not the opposite, as stated here:

It is not necessarily the opposite of the role as evil is to good, but rather other sides of the role that may be denied or avoided or ignored in the ongoing attempt to discover effective ways to play a single role (p. 68).

The final part of the triad is the guide. The guide is a "transitional figure that stands between role and CR and is used by either one as a bridge to the other" (p. 68). Most often, the role of the

## ROLE METHOD AND OCD

guide is first played by the therapist, guiding along the client until they themselves can begin incorporating the guide internally.

While role method can be seen in various studies discussed above, the rationale for using role method with patients who have OCD has yet to be explored.

**Rationale for Using Role Method with Individuals with OCD.** Landy (2009) state that “the unhealthy person, from a role perspective, is one who has given up the struggle to live with contradictory tendencies and have instead, embraced one role or a cluster of related ones, at the exclusion of all others” (p. 73). He further states “feeling overwhelmed by complexity, the unhealthy person finds ways to limit the quantity and quality of roles within his inner and outer world” (p. 73). This statement perfectly describes what many patients with OCD are exhibiting - the rigidity and inflexibility of any role outside of OCD. By incorporating role method into treatment, the patient may have a greater chance of breaking free from OCD. The goal then, is for them to feel as though they have the ability to live life with more spontaneity and flexibility. By incorporating role method into treatment, patients can explore roles that may have been shut out by their OCD. Giving them the chance to play and explore can be extremely beneficial to recovery. Haen and Lee (2017) place Landy and Bowlby side by side in their article comparing the two. They discuss the overarching goals of using role method with patients and how important being able to live in balance can be. They quote Landy saying, “The eventual goal is for the client to hold two opposing states of being, role and counterrole, and the ambiguity between them, or “to learn how to live in the role ambivalences” (as cited in Haen & Lee, 2017, p. 55). Learning how to live in the ambiguity is essential in treatment for OCD because OCD demands rigidity and structure. When patients with OCD are asked to give up their rigid lifestyles, it becomes one of their greatest challenges. Sitting with and learning how to play

## ROLE METHOD AND OCD

again, is essential. In *Persona and Performance* by Landy (1993) he states, “the ultimate goal in its use is to help the client construct a viable role system- one that is able to tolerate ambivalence and acknowledge the importance of both negative and positive roles” (p. 53). This directly corresponds to the goal of treatment for clients with OCD, helping the patient learn about other roles apart from OCD and to learning to incorporate them so that they can live a well-balanced life. Landy (1993) continues to discuss the importance of balance when exploring the role system and says “Integration, though often difficult to specify, implies a reconfiguring of one’s role system... the proof of the shift of roles can be seen in the ability to live with role ambivalence without undue distress and to discover new possibilities of being with oneself and others” (p. 54).

### **Methods**

This thesis focused on developing an adapted version of role method with an individual patient in an inpatient hospital setting. I met with adult patient “Elle” twice a week for three weeks, totaling six sessions for fifty minutes each. Elle was a prime candidate for working within role because of her rigid set of roles presented in her symptomatology. Before working together, she often stated that her OCD kept her from living a full and balanced life and that OCD was her only identity. We met in one of two places around the unit, either in a private office or a small space at the end of a hall that was tucked away. I began each session by doing a quick check in and a plan for how we would spend our time. Our check in’s consisted of her giving me one word or feeling for how she was doing in the moment. I chose this particular warm up because it gave me an idea of where she was both mentally and emotionally.

During our first session, we utilized the Tell-A-Story (TAS) assessment (Landy, 2009) which is frequently used with role method interventions in order to assess whether or not a

## ROLE METHOD AND OCD

patient's role system is balanced. Landy (2009) states "imbalance can mean the attachment to a single role or related cluster of roles to the exclusion of all other counterroles" (p. 110), which indicates to me a link between the rigidity of OCD and the attachment to the OCD role. Given this, I believed the TAS would be of value for patients with OCD because their limited role repertoire could be used to help clients gain insight and develop a plan for expanding their role repertoire. Indeed, Landy (2009) describes the purpose of TAS, writing, "Its aim is to assess an individual's ability to invoke a role, CR and guide and to move toward some integration and connection among the roles" (p. 74). When conducting TAS, Landy (2003) stated that the directive be as follows:

I would like you to tell me a story. The story can be based upon something that happened to you or to somebody else in real life or it can be completely made up. The story must have at least one character. (p. 152)

After telling a story, the patient is asked to answer questions that determine whether they can identify each character's qualities, styles, and functions as well as themes and the stories connection to the patient's real life (if applicable) (Landy, 2003). I decided not to alter the TAS assessment as Landy had it written, because I felt it was sufficient in answering all of my questions and there are no current studies which report on the use of TAS with clients diagnosed with OCD.

I gave Elle the prompt suggested in the literature (begin with "Once upon a time..."). When we finished, I asked her about the themes, character details, and relevance between the story she told and her current life. Beginning with the TAS allowed me the opportunity to see how many roles Elle was able to access with ease and if she could discuss them with a sense of flexibility and spontaneity. Where a verbal inquiry would have provided me with baseline

## ROLE METHOD AND OCD

answers, the TAS showed me where Elle was in regards to her role system, which would be useful moving forward. As a closing activity, I brought out a fictional scrapbook and mimed putting in photographs, notes, and memories from our session. I asked her to do the same. I explained that after each session we would be adding more to our scrapbook. I chose to do this as a way to further facilitate a relationship and build a connection with Elle, while using an imaginal frame.

At our next session, Elle arrived dysregulated and angry. I chose to use those feelings of frustration and upset with a warm up using authentic movement, where I first asked Elle to point to a part of her body that she was feeling the anger from. After, Elle and I participated in an authentic movement exercise, focused on that part of her body. Authentic movement, which has its origins in dance movement therapy, is a “mindful movement exploration between a mover and a witness which encourages the development of consciousness” (ADTA). I chose to begin with this because Elle, and others with OCD, often exhibit a rigidity and disconnection in her body (Hodgson & Rachman, 1972; Phillips, Gunderson, Mallya, McElroy, Carter, 1998 & Schneider & Wood, 2015). I hypothesized that incorporating authentic movement would allow her the opportunity to practice connecting to her body in new ways, thus further exploring her ability to be flexible and spontaneous. We played for a little bit with this and eventually a character emerged, the evil queen. This is different than the normal process of authentic movement, which would typically remain only in movement and reflection. Here, I used authentic movement as a jumping off point to then transition to role. We explored the evil queen in several ways including inside the play space where I interviewed her (as the evil queen) asking questions like “What made you so evil?” and “Are you happy being this angry?” trying to focus

## ROLE METHOD AND OCD

on emotions and feelings. We ended by exiting the play space and shaking off our characters. I also brought our scrapbook out and we added quotes and photos from the session.

The third session focused on exploring more roles that Elle presented in her life. I started with a one word check in and went directly into role play. Before we began, I laid out several stuffed animals including a dinosaur, an octopus, a tiger, a unicorn, a moose, and a giraffe, because I found the use of projective techniques to aide Elle in the ability to talk about herself without feeling overwhelmed. The specific animals I chose held no particular meaning and were interchangeable to the intervention. I asked Elle to choose one that she felt most drawn to in the moment. She chose the dinosaur and promptly named him Spike. I also chose a stuffed animal and we began the role play, focused on a dialogue between the two of us. I found that Elle was able to dialogue with me by using the projective technique where, had I tried to engage in a conversation with her, she would not have been able to. I also did this because I wanted to see if Elle had the ability to let go and play, even for a short time. We ended the session by adding to our scrapbook.

Our fourth session consisted of a quick check in and role sort. I chose to incorporate Landy's (2008) role sort at the midpoint of our sessions to check the progress of my client and how well she was able to access certain roles (Landy, 1993; Landy, 2001; Landy, 2008, Landy, 2009). I presented the cards to Elle with the prompt:

This experience is intended to explore your personality as if it were made up of characters commonly found in plays, movies, and stories. You will be given a stack of cards. On each card is the name of a *role*, which is a type of character you have probably seen in movies and plays or read about in stories. Please shuffle the cards thoroughly. Place each card in one of four groups that best describes how you feel about yourself

## ROLE METHOD AND OCD

right now. Each group is labeled by a large card which says: *I Am This, I Am Not This, I Am Not Sure If I Am This, and I Want To Be This*. Try to group the cards as quickly as possible. Any questions? When you are ready, begin. Be sure to place each card in one group only. (Landy, 2003, p. 153)

After I gave her the prompt, she sorted out the cards into the four columns. After she completed all of the cards, I asked her if she felt that any of them needed to be moved to another column. After she did this, we both looked through the cards and I asked her if she could choose one card from the “I Am This” column to work with today and she chose the “Killer” card. When I prompted her as to why she chose that card, she stated that it was because she felt like a murderer. After further exploration, which will be explained in more detail in the results section, she wanted to move on to another card. Unfortunately, we ran out of time and decided to end session by doing a full body shake out and one word reflection.

During our next session, I brought back the role sort and asked her to choose a card from the “This Is Who I Want To Be” column. She chose warrior. We began by doing an authentic movement, focusing on the word warrior and how it felt in her body. She struck her “warrior pose” and I interviewed her, asking questions like “What is your warrior name?” “What are your superpowers?” “How do you like being a warrior?” “Do you have any arch enemies?” and “Is there anything you would like to tell the audience?” After role playing as the warrior, we stepped outside of the imaginal space and discussed what that felt like. I asked her to choose one more card that she wanted to explore in the “I Am This” category during the session and she chose “lost one.” Again, I interviewed her as the lost one, asking questions like “Where are you going?” “What is your name?” “Why do you feel like you’re lost?” Afterwards, we moved out of the play space, shook it off, and discussed what that felt like and compared it to the warrior. We

## ROLE METHOD AND OCD

closed with one way she could incorporate the warrior into her daily life as well as adding to our scrapbook.

For our final session, I implemented the TAS assessment once again. I gave the same prompt as before and Elle was able to tell me a story with limited reassurance seeking and support. I closed out our time together by bringing out the scrapbook that we had been working on as a closure for the previous sessions. We reviewed all we had put in and added a few lasting memories. I promised to keep the scrapbook safe.

I decided to track my observations by taking extensive notes during and after each session with Elle. I paid attention to her body language and any changes in her voice including tone, inflection, and pitch. I was also able to do my own processing by collage, painting, and sketching (see examples below).

### **Results**

After the final session with Elle, I reflected back on our time together and what I noticed. When we first began, I noticed that Elle was extremely rigid and appeared set in her ways. She had a limited role repertoire and felt as though OCD was her primary role. During our first session, she asked many clarifying questions and negative statements like “I’m not a good storyteller” and “You should have picked someone else”. When she was finally able to begin, I noticed that her body relaxed as she became lost in her storytelling. She did, however, stop at various points and made comments like “This is crazy...I sound crazy” and “I didn’t tell the story good enough”. I began to notice that if I gave her reassurance about how she was doing, it would only reinforce her OCD. Instead, I continued with the imaginative exercise, and she would be able to relax again.

## ROLE METHOD AND OCD

At our next session during our authentic movement, Elle chose to focus on her shoulders, noting a heaviness that resembled a rock sitting on them. Her posture was hunched and she looked as though she was experiencing discomfort. I mirrored this action with her until a character emerged.

In our third session, Elle was more comfortable and relaxed. She sat across from me with her feet up and her body posture indicating an openness I had not seen before. She appeared happy and talkative. During our role play, she became attached to a stuffed dinosaur that she was hesitant in giving away. There were moments when she would tell me that she was going to steal him and she would laugh, as if joking. However, during those moments, I noticed a change in her posture, closing off and shutting me out. She was able to return the stuffed dinosaur at the end of the session, reluctantly.

Our fourth session involved the role sort. After Elle had placed all the cards into their respective columns, I made observations noting how many cards were in each column, what column had the most and least amount of cards, and making special note of the cards she found easy to place and those where she had difficulty. After making the declaration that she was a “murderer”, Elle’s body responded by putting her feet up and facing away from me. When she finally spoke again, she made self-deprecating remarks, deflecting from the feelings and emotions that were coming up for her. I tried to get her to open up and discuss those fears however she was unable to be vulnerable with me in that moment.

At our next session, I brought back the role sort and she chose “warrior”. While doing our authentic movement, focused on embodying the warrior, I noticed her body transform from having poor posture and a general sunkennes to a straight posture with her chest out and neck up, making steady eye contact with me. This was the first time I noticed a major shift in the way

## ROLE METHOD AND OCD

Elle presented herself. There have been small moments in previous sessions where she verbally expressed herself but this was the first time I have noticed a positive change in her body. I could tell that she enjoyed being the warrior and expressing her confidence and assuredness.

During our final session I implemented the TAS once again. I noticed subtle changes in the way she expressed her storytelling, including a deeper involvement in her character choices and descriptions. When I brought back our scrapbook at the end, I observed Elle become emotional, tearing up while she thought through our time together. She was finally allowing me to see a glimpse of her vulnerability, something I had not experienced before. I noticed some emotional vulnerability in myself as well, having gone on this journey together.

After our short time together I noticed a subtle shift in Elle's ability to embody other roles. While she was still unable to incorporate all of these new roles into her life, she was able to see how many roles she had and began to play with the qualities of these different roles. I also noticed a subtle change in her willingness and openness to the experience. In the beginning, she expressed a rigidity and resistance to emotional vulnerability. However, as our sessions moved deeper and we began to explore some new roles for her, I noticed a shift in her openness with me. By the end of our time together, she was her most vulnerable self, tearing up and expressing a genuine connection I had not seen prior. This intervention taught me that using role method with patients with OCD might not only teach flexibility and spontaneity, but also provide an opportunity for true connection and emotional vulnerability that OCD often stifles.

In addition to changes I noticed in Elle, I also noted my own thoughts and feelings. In the beginning, I was apprehensive and nervous. In some ways, I was also practicing a rigid role repertoire. However, after our first session, I began to relax and noticed myself taking on a "therapist" role with her. By the end of our time together, a level of trust between us had been

## ROLE METHOD AND OCD

made and we were both more comfortable and less pressured to perform perfectly. My body at the end felt relaxed and I found a confidence and ease that had previously been absent from our sessions. There was likely some dual process occurring in the work. As seen in my art work (see photos on pages 30-31), I noticed a rigidity in the beginning, harsh lines and attempting to create neatness and perfection. However, as our time together went on I began to explore more authentic art making, doing what came to me in the moment and trying not to focus on neatness or perfection.

### **Discussion**

This thesis contributes to the fields of OCD and drama therapy by implementing an intervention with a client focused on Landy's role method and reporting on the learnings from implementing this intervention with a patient. This has the potential to further the therapeutic approach to treatment for patients with OCD. I chose to explore this by meeting individually with a client twice a week for three weeks for fifty minutes each. At the beginning of our time together I noticed inflexibility and rigidity in her, a common trait for those with OCD. The goal for us was to explore the role of OCD, where it came from, and how it has impacted her life. Then, exploring other roles in her life that OCD may be trying to stifle appeared to help her expand her role repertoire and connect her to someone that is not consumed by OCD, but rather recognizes that it is simply a part of her. Landy (2009) talks at great length about the rigidity seen in the unhealthy person and how, when using role method with these clients, they are able to practice other roles that might not have been consumed because of OCD.

Throughout the following weeks, I noticed a subtle shift in the way Elle presented herself. Upon our first meeting, she was extremely rigid and lacked any flexibility. However, as our time together grew, so did her willingness to participate. She found storytelling her favorite

## ROLE METHOD AND OCD

and I noticed a shift in her exploration of her other roles. However, in order for her to experience spontaneity she needed first to re-learn how to play. Playing is an essential component of drama therapy and Elle needed to be able to let go enough to explore these other roles. Landy (1993) discussed the importance of play and of using play in role method. When a client is able to play, they are learning that being spontaneous is okay and that the rigidity they felt previously does not have to be the norm. For people with OCD, this is paramount. It would certainly take longer than three weeks to see Elle get to this point, but I believe she did make great strides during our time together and I began to notice her letting go of the structure and rigidity little by little.

Overall, the findings suggest that implementing role method into treatment for patients with OCD could provide them the opportunity to explore other roles in their life outside of OCD as well as learning to let go and practice living with spontaneity and flexibility instead of the structure and rigidity they are accustomed to.

### **Recommendations**

For me, the act of taking physical notes was very helpful as it gave me a way of remembering details that I would have otherwise missed if I was simply observing. In the future, I would recommend taking notes as well as recording sessions so that the therapist does not miss anything. I would also recommend the use of an office or private room so that the client has little distraction. I found it challenging trying to find a space that gave us privacy as well as one that provided little distraction.

In addition to those listed above, I would recommend taking it slow with this population and providing scaffolding when it comes to the directives. By keeping the directives structured, patients get enough direction so that they are able to try the directive while also being able to

## ROLE METHOD AND OCD

explore the flexibility and spontaneity safely. If patients are not given any direction, they may become flooded with anxiety and unable to continue.

I would also recommend, specifically with this population, the importance of not giving the patients verbal reassurance during the sessions and in particular during the TAS assessment. In my study, I noticed that Elle would seek out reassurance quite frequently but was unable to take in this positive feedback, reinforcing her rigidity. Instead, when I was able to redirect her and move her through to the imaginative space, her storytelling was more in depth and she calmed. For future studies with the OCD population, I would recommend being keenly aware of when patients seek reassurance and being able to redirect to allow for optimal results.

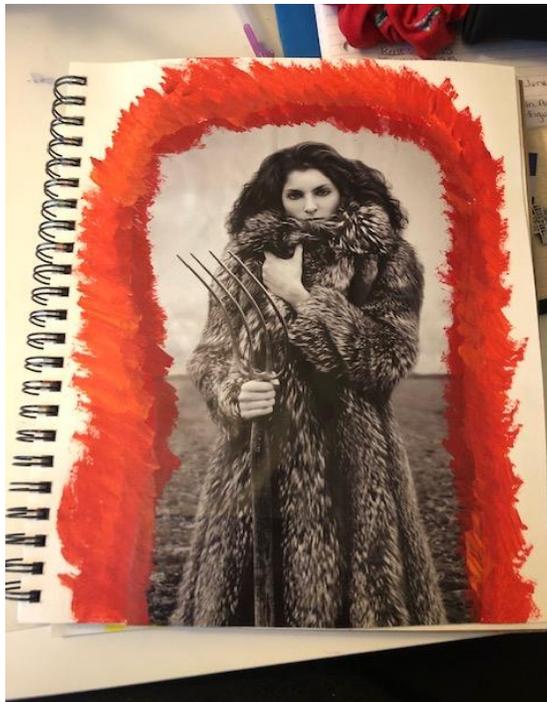
Lastly, I would recommend conducting further studies looking specifically at the role of embodiment with patients who have OCD. I found that the use of small moments of authentic movement and role play allowed Elle to be able to embody without feeling overwhelmed. I would recommend exploring this further in the future, considering the effectiveness of drama therapy to increase patients' comfort with embodiment.

### **Limitations**

There are several limitations that I would like to point out for consideration in applying this intervention in practice or for future studies. First, my results and recommendations are based on only a single participant and thus cannot be generalized. This case notably was with a cisgender white female, identities that are overrepresented in mental health research. Another limitation I noticed was the time frame. For the purposes of this thesis, as well as the general timeline of patients on unit, I was limited for time that I could work with Elle. I would have liked and would recommend in the future, the ability to work with patients for the duration of their

## ROLE METHOD AND OCD

stay (or longer) instead of a few sessions. Despite these limitations, I believe the findings are still useful in considering how role method might be applied to the treatment of patients with OCD and can be used as a jumping off point for future research.



ROLE METHOD AND OCD



## ROLE METHOD AND OCD

### References

- Abramowitz, J.S. & Arch, J.J. (2014). Strategies for improving long-term outcomes in cognitive behavioral therapy for obsessive-compulsive disorder: Insights from learning theory. *Cognitive Behavioral Practice, 21*, 20-31.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Berkhout, L. J., Dekker, M. R., Ruiter, C., Sternheim, L., & Van Der Burgh, M. (2014). Poor cognitive flexibility, and the experience thereof, in a subclinical sample of female students with obsessive-compulsive symptoms. *Scandinavian Journal of Psychology, 55*(6), 573–577.
- Cerqueira, R., Torres, A.R., Torresan, R.C., Negreiros, A.P., & Vitorino, C.N. (2008). Emotional burden in caregivers of patients with obsessive-compulsive disorder. *Depression and Anxiety, 25*(12), 1020-1027.
- Chang (2017). A case study on the application of role method in a therapeutic theatre production at National Taiwan University of Arts. *Drama Therapy Review 3*(1), 63-74.
- Cohen, D., Delaroche, P., Flament, M. F., & Mazet, P. (2014). Case report: Individual psychodrama for treatment resistant obsessive-compulsive disorder. *Neuropsychiatrie de l'Enfance et de l'Adolescence, 62*(1), 19–21.
- Conner, E., Landy, R. J., Luck, B., & McMullian, S. (2003). Role profiles: A drama therapy assessment instrument. *The Arts in Psychotherapy, 30*(3), 151–161.
- Cottraux, J., Olatunji, B.O., Powers, M.B., Rosenfield, D., Smits, J. A. J., & Tart, C. G. (2013). Behavioral versus cognitive treatment of obsessive-compulsive disorder: An examination of outcome and mediators of change. *Journal of Consulting and Clinical Psychology, 81*(3), 415-428.
- Coz, J. M., Gunter, R., Twohig, M. P. & Whittal, M.L. (2009). An initial investigation into the processes of change in ACT, CT, and ERP for OCD. *International Journal of Behavioral Consultation and Therapy, 6*(1), 67-83.

## ROLE METHOD AND OCD

- Diamond, G. M., Meiran, N., Nemets, B., & Toder, D. (2011). Cognitive rigidity in unipolar depression and obsessive compulsive disorder: Examination of task switching, Stroop, memory updating and post-conflict adaptation. *Psychiatry Research, 185*, 149-156.
- Elias, J. A., Mathes, B.M, & Van Kirk, N. (2015). Review of psychotherapeutic approaches for OCD and related disorders. *International Journal of Behavioral Consultation and Therapy, 6*(1), 70-83.
- Franklin, M. E. & Himle, M. B. (2009). The more you do it, the easier it gets: Exposure and response prevention for OCD. *Cognitive and Behavioral Practice, 16*, 29-39.
- Garcia, N., Johnson, D.R., Landy, R., & Rosenberg,L. (2006). *Three approaches to drama therapy* [Motion Picture] New York: New York University.
- Goshen, M. C., Grinberg, M. A., Kowalsky, R., & Pendzik, S. (2012). Drama therapy role theory as a context for understanding medical clowning. *The Arts in Psychotherapy, 39*, 42-51.
- Haen, C., & Lee, K. (2017). Placing Landy and Bowlby in dialogue: Role and distancing theories through the lens of attachment. *Drama Therapy Review, 3*(1), 45-62.
- Harris, R. (2009). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy*. Oakland, CA: New Harbinger Publications.
- Hollon, S. D., Magiati, I., & Ponniah, K. (2013). An update on the efficacy of psychological treatments for obsessive-compulsive disorder in adults. *Journal of Obsessive-Compulsive and Related Disorders, 2*, 207-218.
- Kessler R. C., Chiu, W.T., Demler, O., Merikangas, K. R., & Walters, E. E.(2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry, 62*(6): 617-27.
- Landy, R., (2001). *New essays in drama therapy*. Springfield, Il: Charles C. Thomas.
- Landy, R. (2008). *The couch and the stage*. Maryland: Rowman & Littlefield.
- Landy, R. (2009). Role theory and the role method of drama therapy. In R. Emunah & D.R. Johnson (Eds.), *Current approaches in drama therapy* (pp. 65-88). Springfield, Il: Charles C. Thomas.

## ROLE METHOD AND OCD

Landy, R. (1993). *Persona and performance: The meaning of role in drama, therapy and everyday life*. New York: Guilford.

Migliorati, M. (n.d.) American dance therapy association (ADTA). Retrieved from <https://adta.org/>

New York University (Producer), & Landy, R. J. (Director). (2005). *Three approaches to drama therapy*. [Video/DVD] New York: New York University Press.

Schneider, C. & Wood, L. (2015). Setting the stage for self-attunement: Drama therapy as a guide for neural integration in the treatment of eating disorders. *Drama Therapy Review*, 1(1), 55-70.

Springer, K. S. & Tolin, D. F., (2018). Obsessive-compulsive and related disorders. In *APA handbook of psychopathology: Psychopathology: Understanding, assessing, and treating adult mental disorders, Vol. 1*. (pp. 455–479). Washington, DC: American Psychological Association.

Tolin, D. F. (2008). Alphabet Soup: ERP, CT, and ACT for OCD. *Cognitive Behavioral Practice*, 9, 1-9.

Twohig, M. P. (2009). The application of acceptance and commitment therapy to obsessive-compulsive disorder. *Cognitive and Behavioral Practice*, 16, 18-28.

Twohig, M. P. (2014). Introduction: The basics of acceptance and commitment therapy. *Cognitive and Behavioral Practice*, 19(4), 499–507.

Versluys, B. (2017). Adults with an anxiety disorder or with an obsessive-compulsive disorder are less playful: A matched control comparison. *Arts in Psychotherapy*, 56, 117–128.

Zohar, J. (Ed.). (2012). *Obsessive compulsive disorder: Current science and clinical practice*. West Sussex, UK: John Wiley & Sons.

