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Unlocking Recovery: A Role-Informed Drama Therapy Method for Adults with Addictions

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Capstone Thesis

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Abstract

This Capstone Thesis Project discusses the creation and implementation of a drama therapy method with adults receiving treatment for substance use disorders at an intensive outpatient level of care. Disidentifying from the role of Addict proves a difficult task when this identity is reinforced by widespread social stigma, permanent changes to the brain's reward system, and a system of criminalization resulting in financial and political disenfranchisement. A drama therapy framework, Robert Landy's Role Theory, and a trauma treatment framework, Janina Fisher's Trauma-Informed Stabilization Treatment, were used as grounding theories from which to create a method intended to help clients with substance use disorders to disidentify from the role of Addict. The literature and the results of the implementation of the method suggest that a role-informed drama therapy approach may offer clients a way to regain access to roles and parts of self that were rendered dormant during active addiction. Unlocking these hidden roles may help clients develop the strength and self-efficacy needed to survive without the addiction. Based on the findings from the implementation of this method, a set of principles is proposed for maximizing efficacy and minimizing risk when implementing a drama therapy approach with this population.

Keywords: drama therapy, role theory, trauma-informed stabilization treatment, addictions, trauma, shame, stigma, recovery

Introduction

Substance use disorders (SUDs) are chronic illnesses characterized by continued substance use despite significant substance-related damage to physical health and/or substance-related impairments in functioning in one or multiple life domains (American Psychiatric Association, 2017). Other features of SUDs include impairments in control over substance use, cravings for substances, chemical dependency, withdrawal symptoms, and changes in the brain's reward system that persist after detoxification (2017).

SUDs have high rates of co-occurrence with a range of other mental illnesses, including post-traumatic stress disorder (PTSD), mood disorders, personality disorders, and psychotic disorders (National Institute on Drug Abuse, 2020). Comorbid mental illnesses are associated with more severe courses of illness in clients with SUDs (2020). Between increased rates of relapse, reduced treatment adherence, and increased risk of suicide, the co-occurrence of SUDs and other mental illnesses represents a deadly combination (2020).

In 2019, fatal drug overdoses surpassed car accidents as the leading cause of accidental death in the United States (National Safety Council, 2019), while alcohol misuse remains the third leading preventable cause of death (National Institute on Alcohol Abuse and Alcoholism, 2020). Across the country, people view addiction as a pressing issue. In rural areas, 90% of people say addiction is a problem in their communities, as do 87% of people in urban communities and 86% of people in suburban communities (Gramlich, 2018). These figures highlight the reality that addiction is a pervasive problem in the United States, and that efforts to address this problem have been insufficient.

The road to recovery from SUDs is often a tumultuous one, with relapse rates estimated at 40 - 60% (National Institute on Drug Abuse, 2019). One factor associated with relapse and

more severe courses of illness is shame, which is concerning in light of the social stigma associated with alcohol and drug addiction (Randles & Tracy, 2013). Social stigma towards those with addictions has been shown to cause a phenomenon known as self-stigmatization or internalized stigma, which has been linked to poorer treatment outcomes, forming what researchers call "a looping effect" (Matthews, Dwyer, & Snoek, 2017). These studies suggest that interrupting the cycle of addiction requires not only behavior modification strategies, but also interventions that address the shame underlying the compulsion to use substances.

Based on the understanding that shame is a major barrier to lasting recovery from SUDs, this writer has developed a series of drama therapy interventions aimed at challenging self-stigmatizing narratives in adults receiving addiction treatment in an intensive outpatient program (IOP). The interventions combine principles from drama therapist Robert Landy's Role Method and psychologist Janina Fisher's Trauma-Informed Stabilization Treatment (TIST). Role Method is a drama therapy approach focused on integrating and understanding different aspects of self, referred to as "roles" (Landy, 2009). TIST, a model intended for use with individuals with addictions and other self-destructive behaviors, aims to help clients identify and unify parts of self that have become split off or "fragmented", often as a result of trauma (Fisher, 2017). Both approaches seek to reduce feelings of shame by bringing acceptance and expression to all parts of self. The purpose of this writer's method and subsequent analysis is to explore the potential benefits of combining Role Method and TIST in the context of addiction treatment.

Literature Review

The following review will explore the current literature on addiction, evidence-based addiction treatment approaches, and arts-based addiction treatment approaches, including drama therapy approaches.

Response to Addiction in the United States

The treatment of choice for the disease of addiction in the United States is in fact not treatment, but criminalization. The United States has the highest rate of incarceration in the world, with nearly half of all US prisoners facing drug-related charges (Federal Bureau of Prisons, 2019). The mass incarceration of individuals for drug-related crimes disproportionately affects people of color, with black Americans almost six times more likely than whites to be arrested for drug-related offenses, despite having equal rates of substance use (NAACP, 2019). In this light, addiction in America can be seen as a medical disease, a mental illness, a public safety problem, a criminal justice issue, and a manifestation of modern racism, all at once.

While up to 65% percent of US inmates have active SUDs, and another 20% do not meet full criteria for a SUD but were actively using at the time of their crime, only 11% of inmates receive any kind of addiction treatment (National Institute on Drug Abuse, 2019). A growing body of evidence demonstrates the inefficacy of incarceration as a solution to the problem of addiction, as evidenced by a report that 95% of inmates with SUDs return to substance use after their sentences are over (Pew Charitable Trusts, 2018). By contrast, 75% of inmates serving time for drug offenses remain sober two years after completing an addiction treatment program (The Council of State Governments, 2017). Comparing these outcomes, the need for increased access to addiction treatment among incarcerated populations becomes painfully apparent.

Social Stigma

Social stigma towards individuals with mental illnesses is prevalent in the United States, and this stigma poses clinically significant challenges for clients with SUDs. A systematic literature review exploring the phenomenon of public stigma associated with mental illness in the United States revealed that individuals with SUDs were the most consistently and severely

stigmatized diagnostic group (Parcesepe & Cabassa, 2013). This widely held stigma leads to a greater desire for, and maintenance of, social distance from individuals with SUDs among the general population (2013). The chronic feelings of isolation and alienation resulting from this social distance are important dimensions of SUDs for treatment providers to understand.

Sadly, many clients with SUDs encounter stigma when interacting with healthcare professionals. Stigma among healthcare workers has been linked to lower quality of patient care, increased levels of internalized stigma, and decreased treatment seeking among clients with SUDs (Goodyear, Haass-Koffler, & Chavanne, 2018). A systematic literature review of attitudes towards clients with SUDs among healthcare workers in Western countries revealed that healthcare workers demonstrate higher levels of stigma towards clients with SUDs than those with other mental illnesses (Van Boekel et al., 2013). Healthcare workers were shown to utilize a more "avoidant" and "task-oriented" approach when working with clients with SUDs, as evidenced by shorter visits and less one-on-one time spent with these clients (2013). Negative attitudes towards clients with SUDs among healthcare workers were associated with lower levels of client empowerment, lower levels of satisfaction with treatment, and lower likelihood of completing treatment (2013). With these findings in mind, reduction of stigma among healthcare workers can be seen not merely as an aspirational ideal, but, rather, as a matter of life and death for clients with SUDs.

Trauma and Addiction

A comprehensive and growing body of research suggests that a positive correlation exists between trauma and SUDs (Thege et al. 2017). Traumatic experiences, particularly childhood traumatic experiences, have been shown to cumulatively increase one's risk of developing a SUD. This cumulative effect is observed in clients diagnosed with PTSD as well as those with

subthreshold symptoms (Khoury, Tang, Bradley, Cubells, & Ressler, 2010). From an object relations perspective, the lack of a "good enough" parent in childhood leads to profoundly disrupted attachments in adulthood. Specifically, the client with a SUD learns to use substances as a "false parent" for their wounded inner child who learned that other people are not suitable attachment figures (Carruth & Wallen, 2014). Attaching to substances rather than other people allows clients with SUDs to self-regulate without the threat of further interpersonal injury. It is essential that clinicians understand the role of trauma in the development of addictions, as the attachment wounds that created the addiction necessarily affect interpersonal functioning, and, by extension, the therapeutic relationship.

Current Approaches in Addiction Treatment

A 2011 meta-analysis of evidence-based practices in the field of addiction treatment determined that four types of interventions showed particular promise in the treatment of SUDs (Glasner-Edwards & Rawson, 2010). The four types of interventions highlighted were contingency plans, motivational interviewing, cognitive-behavioral therapy, and couples and family therapy (2010). While each of these treatment approaches are beneficial on their own, the approaches show even greater therapeutic benefit when used in conjunction with one another.

A 2019 report on evidence-based practices in addiction treatment highlighted the importance of medications that negate the effects of opioids while reducing cravings and withdrawal symptoms. These medications, including methadone, naltrexone, and buprenorphine, have been shown to improve treatment outcomes and reduce the risk of overdose, but stigma and lack of education among healthcare providers results in underutilization of these life-saving resources (Weir, 2019). Cognitive-behavioral therapy, behavioral therapy, and contingency plans, in combination with medication when necessary, are the current addiction treatment

approaches of choice in the United States (2019). While therapists cannot prescribe medication, they play a crucial role in reducing the stigma associated with medically assisted treatment and ensuring that clients and other healthcare providers receive education about this important treatment option.

Expressive Therapies and Addiction Treatment

A 2017 meta-analysis of the efficacy of Expressive Arts Therapy interventions in the treatment of substance use disorders found that Expressive Arts Therapy treatments were correlated with reduced substance misuse (Megranahan & Lynskey, 2018). The authors noted, however, that these results are inconclusive due to the paucity of studies that met the criteria for inclusion in the analysis. Many of the studies originally considered were rejected on account of having small sample sizes. For example, a qualitative study published in Hong Kong's Children and Youth Service Review found an arts-based intensive outpatient program to be effective at preventing relapse in a group of young adults with psychotropic drug dependencies (Tam, Shik, & Lam, 2016).

Art therapist Marie Wilson has written about the particular applicability of the Expressive Arts Therapies to the reduction of shame in the context of addiction treatment. While her writing focuses on her work with clients with sex addictions, she discusses the use of arts-based approaches with clients with addictions more broadly. She theorizes that shame is at the root of all self-destructive behaviors, including behavioral addictions, SUDs, and eating disorders (Wilson, 2012). In addition to the behavioral defenses that clients with addictions use to protect themselves from shame, Wilson claims that clients with addictions also rely on cognitive defenses. She writes that the arts are uniquely helpful in addressing shame because of their ability to bypass conscious defenses and facilitate access to authentic emotional experiences

(2012). Finally, Wilson stresses that the act of art creation itself, which is by nature spontaneous, imaginative, and playful, nourishes the inner child whose unhealed wounds she believes to be the underlying cause of chronic feelings of shame (2012).

Drama Therapy and Addiction Treatment

Drama therapists continue to develop new methods for working with clients recovering from SUDs. A qualitative study from 2017 demonstrated that a psychodrama-inspired method had positive effects on the treatment outcomes of individuals recovering from addictions, both when used alone and as a supplement to other therapeutic approaches (Krasanakis, 2017). The author cited four key benefits of his psychodrama-inspired intervention, including observed increases in emotion regulation skills, interpersonal effectiveness skills, development of an internal locus of control, and increased ability to cope with triggers (2017). Testoni et al. used a mixed methods case study design to investigate the role of psychodrama in the change process of clients in an addiction treatment center in northern Italy. The researchers observed that the four clients studied reported an increased sense of self-efficacy, introspective ability, and ability to form and maintain healthy relationships with others after participating in six months of psychodrama treatment (Testoni, et al., 2018). These studies point to the usefulness of drama therapy approaches in the treatment of SUDs.

Role Method

Role Method refers to the application of Role Theory, a therapeutic framework created by drama therapist Robert Landy. Landy proposes that the self is not a singular entity, but, rather, a vast repertoire of roles (Landy, 2009). Role Theory asserts that dysfunction and suffering stem from over-identification with certain roles and rejection or denial of other roles in one's "role system" (2009). In this paradigm, the goal of therapy is to help clients find health, balance, and

integration by expanding their role repertoires (2009). Role Method may be particularly relevant to the prevention and treatment of SUDs, as having a greater number of social roles has been shown to be a protective factor against problematic substance use (Kuntsche, Knibbe, and Gmel, 2009).

Role Transformation

Some drama therapists have focused on role transformation as a foundational component of addiction treatment. For instance, drama therapist Tanya Newman created a variation of Robert Landy's Role Method (Landy, 2009) that focuses on transforming what she calls the "symptom roles" that are left over once the role of Addict is eliminated (Newman, 2017). The author noted that such transformation is necessary not only for relapse prevention, but also as a way to "improve resilience and self-worth" (2017). In another variation on Role Method, a team of drama therapists created an intervention in which clients create and embody a clown character comprised of two seemingly paradoxical parts of themselves (Gordon, Shenar, & Pendzik, 2018). Among myriad benefits, clients who received the intervention reported an increased sense of accomplishment and the discovery of strengths they had not previously recognized. These findings are particularly noteworthy in light of the fact that self-efficacy has been shown to be an important predictor of outcome in the treatment of SUDs (Abdollahi et al., 2014).

Trauma-Informed Stabilization Treatment

TIST is a therapeutic approach designed to help clients interrupt cycles of self-destructive behaviors, such as eating disorders and addictions. Janina Fisher, the creator of TIST, observed that when shame is reduced, self-defeating behaviors are also reduced (Fisher, 2017). By helping clients appreciate the misguided wisdom in their maladaptive coping strategies, TIST aims to help clients understand their behavior while reconnecting with their desire for survival and

health. Fisher argues that by reframing self-defeating behaviors in this way, clients find "'resolution'—a transformation in the relationship to one's self, replacing shame, self-loathing, and assumptions of guilt with compassionate acceptance" (2017). Once clients make the shift from viewing self-destructive behaviors as a moral failing to seeing them as the best strategy they had for coping with unbearable pain, they can stop wondering what is wrong with them and start wondering about the wound that underlies their compulsion to use.

In the TIST framework, the self is made up of an amalgamation of subpersonalities or "parts". When a person is healthy, Fisher believes that these parts are conscious of each other and share equal responsibility for supporting a client's survival and emotional wellbeing. When a client has been traumatized, Fisher argues that these parts of self become "fragmented": unaware of each other and assuming disproportionate amounts of responsibility for the client's survival. In the case of addiction, the author posits that a fleeing impulse or "flight part" has "hijacked" the other parts of the self (Fisher, 2017). At some point in the client's life, likely in response to trauma, they learned that substances provided a reliable, effective flight from reality, and an escape from physical and emotional pain. This flight from reality allowed what Fisher calls "the going on with normal life self" to continue to endure the abuse, pain, or traumatic memories they learned there was no other way to escape.

Fisher stresses that "self-destructive behavior has its origins in being terrified for our survival" (Fisher, 2017). In this way, even the most self-defeating behaviors can be understood as survival strategies. The author points out that when a clinician makes the error of assuming that self-harming behavior is destruction-seeking, rather than survival seeking, they must take a "policing role", resulting in a polarized relationship between client and clinician. By choosing to

see the client as a survivor and helping them see themselves this way, the clinician can join with the client in a shared effort towards the client's survival, recovery, and wellbeing.

Methods

The array of literature reviewed above was used to inform the creation of a drama therapy method consisting of three (non-consecutive) group sessions. The interventions used in these sessions are outlined below.

Participants

The following three-session drama therapy method was implemented in an open group in an adult intensive outpatient program (IOP) for adults with SUDs. Sessions consisted of approximately 20 - 25 individuals (attendance at the IOP fluctuates daily), who were recruited by a convenience sample. All members present at the IOP were expected to participate in the sessions. Group membership consisted of more male than female participants, with approximately two thirds to three quarters of the group identifying as male. Group members ranged in age from 18 to 60, with an average age of approximately 30. Around half of participants identified as white/Caucasian, with most non-white participants identifying as Hispanic. The majority of participants reported living below the poverty line. The vast majority of participants were court stipulated to attend treatment. Some group members had previous experience with drama therapy, having participated in drama therapy groups earlier this year, while group members who were newer to the program had never experienced drama therapy prior to participating in the sessions described below.

Materials

Session One and Session Two required no materials other than chairs for sitting. Session Three required writing materials. Participants were invited to use their own journals and writing

utensils, if they had them, while blank paper, pens, and clipboards were provided for those who did not have their own supplies.

Procedure

Sessions took place in a large room used for group therapy activities. Sessions occurred during a weekly Expressive Arts Therapy group period. All sessions began with group members sitting in chairs arranged in a large circle.

Week-by-Week Session Descriptions

Session One: Drawing Out the Inner Child and Strengthening the Adult Self

Session One began with a guided visualization led by the facilitator in which participants were invited to turn their focus inward, close their eyes if they felt comfortable, and think of a person in their lives who admires them. Participants were then instructed to imagine looking at themselves through the eyes of the person they had identified. The facilitator then asked participants to imagine being this other person, and to sit in their chairs the way the person they had chosen would sit. At this point, participants were invited to open their eyes again and turn their focus back to the group.

The next phase of Session One began with a series of short interviews between the facilitator and the participants, who were still embodying the roles of people who admired them. Participants were interviewed one at a time, and other participants were instructed to actively listen and quietly witness the interviews of their fellow group members. Interviews consisted of questions about the relationships between the admirers and the participants, the admirers' favorite things about the participants, and what the admirers had learned from the participants. Questions about substance use and sobriety were asked only when participants raised these issues, themselves, during their interviews.

In response to assertions made by some participants partway through the group that they were unable to think of anyone in their lives who admired them, the option was given for participants to take on the roles of people they admired. Interviews with participants who took on roles of people they admired consisted of questions about the relationship between the admired people and the participants, as well as questions for the admired people about the qualities they saw in the participants. Again, questions about substance use and sobriety were only asked when those topics were introduced by the participants.

To conclude the session, the facilitator asked participants to reflect on their experiences participating in the activity. Participants who had been interviewed and those who had simply witnessed were all encouraged to share what they had learned from the activity. The facilitator ended the session by encouraging participants to remember what it felt like to see themselves through the eyes of another, particularly at moments when they have lost sight of the admirable, lovable qualities they all have.

Session Two: Externalizing the Addiction

Session Two began with an introduction in which the concept of separating self and addiction was discussed. The ability to differentiate one's identity from one's addiction was presented as an important milestone in recovery from SUDs. When the facilitator told the group that they were going to begin the day's activity with a visualization, the group asked what the next phase of the activity was. Per their request for a full description of what was to come, the facilitator explained that the next phase of the activity would be a "partner sculpt" in which they would position other participants in relationship to one another to create a representation of themselves in relation to their addiction. After answering some questions that emerged in the group at this point, the facilitator began the guided visualization portion of the activity.

The visualization portion of Session Two opened with an invitation to participants to turn their focus inward, close their eyes if they felt comfortable, and imagine what their addiction would be like if it were a separate person, being or creature. The facilitator asked a series of questions to help participants flesh out their images of their addictions, including questions about physical characteristics, gender, personality traits, and speech patterns. Once participants felt they had a clear image of their addiction, they were invited to open their eyes and turn their focus back to the group. Due to participant anger, confusion, and resistance, the partner sculpt portion of the activity was not carried out, and the remaining portion of Session Two consisted of a group discussion regarding the images the participants saw during the visualization. The facilitator concluded the group by highlighting that different participants were in different stages of the recovery process, and that difficulty separating self and addiction is a normal stage of this process.

Session Three: Dialogue with the Addiction

Session Three began with an open question for the group. Participants were asked what kinds of lies their addiction had told them, either in the past or in the present. After several participants shared examples, participants were asked to work individually to come up with a list of ten lies their addiction had told them, followed by a list of ten responses their "wise self" had to these lies. Paper, pens, and clipboards were distributed to the participants, and the group was given approximately twenty minutes to generate their lists.

After completing their lists, participants were invited to turn their focus back to the group and share what they had written on their lists. Participants were then asked the question: "What is the value of an activity like this?" The session ended with a brief group discussion on the applicability of the week's activity to the process of recovery.

Data Collection

Data consisted of reflections by the researcher on verbal feedback from participants and staff, process notes written by the facilitator, and poetry written by the facilitator.

Results

Results of the group sessions and subsequent data analysis are presented below. Salient points from each session will be highlighted, as well as emergent themes from each of six poems written about the facilitator's experience leading the sessions.

Salient Themes from Observations

Salient themes from Session One include parent and child roles, mentor and teacher roles, overcoming adversity, recovery, and feelings of pride. High levels of engagement with the activity were observed, and feedback centered on themes of seeing self in a new light.

Session Two revealed themes of confusion, anger, and resistance. Two distinct groups were observed to emerge: separatation from addiction and non-separation from addiction. The distinct groups mentioned were observed to fall almost exactly along gendered lines, with self as separate from addiction being associated with women and self as merged with addiction being associated with men. Within the group category of the addiction as distinct from the self, descriptions of the addiction revealed themes of beauty, power, manipulation, danger, and abuse. Within the group category of addiction as merged with self, descriptions of the addiction revealed themes of displeasing physical appearance, dangerous and abusive behavior, negative physical health consequences, and perceived low moral character. Engagement appeared to be less consistent than in Session One, with mixed negative and positive experiences. Figure 1 shows the differences and similarities between the two characterizations of addiction observed in Session Two.

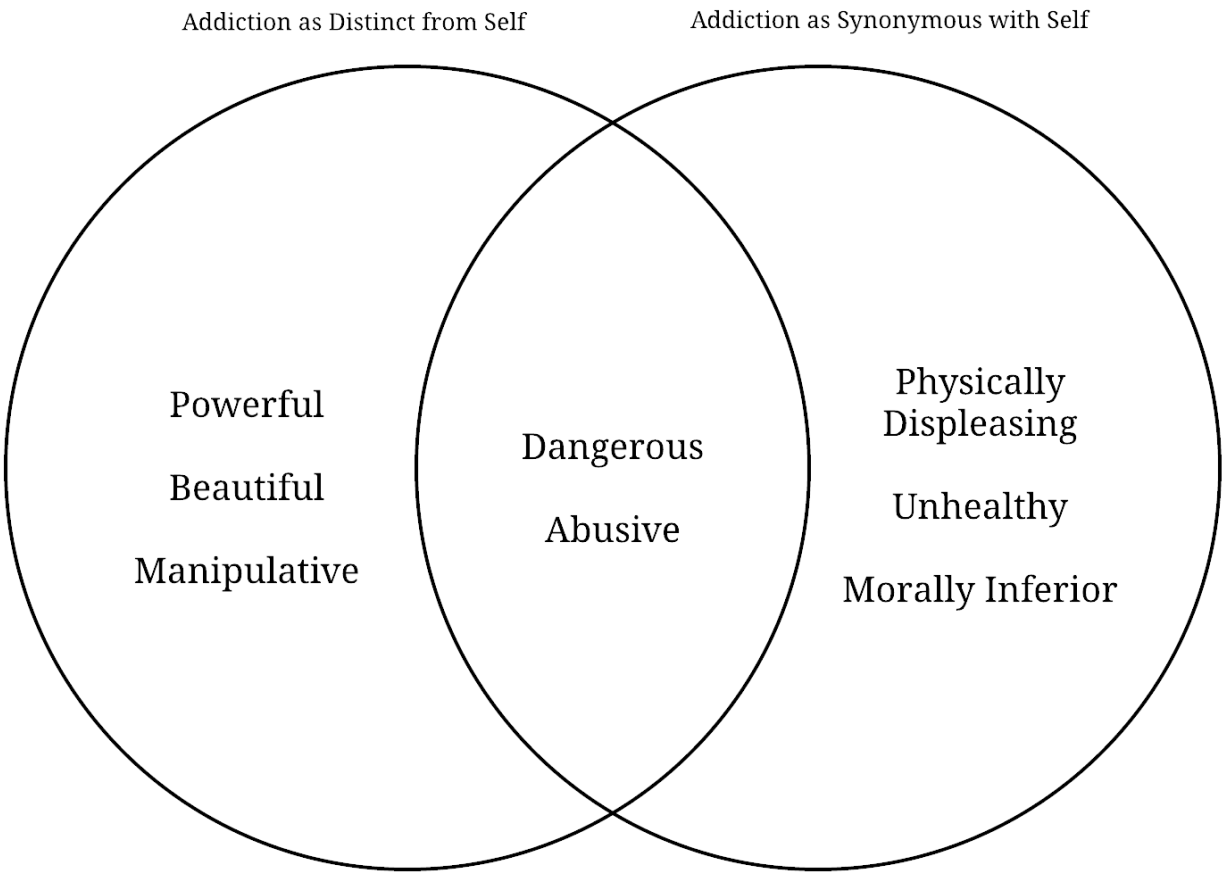

Figure 1. Showing *Differences and Similarities Between Characterizations of Addiction in Session Two.*

Session Three revealed themes of denial, reality distortion, and manipulation. Again, two distinct groups were observed to emerge among participants (see Figure 2). The first group, composed mainly of female participants, was observed to characterize the addiction as shaming and cruel, and as a driver of suicidal ideation. The other group, composed mainly of male participants, was observed to characterize the addiction as emboldening, provoking, and encouraging of delusions of grandeur and invincibility. Both groups were observed to characterize the addiction as deceitful, and both groups were observed to characterize the addiction as an enemy. High levels of engagement with the activity were observed, and

participant feedback on the activity revealed themes of relapse prevention, preparedness, and "fighting back".

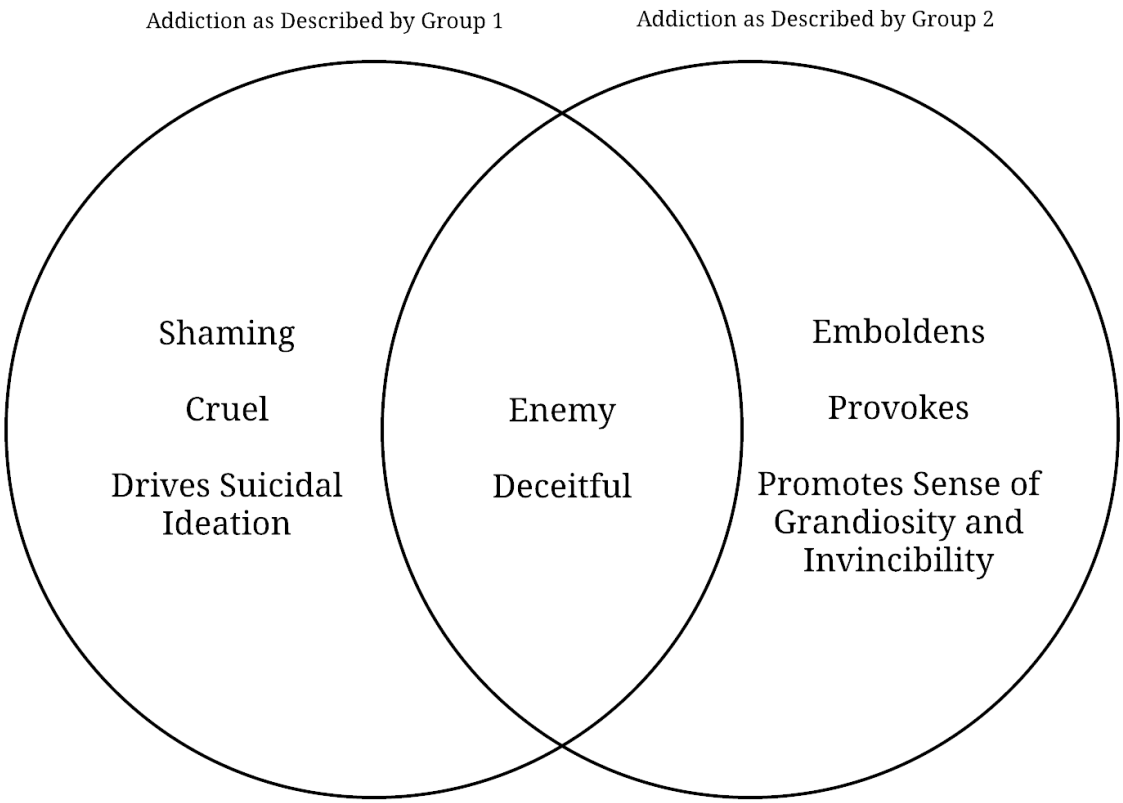

Figure 2. Showing *Differences and Similarities Between Characterizations of Addiction in Session Three*

Poems: Tracking the Writer's Change Process

Poems selected for inclusion in data analysis include four poems about the therapist's experiences written immediately after leading each session (two different poems were written in response to Session Three), and two poems written in the following months. The poems were then analyzed using an inductive analysis method outlined by research reviewer David R. Thomas. The approach begins with multiple, close readings of the data (in this case, the poems), which leads to the creation of thematic categories. The categories are then viewed as a new set of

data, which are culled and analyzed for thematic links; this process may be repeated several times. From these thematic links and relationships, a theory, model, or framework is developed (Thomas, 2003). The results of the analysis of the poems are presented in Table 1. Table 1 was then analyzed as a new set of data; the results of this subsequent analysis are presented in Figure 3. The model resulting from the multi-step analysis described above is presented in the Discussion section.

Table 1

Table Showing the Emergent Themes from Poems

Session I: "Diving Instructor" (Appendix C)	Session II: "Life Ring" (Appendix D)	Session III: "Oz" (Appendix F)	Session III: "Little Bo Peep" (Appendix E)	One Month Post-Sessions: "Anger Management" (Appendix B)	Two Months Post-Sessions: "A New Light" (Appendix A)
Another world Light and dark Pride Savior Strength Swimming/ drowning Teacher Transforma-tion	Anger Another world Burning Failure Incompe-tence Light and dark Savior Shame Swimming/ drowning Trapped	Another world Doubt False self Feeling small Incompe-tence Light and dark Mess Role-lock vs. role expansion Trapped	Control vs. surrender Courage Doubt Faith Feeling small Learner Lost Resilience Shepherd	Anger Another world Burning Equals Feeling small Mess Mirrors Player Not alone Trapped	Faith Home Learner Light and dark Mirrors Not alone Resilience Transforma-tion Trapped Witness

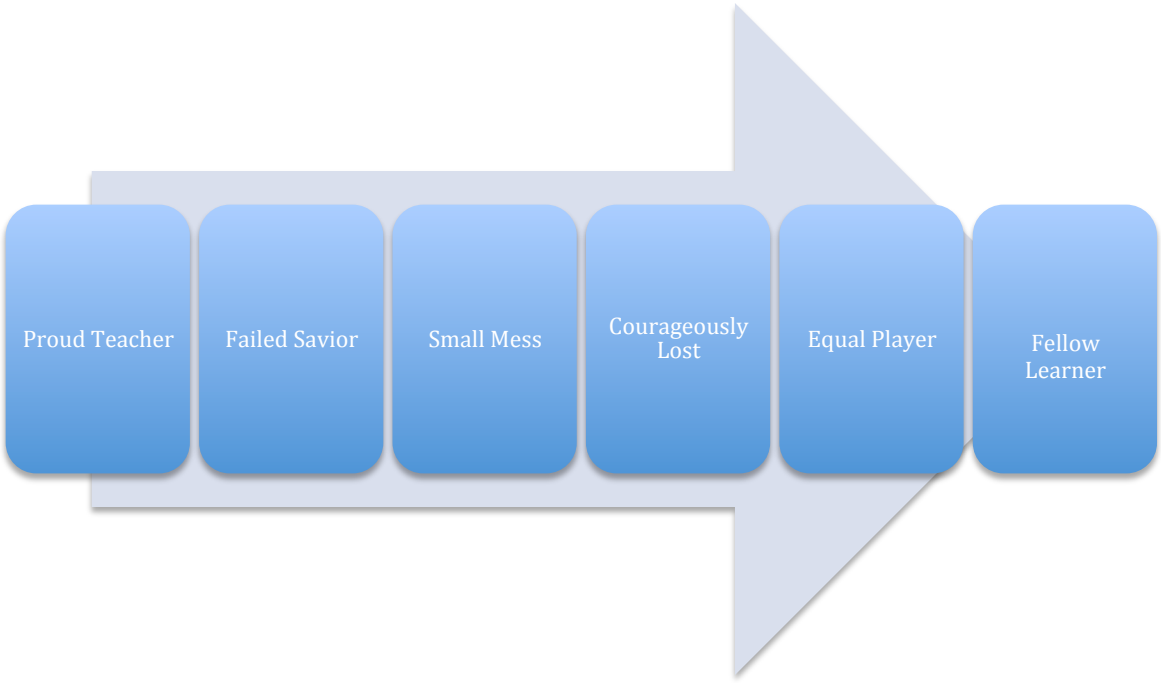

Figure 3. Showing the *Progression of Characterizations of Therapist's Role*

Discussion

The results reported above are based on the writer's observations, experiences, and countertransference reactions during the implementation of a method based on Robert Landy's Role Method and Janina Fisher's TIST with 25 - 30 adults in an intensive outpatient addiction treatment program. The literature on addictions and the treatment thereof describes shame as the catalyst for addiction (Wilson, 2012), a resulting consequence of addiction (Matthews, Dwyer, & Snoek, 2017), and a barrier that prevents clients from seeking treatment (Goodyear, Haass-Koffler, & Chavanne, 2018). Conversely, self-efficacy is associated with positive treatment outcomes for individuals with addictions (Abdollahi et al., 2014). With these understandings in mind, the method implemented in the IOP was designed to build feelings of self-efficacy by helping clients appreciate their admirable qualities. In addition, the writer theorized that helping

clients differentiate between self and addiction would facilitate the challenging of shame-based beliefs about self.

The Inner Child and the Adult Self

Responses to Session One revealed that playing the role of an admirer—and playing the role of an admired person—facilitated access to feeling states associated with pride, self-love, and self-efficacy. Another key finding was that playing admirers resulted in the emergence of playful, childlike roles. According to Marie Wilson's theory of shame as the mark of a wounded inner child, inviting childlike parts to express themselves freely is an ideal way to help clients let go of feelings of shame.

The emergence of parent and mentor roles highlights this intervention's potential to cultivate feelings of responsibility, determination, and empowerment, feelings associated with what Janina Fisher describes as the adult self (Fisher, 2017). Fisher argues that addiction is sustained by protector parts that do not realize the client has grown up into an adult with adult parts who are able to work together to take care of the inner child (2017). In this light, activities that strengthen a client's adult self can be seen as a way to show the parts sustaining the addiction that the client now has the wisdom and strength to survive without the use of substances.

Role-Lock vs. Separation from Addiction

Observations of Session Two revealed the appearance of the struggle to differentiate self and addiction. This difficulty likely stems from a combination of permanent changes to the brain's reward system, widespread social stigma, and trauma-based schemas, which all reinforce identification with the role of Addict. In addition, the criminalization of individuals with SUDs results in individuals facing charges that permanently affect their job prospects and may result in

political disenfranchisement; these consequences further cement the bond between the client and the role of Addict. This cemented bond is what Robert Landy calls “role-lock” (Landy, 2009) and what Janina Fisher calls being “merged” with a part of self (Fisher, 2017). Interestingly, one group was observed to break out of this role-lock/merged state in Session Two, while the other group was observed to remain merged with the addiction.

One explanation for the discrepancy in ability to differentiate self from addiction is that clients in IOPs for the treatment of SUDs are at different stages of change. Clients in the pre-contemplative stage of change experience their addictions as ego-syntonic and therefore would not experience a desire to dis-identify with the role of Addict, while those in the contemplative stage of change are ready to consider disidentifying from this role. Another explanation for this discrepancy is that the concept of personification may have posed a cognitive challenge for some clients, while other clients were able to easily grasp the idea. A final explanation is that the observed gender divide suggests that male clients may have greater difficulty separating themselves from the role of Addict than female clients. This last explanation is particularly compelling in light of findings that males with SUDs have been shown to face even greater degrees of social stigma than females with SUDs (Sattler, Escande, Racine, & Göritz, 2017). In this light, perhaps the disparity observed in Session Two was not indicative of a discrepancy in desire to dis-identify with the role of Addict, but a discrepancy in intensity of internalized social stigma. The frustration observed during this session may have been an expression of the frustration inherent in trying to separate from an identity into which one has been repeatedly, forcibly locked.

Importance of Clinician Flexibility

Initially, the writer's goal was to follow Session Two with a third session called "Addiction Career Change," in which the role of the addiction would be interviewed and given a new job that capitalized on its strengths, but did so in a way that did not wreak havoc on clients' lives. The intention of this hypothetical third session was to facilitate the transformation of a part of self that is continuing to try to protect the client in a way that no longer serves them. Due to the observed inability of one group to differentiate between self and addiction, it was determined that an alternate third session focused on practicing this differentiation was a more appropriate intervention. The necessity of this shift is supported by the data revealed in Session Two (see Figure 1). Identifying the "abusive", "dangerous", and "unhealthy" nature of the addiction may be countertherapeutic if a client has not yet separated self from addiction, as the client will confuse these qualities of the addiction for qualities of self. Until a client has separated self from addiction, highlighting negative qualities associated with the addiction may reinforce the shame-based "looping effect" that drives addictive behavior (Matthews, Dwyer, & Snoek, 2017).

Due to the high death rates associated with SUDs (National Safety Council, 2019) and the possibility of the wrong intervention triggering unsafe substance use behaviors, it is essential that clinicians be flexible in their session planning when working with this population. The need for clinician flexibility and commitment to titrating interventions to the needs of the group at hand is particularly important in the context of an IOP level of care. Unlike a residential program, an IOP, by definition, allows clients to return to their homes and communities each day. As such, the time clients spend in IOP should be focused on achieving the emotional stabilization needed to navigate their lives outside of the program while staying sober. In this light, separation between self and addiction must be the first goal of treatment with this

population, as any negative evaluation of the addiction prior to this separation has the potential to be interpreted as a destabilizing assault to self.

Use of Alternate Expressive Modalities

The simple writing exercise used in Session Three is based on a verbal intervention Janina Fisher uses in sessions with clients who present as merged with one of their parts. Fisher tells clients in a merged state to simply talk to their part in the second person, even if they are experiencing the part as if it is in the first person (Fisher, 2017). By creating a dialogue between addiction and self, this writer aimed to help clients practice distancing themselves from their addictions. Writing was selected as a modality because it is a more cognitively demanding task than the dramatic approach used the previous week (Erhard et al., 2014). The writer theorized that the increased activation of the prefrontal cortex required to write would aid in emotion regulation during what had the potential to be a frustrating activity for clients (Wilcox, Pommy, & Adinoff, 2016). Responses to Session Three revealed that the new format facilitated differentiation between self and addiction.

One explanation for the absence of a self as merged with addiction group during Session Three is that clients were simply more familiar with the concept of separating self from addiction after being exposed to this idea the previous week. Another explanation is that concretizing the addiction as a separate entity by identifying ten things the addiction would say felt more accessible to clients than personifying the addiction as a character. Finally, the use of writing rather than drama may have created a degree of emotional distance that supported the process of differentiation from the addiction. It is important for drama therapists to consider the applicability and timing of drama therapy interventions in the context of the needs of the group at

hand, and it is important for drama therapists to have familiarity with a range of interventions outside of the modality to use when therapeutic goals cannot be achieved using drama therapy.

Gender and the Two Faces of Shame

A key finding from Session Three was one group's use of cruel, shaming language when speaking as the addiction, while the other group used language indicative of grandiosity and invincibility when taking on this role (See Figure 2). Once again, this distinction fell almost exactly along gendered lines, with women in the explicit shaming language group. This remarkable difference in characterization of the addiction highlights a well-established gender difference in the expression of shame (Nystrom et al., 2018).

While gender differences in rates of occurrence of shame are minimal (Else-Quest et al., 2012), the expression of shame in women is marked by greater utilization of internalizing coping mechanisms, including self-harming behaviors, as well as greater frequency of explicit expressions of shame (Rosenfield & Mouzon, 2013). By contrast, the expression of shame in men is marked by greater utilization of externalizing coping mechanisms, including acts of physical aggression, narcissistic behavior, and antisocial behavior (2013). In this light, themes of grandiosity and invincibility can be seen not as expressions of shamelessness, but as expressions of shame translated through the coping mechanisms typically seen in men. The notion that narcissistic traits indicate the presence—not the absence—of shame is supported by a comparative study that found that individuals with Narcissistic Personality Disorder (NPD) scored higher on measures of implicit shame-self associations than individuals with Borderline Personality Disorder and individuals without personality disorders (Ritter et al., 2014). It is important for clinicians to understand that the voice of the addiction role will sound different depending on a client's defensive strategy, and that the differences in defensive strategies often

fall along gendered lines (see Figure 2). Clinicians must understand that both strategies, while apparent opposites, stem from a shared experience of shame.

Countertransference, Therapist Roles, and the Therapist's Change Process

A key finding from the analysis of the poetry was the shift in characterization of the therapist's role over time (See Figure 3). There are several possible factors that may have contributed to the emergence of this phenomenon. One factor to consider is that the identity of the therapist-in-training is, by definition, still emerging, and is naturally characterized by a sense of flux and transformation. This state of flux can lead to feelings of fragility and incompetence, resulting in the well-established phenomenon of imposter syndrome commonly observed in therapists-in-training (Sweeney & Creaner, 2014). Roles such as "Failed Savior" and "Small Mess" (see Figure 3) can be seen as expressions of the experience of imposter syndrome.

Another factor to consider is that the marked shifts in therapist identity, when viewed as countertransference reactions, are consistent with the reactions that can be expected when working with clients with SUDs (Reyre et. al., 2017). Countertransference reactions marked by role confusion and frequently shifting roles are particularly common when working with clients with Cluster B personality disorders, such as NPD (Colli, Tanzilli, Muzi, Ronningstam & Lingiardi, 2014). In addition to shifting roles, the appearance of powerless roles, specifically, has been noted by therapists working with clients with SUDs and personality disorders (Newman, 2017). Given the high rates of comorbid personality disorders among clients with SUDs (National Institute on Drug Abuse, 2020), it is important for clinicians to understand and prepare themselves to experience countertransference phenomena such as role confusion and feelings of powerlessness when working with this population.

Limitations of the Findings

This Capstone Thesis Project was limited by time constraints, and therefore does not represent the full potential of a drama therapy method to facilitate change in clients in an IOP for SUDs.

A Set of Principles for a Role-Informed Drama Therapy Model of Addiction Treatment

A proposed set of principles for a drama therapy model of addiction treatment is outlined below. This model is informed by Role Theory, TIST, and the key findings from the analysis of the implementation of a drama therapy method with clients receiving treatment for SUDs. The following model is intended for use with adults in a group setting in an IOP level of care. Figure 4 represents an overview of the client change process this set of principles aims to facilitate.

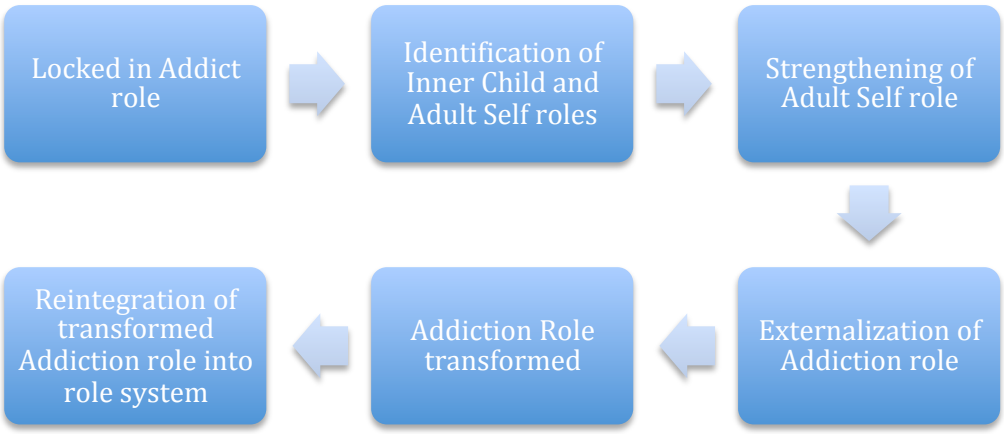

Figure 4. Figure Showing *Client Change Process Facilitated by Proposed Principles*

Principle 1. Understand that the client is role-locked in the role of Addict

Other parts of the self have been rendered temporarily inaccessible, and clients need interventions that help them regain access to blocked parts (see Figure 5).

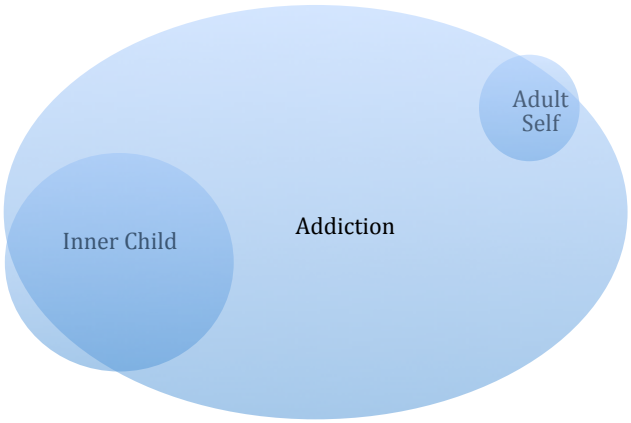

Figure 5. Figure Showing the *Addiction Obscuring the Inner Child and the Adult Self*

Principle 2. Begin with drama therapy interventions that draw out the inner child role and strengthen adult self roles

The inner child needs assurance that it will be protected by the adult self, and the adult self needs to build on its existing strengths and discover new roles so it can take care of the inner child without the help of the addiction. Challenge clients to identify a variety of adult roles; these roles will work together to take care of the inner child. Figure 6 illustrates the potential of newly discovered adult roles to facilitate separation from addiction by protecting the inner child.

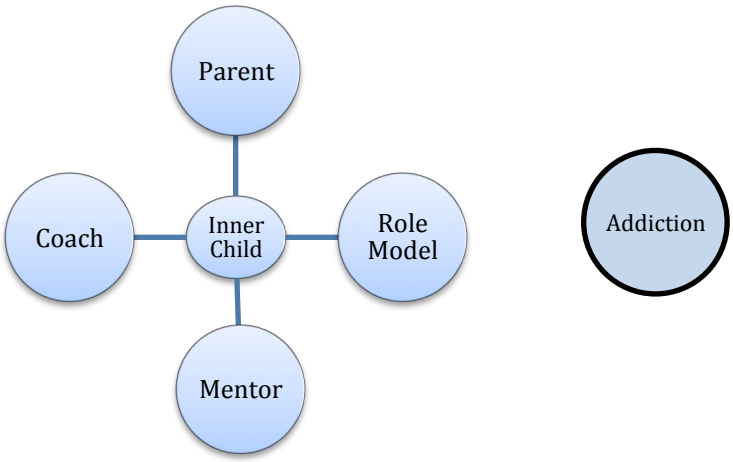

Figure 6. Figure Showing *Adult Roles Protecting Inner Child Without Addiction*

Principle 3. Utilize a variety of arts-based interventions to help clients fully separate self from addiction

Understand that the rewriting of shame-based narratives about self depends on creating a separation between self and addiction. Know that this separation is difficult for clients cognitively, emotionaly, and even physically, on account of permanent changes that have been made to the brain's reward system. Utilize multiple arts-based strategies to begin to loosen the identification with the role of Addict, beginning with more distanced, cognitively demanding interventions such as writing.

Principle 4. Use modified role interview techniques to transform the addiction role

The addiction does not need to be eliminated; it needs to be transformed. While the behavior of substance use needs to be elimnated, there is a wealth of misguided wisdom behind the behavior, but it needs to be harnessed in a healthier way. Seeking relief, pursuing freedom from shame, and protecting the vulnerable inner child are noble impulses that need new behaviors through which to express themselves. Encourage the client to inform the Addiction role that it is not the sole provider of protection to the inner child anymore, and that it no longer needs to resort to the extreme protective measures once necessary for survival. Help clients transform the Addiction role into a Protector who can be welcomed back into the role system as a valuable member of a team of adult self roles that can work collaboratively to nurture the inner child.

To facilitate this transformation, use a reversed role interview technique in which therapist takes on the role of the client's addiction and the client takes on the role of career counselor. Having clients take on the role of the addiction is not encouraged at an IOP level of care, as embodying this role in early recovery may trigger addictive behavior.

Principle 5. Utilize interventions that expand the role system

Once the inner child feels safe and nurtured by a variety of competent adult roles, it is free to express its many roles, resulting in a restoration of a full, dynamic role system in which the client has awareness of, and access to, a wide range of intra-psychic roles.

Principle 6. Utilize a variety of techniques to help clients rehearse for their new sober lives

Build feelings of self-efficacy by allowing clients to practice new behaviors with role plays of real-life scenarios. Use role interview techniques to draw wisdom and advice from future, sober self roles. Give clients the embodied experience of continuing on with life, sober. Every time clients practice embodying their new, sober selves, they are challenging stigma, correcting shame-based beliefs, and showing themselves that they have the strength to take care of themselves without the use of substances.

Principle 7. Be willing and ready to shift session plans to meet the needs of the group

Understand the ever-present risk inherent in working with clients with SUDs, and understand the need for sensitively timed implementation of therapeutic interventions. Prioritize building ego-strength over processing painful emotional content. Acknowledge that the power of drama therapy to elicit intense emotion can also be a liability.

Principle 8. Drama therapists are encouraged to view self-expression through their preferred art medium as a matter of personal and ethical responsibility

Between vicarious traumatization, watching clients relapse, and exposure to a range of personality pathology, it is an unavoidable reality that therapists who choose to work with clients with SUDs are at an increased risk of burnout (Young, 2015). As drama therapists, we already have a remarkable tool in our arsenal in the form of artistic expression. Burnout hurts clients and

therapists, alike. Drama therapists must protect themselves and their clients by using art as a strategy to cope, express, self-reflect, and heal.

During the course of creating this Capstone Thesis, the writer has written a total of eighty poems, the majority of which deal, in some way, with her work with her clients in the IOP. While it was not feasible to include the entire body of work in the data analysis, these poems were an important part of her efforts towards the creation of this set of principles, as they allowed the writer to process her countertransference reactions, track emergent themes in the therapeutic work, and document her own change process. The writer intends to continue writing and performing her poetry in hopes of helping others to heal and combatting the social stigma faced by individuals with addictions.

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Appendix A

A New Light

I've been studying that moment when the darkness starts lifting,
And you find yourself again among the living.
The imaginary glass you've been trapped behind cracks;
There's a story—and you're finally in it.

When you work in an addiction treatment center,
You see glassy eyes crack open every day.
"There are people who love me—and I can bear to be near them."
"Songs are playing through my headphones—and I can finally hear them."
I watch as faces stuck in grey-scale fill with color.

I listen as a grown man weeps about water,
The way the afternoon sun kissed golden ripples on the harbor—
It's as if he had never seen sunlight before;
The things we miss when we can't stand our own reflections.

Pupils return to their normal size,
And the sun that's been trying to rise in your eyes
Ripples gold across the room;
Foggy windowpane removed; you're shining through.
I watch you smile at your shoes, and welcome you back home to you.

Appendix B

Anger Management

Large man yells loud in small room with Small girl.
Large man tells her he feels like he's trapped in his world,
Trapped in this office, asks, "Is it hot or is it just me?"
I say, "Trust me, I get it."
I feel a story pouring out—but I don't let it.

Large man resumes his yelling, says, "I'll tell you what I mean."
He says, "It's hot in here; I mean, *in here*, inside my head.
I mean, I feel my blood heat up, and I can feel my face get red,"
Says his fingers start to itch and his whole body's braced to fight—
He turns from Jekyll into Hyde into a terror of the night.
Large man sits back as if to ask if I can stand the words he said,
And I say, "Trust me, I get it."

My tongue stops but my thoughts are still racing full throttle—
Little girl had a temper too big for her body.
Little girl, fingers curled, throwing fists—"What's all this?!"
Little girl in big trouble.
Mad dog without a muzzle,
Mad girl kicking and screaming that something's not right;
Back in the principal's office. "Really, girl, another fight?"
Tiny office, tiny girl; was it hot or was it her?
Little girl, big heat.
Echoes of hot Little girl's stomping feet
Are ringing in the ears of Small girl in her office.

Now the large man stops yelling.
Large man's large eyes start welling, but he wipes the tears away.
Large man tells me he wishes he wasn't this way;
Large man tells me he's afraid.
Tells me he's scared of the mess that he's made;
Large man tells me he's tired.
Tells me he can't take another day of this—
Large man shows me his fists; says he wishes they weren't his.
Says he wishes he could take back all the shitty things he did;
Says he's facing a sentence.
As he sits, facing me, Large man faces himself;
"I feel so trapped," he says.
"Stuck: in this room, in myself, in this body;
Fight stuck in these fists."
Small girl almost tells him she, too, has felt this.

Thing is, Small girl never did face a sentence.
At least, not the kind in the sense Large man mentioned.
Her sentence was of a different sort.

Little girls learn little tricks, of course.
Little girl learned to jail herself up so no force
Would ever be needed to keep her in line.
Large man sighs as he realizes he's out of time.
Large man thanks Small girl, and the girl thanks Large man too.
It's a funny thing we therapists do:
Sharing stories without stories, giving us without the us;
Is "I get it" enough?

In a world above this world,
Large man and Little girl
Have a boisterous boxing match.
Then they play a game of catch,
Then they part ways and go to sleep.
And in the deep of the night,
When they wake in their homes,
They both smile and know that they aren't so alone.

Appendix C

Diving Instructor

Sometimes I go swimming in a certain kind of ocean
In a realm to the right of the corpus callosum.
In this underwater world all the parts of me are swirled
Into a soup that's been stewing since before I was born.

On the sea floor, there are shipwrecks and bones,
But in the remnants of destruction, new life finds a home.
Coral reefs; schools of fish—opposites coexist; there is wisdom in this.
Treasure troves can be found here, but you will drown here
If you don't know how to access these depths safely.

We need oxygen tanks and strong left brains,
And anchors to make sure our ships stay afloat
When we go to these depths—
Call it creative connection or collective unconscious—
When we go here, we need to bring what we discovered to the surface.

From the darkness to the light; we need to translate the metaphors into real life,
Right and left brain together; healers, we are the tethers.
Healers, we are the diving instructors, helping our clients
Learn to build up the muscles they need to dive down to the wisdom inside them.

The answers are there; they just need to learn to find them
Without getting lost in the soup of the soul.
Integration: that's the goal; self-realization, expansion of role repertoire;
It's amazing how many terms there are for the act of becoming more fully conscious.

We know this process; we've lived it.
Now as healers, we give it to the people we serve.
Healing: it's a gift that takes hard work to earn,
A gift that requires its recipient relearn everything they thought they knew.
We give our clients faith that they have the strength to do this,
That they too, can learn to swim through this without drowning—
We are healers; we make these miracles happen everyday.

Appendix D

Life Ring

I hear the call, and I come running.
I waste no time wondering which things I should bring.
There's just one option; I've got it: my flotation ring—
Escape route created, it was needed, and I made it.
I was drowning; searched for

something
solid
somewhere—

and I found it.

Time went by, and those memories faded to echoes,
But today, I hear the cries, and my body remembers.
Ring in hand, my feet reach strange, uncharted land.
The sky is dark here; the brush has been burning for years;
The earth is parched here—as are all the people screaming.
My heart almost stops beating as I feel our eyes meeting.
My throat stings from the smoke; air so toxic I don't know
What keeps them from choking; there are no words to be spoken.
My error has been noted—it's out in the open—brought a life ring to the desert.

They can see by the light of the smoldering embers:
I did not come prepared for the world I just entered.
Chorus of hoarse voices roars in anger.
The fires around them rage on; they're in danger,
And I might as well have come empty handed.

I had heard of their world but I did not understand it;
Now I'm in it. And still, I know nothing; I admit it.
I've read tales of what ails them, but I've never lived it—
"Please, get up, follow me this way," I beg.
I point back behind me to the path down the ledge
That I ran down when I got here; they try to walk there,
But their blood's been exhausted of oxygen,
Horrified, I watch them as they topple to the soot.

I am pelted by a well-deserved barrage of dirty looks.
Then I see it; a sight I've only read about in books:
There—the closed, crusted eyes of the ones who stopped trying,
The ones who stopped yelling and stopped crying long ago.
At first I mistook them for the ground down below;
Then I noticed they were breathing, heaving, slowly.

“What else have I missed?” I say. “Please. Teach me. Show me.”
They don’t trust me; I don’t blame them.
Just another wide-eyed tourist who believed I could save them.
“Go back where you came from,” the chorus retorts.
“Right. Yes. Of course.” Abandon mission; abort.
Grab my life ring. They have no use for that; that’s for sure.

Appendix E

Little Bo Peep

Little Bo Peep has lost all her sheep,
The girl hasn't a clue where to find them,
It's just one time of many; she's lost track of them plenty,
Some days, people ask where her mind went.

So Little Bo Peep's grown obsessed with her sheep,
And she counts them, from one to a thousand.
Counts each single one, to make sure none have run,
But each time, some run off while she's counting!

If you count sheep this way, you'll pass out by midday,
So Bo Peep's often sleeping by noon,
By the time she wakes up, her plan's gone all amuck,
Silver tears in the light of the moon.

Neighbors hear our Bo Peep; they wake up from their sleep,
And they rush to the fields where the noise is.
"Good God, girl, you're joking!" They shout, mouths flung open,
Bo Peep can't think over their voices.

The girl's wide eyes weep as she hears of her sheep,
Who are all lost forever, they tell her.
"They'll never come back; sure they have in the past,
But not this time!" Cries one of the yellers.

Then the neighbors retire; it's midnight, they're tired;
Bo Peep stays behind in the pasture.
She looks up at the sky; she remembers; she sighs.
My sheep always come back. Tears of laughter.

These days, Miss Bo Peep has stopped counting her sheep,
And each day, she embarks on a mission
To learn what her creatures have been trying to teach her:
That the earth's full of gifts—and she is one.

It's a rare kind of person who's cut out to work in
A field where one's flock always scatters,
Her neighbors aren't shepherds; they don't get it; they don't get her,
But she has faith in her flock—and that's what matters.

Appendix F

Oz

There's been this ringing in my ears as long as I've been working here;
The cops at the door and the needles on the floor and I'm sure as hell not in Kansas anymore.
I'm supposed to lead tin men and scarecrows down a golden road;
I'm the girl for the job—or so I've been told.

As if I'm not the brainless, bursting mess falling apart;
As if I don't have trouble keeping track of my own heart.
Am I not both too cowardly and lion-like at once?
I bite so hard it scares me—so I don't let myself hunt—
But they don't see that; they don't need that; they need Dorothy's smile,
And I can keep my mouth in that position for a while;
Stuff myself into a blue dress, add a ribbon, braid my hair,
Reassure this group of lost men there is hope; I'll lead them there.

Let them believe there's a Wizard who will rid them of their sickness,
But the truth is that they have to fix themselves; He's just their witness—
The truth is, half these tin men won't survive to see next Christmas.
Don't cry, Dorothy. Don't get tearstains on the ruffles of your dress;
Don't fret, Dorothy. They don't need to see the bloated swell of stress
That wants to spill out of your corset; pull those laces.
Suck it in—squeeze that shit—force it into place and
Play that role as if your fucking life depends on it.
Til that moment, clinic closes, work week ends and it's
Just me and car keys turning; I can feel myself unlacing.
As I drive through the night, no one can hear my heart racing,
Tinted windows so no one can see me escaping.

Somewhere over the rainbow, there's an empty parking lot
Where a girl in her car sits alone with her thoughts.
Night falls, and the moon smiles wide so the girl
Can let go of the role of bringing light to the world.

She steps out into the darkness, walks a ways into the woods—
Out here, she can be heartless, brainless, cowardly, and good.
She can be wicked if she wants it—and she wants it, let's be real,
Here, at the witching hour, under starlight, she peels
Out of her costume, and lets all of herself out;
She's not just Dorothy; she is everything that story was about.
There's a time and place for braids and walking men down yellow roads,
I know they need me there, but there is no place like home.

THESIS APPROVAL FORM

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