

THERAPEUTIC ENACTMENT AND ADDICTION:
INVESTIGATING THE PROCESS OF RECOVERY

by

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Abstract

While the literature is replete with studies that investigate Psychodrama as a method for working with individuals who suffer from the very serious problem of addiction, many are descriptive and do not employ a comprehensive theory of addiction to explain how or why this intervention might be effective. There is a dearth of research that systematically investigates what exactly changes in addicted clients as a result of psychodramatic intervention. The present study links a particular formulation of Psychodrama (called Therapeutic Enactment) to the Adaptive Model of addiction (Alexander, 1990). Clients in 28-day residential treatment participated in Therapeutic Enactment as part of their program of recovery. Therapeutic Enactment sessions were videotaped and then observed by the co-investigator and participants. In-depth interviews were conducted after treatment intervention and again at three-month follow-up. Additional data sources included direct observations and documentation from client files. Qualitative data analysis revealed 16 reliable themes, the four most predominant being Self-Expression, Self-Awareness, Corrective Emotional Experience, and Change in Self-Schema. These findings lead to a better understanding of how Therapeutic Enactment facilitates the process of recovery from addiction. This study also supports previously identified therapeutic objectives and the use of Therapeutic Enactment in addiction treatment.

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CHAPTER ONE

Introduction

Statement of the Problem

The phenomenon of addiction is very prevalent in contemporary Canadian society, and for some, it leads to extremely detrimental effects. The 1993 General Social Survey, for example, revealed that nearly one tenth of those interviewed (9.2%) reported a problem with alcohol consumption (Canadian Center on Substance Abuse, 1999). The most common problems described were physical health complications (5.1%) and financial difficulties (4.7%), although many respondents pointed to problems associated with other people's drinking, such as being insulted, having arguments, and being disturbed by loud parties. Some of the more serious effects of alcoholism include cirrhosis of the liver, suicide, motor vehicle accidents, and other alcohol-related accidents (Canadian Center on Substance Abuse, 1999). Illicit drug consumption also results in severely damaging effects, as 804 deaths in Canada could be attributed to illicit substances (such as opiates) in 1995 alone (Canadian Center on Substance Abuse, 1999). According to the 1996-97 National Population Health Survey, it appears that the use of licit drugs is fairly widespread as well, as 11.6% of Canadians reported using a prescription medication in the last month (Canadian Center on Substance Abuse, 1999). Data from this survey indicate that 4.7% of Canadians aged 15 or older had used opioid analgesics, 3.6% had taken antidepressants, 3.5% had utilized sleeping pills and 2.7% had consumed tranquilizers. Owing to the broad range of denotations associated with the word addiction, the terms addiction, substance abuse, substance misuse, and alcoholism will be considered synonymous for the purpose of brevity in this discussion.

The impact of addiction on the economy is also extremely high. Some research has estimated that substance abuse cost Canadians more than \$18.4 billion in 1992, representing \$649 per capita or about 2.7% of the total Gross Domestic Product (Single, 1996). Evidence in support of the high societal cost of addiction can be found in the fact that in 1992, 48% of the drivers involved in fatal motor vehicle accidents had been consuming alcohol. Also, in British Columbia alone, a total of 8,391 patients were admitted to inpatient detoxification programs in the Provincial 1999-2000 fiscal year (Ministry for Children and Families, 2000). Taken as a whole, these statistics give rise to an increased need to both understand and treat those individuals who struggle with addiction, since there are so many negative effects that are associated with this problem.

The need to intervene in ways that effectively and efficiently help individuals who suffer from addiction has been the focus of legislators and other interest groups in Canada. For example, one government document, entitled "Best Practices: Substance Abuse Treatment and Rehabilitation" attempted to define the most useful strategies in the treatment of addiction (Minister of Public Works and Government Services Canada, 1999). In December 2000, the Deputy Premier of British Columbia appointed a task force to study and make recommendations on the future of the addiction services system in the province. The result of this effort was a document entitled "Weaving the Threads Together – A New Approach to Address Addictions in British Columbia" (Kaiser Foundation, 2001). Some of the recommendations of this document include a call for accountability and evidence based treatments, which requires that, "target groups be involved in research, program planning, development, delivery, and evaluation" (p.3). Both of these reports address the issues of

theoretical models for intervention and recommend initiatives to coordinate strategies across various levels of government, ministries, and delivering agencies.

The movement toward identifying and developing best practices in addiction treatment takes place within the larger context of a health care Zeitgeist that is recently become more popular in North America. This health care Zeitgeist is characterized by an attempt to reduce the immense cost of health care delivery through limitations that are designed to reduce consumer and services provider abuses. Such limitations in consumer health care are particularly salient in the United States, where about 80% of those under age 65 with private insurance are covered by managed care plans that economically limit the treatment of disorders such as addiction and depression (American Counseling Association Office of Public Policy and Information, 1997, 1999). This trend toward managed health care techniques is also appearing in Canada, where many citizens are now limited as to the particular brands of drugs that are subsidized by government health care plans. Largely as a result of this current health care Zeitgeist, time-limited counselling approaches have become the focus of much research and clinical practice, with the goal of continually improving the efficacy and efficiency of counselling services (Eckert, 1994; Hoyt, 1995; Johnson & Shaha, 1996).

What can helping professionals do to assist people to deal with addiction in both an effective yet efficient manner? To answer this question, it is useful to consider how some traditional theories have conceptualized addiction, given that several authors suggest that therapists choose treatment methods based on their views of the cause of this problem (Glaser, Greenberg, & Barrett, 1978; Harris, 1990; Lawson, Peterson, & Lawson, 1983). Unfortunately, the scholarly literature on addiction can appear to be chaotic and bewildering

because the proposed causes of addiction are both numerous as well as disparate. One early conception of addiction, known as Moral theory, considered the phenomenon to be a vice or sin, where individuals freely chose to become substance abusers. Proponents of this perspective often used shame and blame to treat addiction in an attempt to coerce individuals into accepting responsibility for their actions. In some extreme situations, people were even punished through religious persecution or criminal incarceration (British Columbia Ministry of Health and Ministry Responsible for Seniors 1996).

Another traditional approach to addiction is termed Spiritual theory, where addicted persons are thought to become powerless over substance use as a result of a lack of metaphysical involvement (British Columbia Ministry of Health and Ministry Responsible for Seniors 1996). Thus, recovery is thought to be possible only if the affected person acknowledges his or her powerlessness over their behaviour and seeks guidance from a spiritual force.

Some major paradigms within psychology have also addressed addiction, offering separate etiological theories and interventions for treating this problem. Psychoanalytic theory, for instance, views alcoholism as the result of a person's pursuit of sensuous satisfaction, fixation at an early stage of development (e.g., oral fixation), and conflict among components of the self (ego, id, superego) (Barry, 1988). Behaviourists, on the other hand, were unsatisfied with the postulation of inferred or unobservable variables and instead postulated that alcohol abuse and its related behaviors can be understood as being the products of reinforcement (Lipps, 1999). In other words, it is assumed that abnormal behaviour (such as addiction) is learned in the same way as so-called normal behaviours and that this learning occurs as a function of environmental influences (Craighead, Craighead,

Kazdin, & Mahoney, 1994). It is assumed that addiction generally develops as a result of the euphoric effects of drugs, which act as positive reinforcers (Tarter & Sugerman, 1976).

Conversely, negative reinforcement of addictive behaviours is assumed to occur when environmental stressors stimulate the response of substance use, which in turn, reduces the aversive stimulus of tension and discomfort (Tarter & Sugerman, 1976).

The field of biological psychology views addiction as behavioural deficits that can be interpreted in terms of the dysfunction of neural systems in the brain (Tarter, Alterman, & Edwards, 1988). More specifically, addictive behaviour is thought to result from a disturbance at one or more levels of biological organization (i.e., neurochemistry, neurophysiology, and neural anatomy). At the neurochemical level, genetic predisposition to disequilibrium of neurotransmitter mechanisms might be considered, while at the physiological level, disruption of homeostatic mechanisms may be the focus of attention. These and other biological areas are employed to account for a variety of psychological capacities related to addiction, such as cognitive functions, motivation, emotion, and arousal processes (Tarter et al., 1988). Biological explanations are the foundation of the medical model of addiction, which is closely linked to the disease model to be discussed in detail below.

A fundamental transformation took place in the development of addictions theory when the field of systems theory approached the issue of substance misuse. From this perspective, the focus on the individual (referred to as the “identified patient”) continued, but the family began to be seen as either being the cause of an individual family member’s addiction or being involved in the maintenance of this behaviour (Thomas, 1989). This view of the individual as influenced by his or her family and larger context is implicit in

sociological theory, which stresses the importance of cultural attitudes, suggesting that alcohol is sometimes used in families as a rite of passage (Lawson, Peterson, & Lawson, 1983). The proponents of adaptive theory (also to be discussed in detail below) view family dysfunction as a contributor to alcoholism as well, although other devastating forces such as unemployment, poverty, violence, and power inequalities in society are implicated (Alexander, 1990).

One of the most popular theories of addiction has been termed the disease model (Alexander & Schweighofer, 1988; Glaser, Greenberg, & Barrett, 1978). From this perspective, addiction is conceived of as a progressive and predictable disease that is characterized by features such as a genetic predisposition and the loss of control over the consumption of alcohol. The description of this predominant theory is intentionally brief, since it will be presented in greater detail later in this introduction.

There are a variety of treatment methods that have been spawned from these theories. For example, where psychoanalytic therapists might attempt to help alcoholic clients resolve internal conflict (e.g., oral fixation) through insights achieved during extensive psychotherapy (Barry, 1988), learning theorists attempt to intervene using a structured system of behavior modification (Lawson, Peterson, & Lawson, 1983).

An exhaustive review of the causes and treatments of addiction from all of these perspectives, however, is beyond the scope of this discussion. Still, the practical question that remains for the therapist working with the addicted client is: "How can I make sense of all of these competing theories in order to successfully help my client to recover from addiction?"

A very popular framework in the field of addictions that furnishes counsellors with a method for concentrating on changing the addictive behaviour of clients is known as the

Transtheoretical Model of Change (Prochaska, DiClemente, & Norcross, 1992). Using this model, the modification of addictive behaviours is viewed as a developmental process that occurs in five distinct stages (Precontemplative, Contemplative, Preparation, Action, and Maintenance). While individuals do not necessarily progress through these stages in a linear fashion, Prochaska, et al. (1992) argue that there are separate goals and interventions appropriate for each individual stage. The major contribution of this model is that it allows several psychotherapeutic orientations to be incorporated into a treatment plan, such as experiential therapy, psychodynamic intervention, existential approaches, as well as behavioural techniques.

In spite of the fact that Prochaska, et al. (1992) do not supply a comprehensive theory to describe, explain, and predict the phenomenon of addiction, they do seem to be concerned with the causes of this problem when they contemplate the issues that are involved in changing addictive behaviour (e.g., maladaptive cognitions, interpersonal conflicts, family and system conflicts, and/or intrapersonal conflicts). Thus, it appears that the Transtheoretical Model of Change attempts to address as many factors that contribute to addiction as possible and provide a method for intervention that utilizes a wide array of approaches. It may be argued, then, that the Transtheoretical Model of Change is more of a multi-factoral model of addiction (or recipe book for intervention) than it is a universal theory of addiction. Multi-factoral models, nevertheless, have been criticized for being so complicated and amorphous that they serve to confuse rather than increase our understanding of addiction (Tesh, 1988). Alexander (1990) concurs, arguing that the multi-factoral approach does not provide the theoretical structures necessary for fully understanding addiction or for evaluating the interactions among supposed causal factors. Owing to these

criticisms, the Transtheoretical Model of Change (if viewed as a multi-factoral model) cannot be considered to be a sufficient approach to understanding and explaining the puzzle of addiction. Notwithstanding, this paper argues that there are two fundamentally different approaches to conceptualizing addiction that provide counsellors with the theoretical means for evaluating and integrating the multitude of proposed etiologies and interventions that arise.

Background of the Study

Defining addiction.

Before we can consider the prospect of counselling individuals who present with the problem of addiction, we must first briefly attempt to define the phenomenon and examine some of the various etiological theories. By briefly considering the word *addiction* itself, it becomes apparent that the term has had different meanings throughout history. An etymological investigation of the word indicates that some traditional meanings have portrayed the term in a positive light. In earlier epochs, the word addiction was not associated with drugs or alcohol, but rather, used to refer to "...devotion, giving over, [or]...a dedication of any one to a master" (Alexander & Schweighofer, 1988).

As a result of the influence of the temperance movement and anti-opium movements of the nineteenth century, however, the word addiction largely became linked with the harmful effects of drug use and the presence of withdrawal symptoms and tolerance (Alexander & Schweighofer, 1988). The temperance and anti-opium movements have worked in concert with scientific, medical, political and legal forces to influence the dominant modern ideology, known as the disease model of addiction (Alexander &

Schweighofer, 1988). While this disease concept has very ancient roots, much support for this perspective comes from contemporary sources. The work of Jellinek, for example, was an early influence on the disease model, when, during the 1950's, he adopted a scientific and medical approach in his studies of alcoholism (Jellinek, 1960). From his famous research conducted at Yale University, Jellinek concluded that alcoholism was a disease that could be traced to a physiological deficit within an individual (Stevens-Smith & Smith, 1998). While the disease concept would develop into the most common way of conceptualizing addiction, we will see that it also forms the backdrop against which an alternative perspective can be compared.

The disease model of addiction.

In one formulation of the disease approach to addiction, Alexander (1990) argues that this perspective predominantly focuses on two factors that are proposed to be the cause of addiction, that is, individual susceptibility and exposure to drugs. These factors can operate separately or through interaction to result in addiction. The disease model submits these factors as pre-conditions that lead to addiction, which ultimately results in other harmful consequences.

The disease approach can serve as a super-ordinate classification under which several theories of addiction can be subsumed (Alexander & Hadaway, 1982). The popular notion that addiction can be inherited, for example, assumes the possibility of a genetic predisposition to addiction, which can be classified under the susceptibility factor of the disease model. Biological theories as well as conditioning theories (which rely on the

behavioural principles of positive and negative reinforcement) stress the importance of exposure to drugs.

While these theories may appear to be quite unrelated, the disease approach provides underlying assumptions that connect them. First, these theoretical perspectives inherently assume that addiction is a disease process, an illness that has both identifiable symptoms and implications for treatment. Secondly, the disease model and the particular theories mentioned above subscribe to a passive conception of human nature and are therefore are predicated on the philosophical tradition of determinism (Alexander & Hadaway, 1982). Third, these explanations of addiction promote the direction of causality outlined by the disease model. The disease model stipulates that susceptibility or exposure to drugs precede addiction, which in turn, leads to negative consequences such as family breakdown, economic disaster, self-hate, criminality, and other catastrophes (Alexander, 1990).

The disease approach to addiction also yields several corollaries. For example, a person's drinking or substance use is evaluated using a dichotomous method of assessment. Individuals are *diagnosed* as either having the disease of addiction or not according to some absolute criteria such as those published in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994). In addition, the deterministic framework of the disease approach suggests interventions based on similar philosophical principles. Behavioural interventions, such as aversion therapy, contingency management, and skills training are born out of this paradigm. Twelve-step programs of treatment also appear to be based on determinism, since they require that a person admit powerlessness over their addiction and must relinquish their personal agency to a higher authority (Alcoholics Anonymous, 1988). Lastly, the cause-effect relationship presented by the disease model

(which posits addiction as being the source of serious life problems) indicates complete abstinence from drug or alcohol consumption as the only plausible goal of treatment.

The adaptive model of addiction.

An alternative paradigm views addiction as a means of coping with severe distress or discomfort in life (Alexander & Hadaway, 1982; Khantzian, Mack, & Schatzberg, 1974; Stephens & Levine, 1971). Figure 1 below depicts the components of the adaptive model in schematic form.

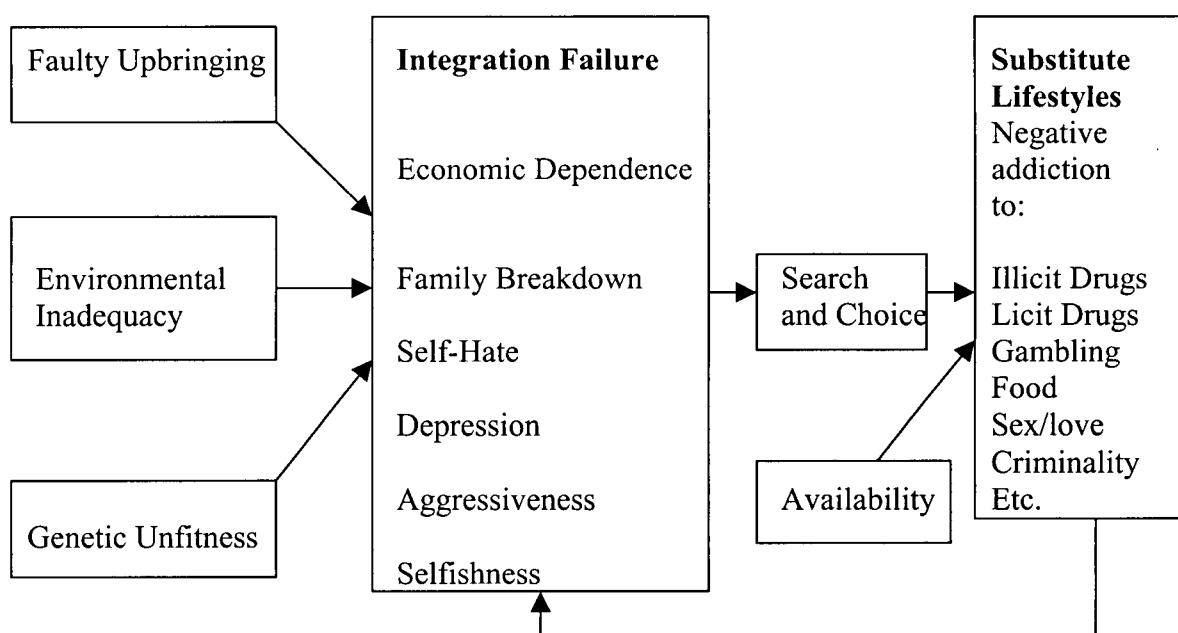


Figure 1: The Adaptive Model of Addiction (reprinted by permission)

The assumptions of this paradigm contradict those of the disease approach outlined above. Where the disease perspective attributes addiction to a disease process, for example, this approach considers addiction to be an adaptive response to the concept of psychosocial integration failure (or simply integration failure). Integration failure refers to a person's

failure to achieve such things as social acceptance, self-worth, and a sense of self-efficacy or autonomy (Alexander, 1990). Without hope of achieving an entirety, an individual is encumbered with a painful sense of incompleteness. Addiction is considered adaptive from this perspective because it provides a remedy for integration failure that numbs, distracts and alleviates the pain of being hopelessly disconnected from the means of satisfying material, social, and spiritual needs necessary for psychological well being. Thus, individuals who struggle with addiction are not portrayed as having a disease, but instead, are depicted as people who have been forced to adapt to their life circumstances because their attempts to attain psychosocial integration have been thwarted (Alexander, 1990).

The adaptive perspective assumes that individuals, while not always conscious of their purpose, actively construct their response to integration failure (Alexander, 1990). In fact, people are thought to freely choose amongst substitute lifestyles (such as addiction) in an attempt to counter the effects of integration failure. This assumption rejects the deterministic notion that a person can become addicted by virtue of mere exposure to a substance or that individuals can become the powerless victims under the control of a disease called addiction. On the contrary, the adaptive orientation emphasizes the attributes of human agency such as hope, will, purpose, integrity and choice. It is also implicit in this assumption that a person is free to attempt to remedy the causes and effects of psychosocial integration failure and gain relief from an addictive lifestyle.

Moreover, the adaptive approach reverses the cause-effect relationship supplied by the disease model, which assumes that addiction is a cause of various life problems. According to the adaptive model, it is severe life problems that can cause integration failure, which then may result in addiction and lead to further life problems. Three general factors—

faulty upbringing, environmental inadequacy and genetic unfitness—are hypothesized to contribute to integration failure (Alexander, 1990). Some specific events that represent examples of these factors include a maladaptive family history (e.g., physical/emotional/sexual abuse), lack of identity formation, social alienation, unemployment, poverty, and learning disabilities. If these problems produce integration failure, an individual may experience isolation, depression or even suicidal ideation if they do not employ some means of coping, such as engaging in addictive behaviours.

The assumptions of the adaptive approach give rise to corollaries that are quite different than those of the disease model. For instance, where the disease approach leads to a dichotomous method of assessing drinking or substance use, the adaptive model is more relativistic. This approach states that people purposefully seek out and choose methods of coping with integration failure. Instead of implying the existence of absolute criteria for labeling addiction, then, the adaptive approach allows for the possibility of addiction to various substitute lifestyles (i.e., not simply drugs or alcohol but addiction to things like gambling, food, sex, or love) as well as varying degrees of these coping responses. It appears that addictive behaviours can be perceived along a continuum from non-problematic to highly problematic using this paradigm (Lewis, Dana, & Blevins, 1994). Furthermore, the relativistic position of the adaptive model evidently suggests that the goal of addiction treatment does not necessarily have to be complete abstinence from drug or alcohol consumption, as is implied by the disease model.

The implications for intervention also seem to be broader when considered from the adaptive perspective. Where the disease model often focuses on the issue of exposure to drugs and attempts to cure some drug-created need within the individual (e.g., tolerance and

withdrawal), an adaptive approach would attempt to identify problems that existed prior to the addiction and strive to ameliorate them (Alexander & Hadaway, 1982). The problems that are believed to precede integration failure and potentially result in addiction can be divided into two categories, factors within and factors that are external to the individual. External factors point to the ways in which the environment has failed to meet the needs of the individual. Ameliorating the external influences of integration failure would involve social improvement measures such as providing meaningful employment to counteract the effects of poverty, and strengthening communities by establishing or widening social support networks. To address the causes of integration failure within the individual, issues such as will, courage, self-esteem, self-efficacy, and identity must be addressed, perhaps through professional therapy. Because many of these intra-personal issues may have been damaged early in a client's life due to a faulty upbringing (through child abuse, neglect, or shaming), successful intervention might involve reversing the effects of trauma through reparative and restorative therapeutic work.

Therapeutic enactment: The bridge between theory and practical intervention.

From a review of research in the area of addiction treatment, it is evident that constructs such as shame, guilt, depression and isolation are important issues that need to be dealt with in order for treatment to be successful (Brown, 1991; Cook, 1988; Fischer, 1988; Houts, 1995; Meehan, O'Conner, Berry, Weiss, Morrison, & Acampora, 1996; O'Conner, Berry, Inaba, Weiss, & Morrison, 1994; Viney, Westbrook, & Preston, 1985). These issues are implicated as possible causes and effects of integration failure from the adaptive perspective. Some authors claim that the disease approach and the twelve steps of Alcoholics

Anonymous can help addicts reduce their shame and guilt by encouraging people to accept their dependency and powerlessness over the disease (Cherian, 1989). Others argue that shame based conflicts from a client's past cannot be sufficiently processed in twelve-step groups, but instead must be thoroughly worked-through in individual, group or family therapy (Brown, 1991). One form of psychotherapy that purports to be advantageous in the treatment of addiction is psychodrama (Blume, Robins, & Branston, 1968; Crawford, 1989; Duffy, 1990; Dushman & Bressler, 1991; Gregory, 1995).

Psychodrama is an approach to group therapy pioneered by J. L. Moreno in Vienna around 1921 (Corey, 2000). The method is designed to help individuals deal with personal problems by dramatically role playing emotionally significant scenes from the past, present or anticipated future (Shaffer & Galinsky, 1989). The approach effects change at several levels—affective, cognitive, behavioural, and spiritual. Psychodrama promotes contact with unrecognized or unexpressed feelings (possibly through a cathartic experience), which often leads to cognitive insight and subsequent positive behavioural and emotional change.

Therapeutic Enactment is an intervention that has evolved out of the foundation of psychodrama but remains firmly grounded in its principles and techniques. This method is slightly different from classical psychodrama in terms of the attention paid to group safety and control, the role of spontaneity, the role of catharsis, and the importance of group process (Westwood, Keats, & Wilensky, 2002). Although it is important to be aware of the differences in the application of these two methods, this discussion will use the terms psychodrama and Therapeutic Enactment interchangeably. A detailed description of the intervention appears later in this paper.

Rationale

Therapeutic Enactment is an appropriate approach to addiction treatment because it employs action to elicit immediate emotional involvement in clients. Oftentimes, it is difficult to obtain emotional involvement in addicts, who can be withdrawn, isolated, lonely, angry or suffering from a host of other symptoms of integration failure. Research has suggested that psychodrama is helpful in treating addiction because it engenders a sense of inclusion, explores and develops self concept, generates insight, repairs trauma and loss, as well as activates a client's unconscious to evoke conflicts, memories and fantasies (Weiner, 1965). The Transtheoretical Model of Change also suggests that psychodramatic methods be used at the Preparation and Action stages of change, where it is assumed that individuals will be helped by interventions that promote self-evaluation at a time when a person is making attempts to change addictive behaviour (Prochaska, DiClemente, & Norcross, 1992). Thus, it appears as if Therapeutic Enactment is a method that is perfectly suited to tackle several causes and effects of integration failure, like early childhood trauma, lack of identity, social alienation, and depression.

Research Question and Purpose of this Study

Based on the assumption that Therapeutic Enactment is a useful method for treating clients who suffer from addiction, the primary research question of this study is: "How is the intervention of Therapeutic Enactment helpful to clients in treatment for addiction?"

In the review of literature on addiction that follows, it becomes apparent that researchers have not attempted to systematically identify the therapeutic factors of psychodrama when it is used with addicted populations. Many authors provide clinical

anecdotes or offer personal contentions as to what factors are believed to be important to therapeutic progress. Still, it seems that there is a dearth of research that systematically investigates how psychodramatic intervention is helpful. The present study, then, is intended to rigorously examine the experiences of addicted clients who undergo Therapeutic Enactment as part of a treatment program, with a focus on uncovering the processes that are most critical to recovery.

CHAPTER TWO

Literature Review

Research Involving Factors in the Adaptive Model

To substantiate the face validity of the theory of addiction favored by this research, it is useful to examine studies that have investigated some of the causes and effects of integration failure postulated by the adaptive model. For example, in their study of opiate addiction, Blatt, Rounsaville, Eyre, and Wilber (1984) investigated the phenomenon of depression among clients in outpatient treatment. These researchers attempted to examine the influences of two sources of depression on addiction: anaclitic depression (concerned with issues of dependency, abandonment, rejection and neglect) and introjective depression (concerned with issues of self-criticism, guilt, and shame). Opiate addicts (36 males and 11 females) and polydrug substance abusers that were not addicted to opiates (31 males and 8 females) were compared with psychiatric patients (43 males and 58 males) and so-called normals (110 males and 152 females) on several measures of depression.

The Depressive Experiences Questionnaire (DEQ) was the central instrument used in the study. The authors report that the DEQ demonstrated good reliability as well as high correlations with other established measures of depression (Blatt, Rounsaville, Eyre, & Wilber, 1984). While the DEQ consists of three subscales, only one (the Self-Criticism subscale that is concerned with feelings of failure, guilt and shame) differentiated the more severely addicted opiate group from the group of polydrug users.

Many comparisons were made across the opiate, polydrug, psychiatric and normal groups, with the overall finding that opiate and polydrug users scored lower on the Dependency subscale (which reflects abandonment, rejection, neglect) than the other two

groups. The findings derived from comparisons between opiate, polydrug, psychiatric, and normal groups should be interpreted with caution, however, since the authors did not provide adequate demographic and sampling information on the psychiatric and normal groups. This represents a potential confound in the study, as some factor other than drug abuse could be operating to produce the difference in depression scores between the addicts and the two comparison groups. Notwithstanding, because no differences were found between the opiate and polydrug user groups when compared on several demographic characteristics, the authors' suggestion that self-criticism, guilt and shame are important factors in serious chronic addiction appears to be supported.

In another study, Meehan, O'Conner, Berry, Weiss, Morrison and Acampora (1996) investigated levels of depression, guilt, and shame among clients in residential addiction treatment. Seventy-five males and thirty-three females participated in the research, although the authors do not report the sampling procedures used. The measures used in the study included the Beck Depression Inventory, the Test of Self-Conscious Affect (a measure of shame and guilt), the Guilt Inventory, and the Interpersonal Guilt Questionnaire (Meehan et al., 1996). Each instrument is described in detail and various reliability coefficients are presented. The validity of each measure was supposedly established through correlations with other measures of guilt and related constructs, but the authors do not report any particulars to support this claim.

Each subject was asked to complete the measures on their own, yet not all of the questionnaires were fully completed. Unfortunately, the authors do not reveal how they overcame this problem, or how many questionnaires could be included in the analysis. At any rate, the participants' scores on these measures were compared by gender to scores generated

by a non-addicted sample. The problem with this comparison is that the non-addicted sample data was already collected in previous research, and like the study conducted by Blatt, Rounsaville, Eyre, and Wilber (1984), these researchers do not supply sufficient information about the comparison group.

In spite of this oversight, the authors found that both men and women clients at the treatment facility scored significantly higher than the normative comparison group on most subscales of each measure. These researchers also used an independent samples t-test to find that women in treatment had significantly higher scores on the Beck Depression Inventory than the group of addicted males. From the data, the authors conclude that drug-addicted clients are especially prone to guilt and shame and are therefore a very fragile population. They suggest that drug addicted clients require treatment that is specifically designed to alleviate the effects of guilt and shame, as opposed to the confrontational strategies that are currently popular in the field (Meehan et al., 1996).

Researchers have also explored the impact of guilt and shame on addiction by utilizing a mixed methodological approach. In an attempt to identify the sources of anxiety among drug addicts, Viney, Westbrook, and Preston (1985) conducted a study using 60 clients (43 men and 17 women aged 17 to 41) who were attending an outpatient treatment center in Australia. The sample was generally low in educational attainment (most subjects had not completed high school) and most were recent polydrug abusers (heroin, barbiturates, LSD, Amphetamines, etc.). Similar to the authors of the other two studies reviewed above, these researchers fail to provide the sampling procedure used to recruit participants.

Following tape-recorded interviews, client descriptions of their lives were transcribed and content analyzed. Although it is unclear, it seems as if the authors completed the Total

Anxiety Scale (TAS) using the information provided by each client during these tape-recorded interviews. The Total Anxiety Scale consists of six sub-scales that categorize client comments in terms of different sources of anxiety, which include death anxiety, mutilation anxiety, separation anxiety, guilt, shame and diffuse anxiety. The instrument has been shown to demonstrate high correlations with self-ratings, psychiatric ratings, as well as physiological measures of anxiety. An apparent shortcoming of this methodology, however, is the possibility that participants did not complete the measure directly. In addition, there is also a lack of inter-rater reliability analysis of the categorization of client comments using the TAS.

Nevertheless, the authors compared the addicts' content analysis scale scores on the TAS to the scores obtained by a sample of unemployed persons and another sample of university students. Another flaw in this research is the lack of demographic and sampling information of these comparison groups. Moreover, the authors assume that the activities of the university students (academic studies and/or full time work) precluded their involvement in drug addiction. This questionable assumption limits the soundness of the findings. If the students were involved with drug abuse, any differences between them and the group of addicts on the TAS might be attributable to a factor other than addiction.

The major finding of this study was that shame (defined as inferiority, inadequacy and concern about the exposure of deficiencies) was the main source of anxiety that differentiated addicts from the other two groups (Viney, et al. 1985). And although the tables were difficult to interpret, the study also found that the addicts generally expressed more guilt, loneliness and death anxiety. The researchers conclude that several sources of anxiety

such as shame, guilt, loneliness and fear must be addressed if counselling for addiction is to be successful.

From the review of the aforementioned studies, it is evident that some of the effects of integration failure (the precursor to addiction in the adaptive model) such as shame, guilt and depression are considered important aspects of addiction treatment by several investigators in this area. In turning to the current research, it is also necessary to examine studies that have employed psychodrama as an intervention for drug and/or alcohol addiction.

Psychodrama in the Treatment of Addiction

It has been suggested that the use of psychodrama in the treatment of alcoholism was most prolific during the 1940's (Weiner, 1965). A recent search of the literature revealed that this method has been used in the field of addiction treatment in the decades following the 1940's and continues to be utilized today (Blume, 1989; Cabrera, 1961; Crawford, 1989; Dobkin-Dushman & Bressler, 1991; Eliasoph, 1955; Gregory, 1995; Manzella & Yablonsky, 1991; Olsson, 1972; Van Meulenbrouck, 1972; Weiner, 1965). Many of these studies describe the use of psychodrama in various drug and alcohol treatment settings as well as with a variety of populations. The article entitled "Psychodrama in Beginning Recovery: An Illustration of Goals and Methods" is a good example of research in this area (Duffy, 1990). Although it is not explicitly stated, it appears that the purpose of this paper is to present psychodrama as an effective method for helping clients work on the tasks that are assumed to be important in the early stages of the recovery process. The article begins with a short

literature review of studies that support the use of psychodrama with alcoholic clients. It continues by providing an exceptional yet concise summary of the psychodramatic method.

The participants of the study were in-patients undergoing drug and alcohol treatment at a large psychiatric hospital. Participation in the psychodrama group is a mandatory component of the hospital's comprehensive treatment program, which lasts three to five weeks. The participants studied in this research were not randomly selected, although this is not a relevant issue since a true experimental design was not utilized. However, the author fails to disclose whether or not individuals were voluntarily participating in the hospital's treatment program. This is an important consideration as the recovery process and the method of psychodrama is probably quite different for voluntary compared to involuntary clients. The members of the psychodrama group are described as having mixed diagnoses, differing skill levels and being at different levels of recovery (i.e., some are detoxing, some preparing to leave recovery, some motivated while others are not, etc.). The heterogeneity of the sample in terms of individuals' progress in recovery represents another potential problem with the research design, as the findings of this investigation may not be applicable to people at various stages of the recovery process. It seems that the term beginning recovery (used in the title of the paper) requires clarification and that the participants used in the study could have been appropriately classified.

The psychiatric hospital setting where this research was conducted should also be taken into account for at least two reasons. First, the treatment approach might be influenced by the medical model, which carries with it certain biases regarding the etiology and treatment of addiction (e.g., goal of complete abstinence). Other researchers and clinicians may not endorse this theoretical perspective. Secondly, if the doctor-patient hierarchical

relationship that exists in a medical environment influenced the participants, the group dynamics and change process might have been affected in a manner that is unique to that specific arena. Any findings from this study, therefore, may not be generalizable to other group settings.

Notwithstanding, the author outlines the goals of the psychodrama group and describes the tasks of early recovery. These goals and tasks seem vague, perhaps due to the brevity of the paper, and are not supported with a rationale as to why they are important to people who are early in recovery. The author cites the article from which the goals have been obtained, although a review of that article also failed to produce an adequate rationale to support the pursuit of these proposed group goals (Bean-Bayog, 1985).

The remainder of the article is devoted the practice of psychodrama and how this method can be used to work with several components of the recovery process. Some of these components include confronting denial, finding new solutions, dealing with feelings, and enhancing self-esteem. This section is very informative and practical because it provides explanations of each component as well as short case vignettes.

There were, nonetheless, a few assumptions inherent in these sections that appeared to be questionable. For example, the author claims that psychodrama can be used with people of any culture or level of education (Duffy, 1990). It might be argued that psychodrama is not an appropriate method for shy or introverted people or for people from cultures where the open display of emotion is not common. On the other hand, Duffy (1990) makes some assumptions that appear to be quite valid. She suggests that the working through of early trauma, for instance, may be more appropriate for stable and cohesive groups in later stages of treatment. Other clinicians have agreed, noting that intense and emotional enactments may

be frightening for clients who are unfamiliar with psychodrama, and therefore may serve to discourage people from participating in this method (R. Wright, personal communication, September 25, 2000).

In sum, this article is an excellent introduction to the use of psychodrama with substance abusers. Case examples are used throughout and are appropriately integrated with the concepts and theory of psychodrama. However, the content of the article leaves it vulnerable to a general critique of research in this area, that is, that most of the relevant studies are limited to a description of the application of psychodrama on addictive populations.

In response to such a criticism, Wood, Del Nuovo, Bucky, Schein and Michalik (1979) adopted a quantitative approach to empirically investigate the effectiveness of psychodrama as a treatment for alcoholism. These researchers set out to examine whether any personality changes in alcohol abusers could be attributable to the psychodrama component of their treatment program. Toward this end, the authors formed two groups of subjects, thirty-six who received a treatment program that included psychodrama, and sixty-five who received exactly the same treatment with the exception of group therapy being substituted for the psychodrama component of the program. Problems with the research design emerge when we discover that subjects were not randomly selected to participate in the study and were not randomly assigned to groups (subjects were included in the psychodrama group at the discretion of a group counsellor). In addition, a no-treatment control group was not used in this study. Even though the psychodrama group can be compared to the group that did not receive this form of treatment, the researchers cannot claim that any improvements are attributable to the intervention, since the study could be

confounded by the effects of history, maturation, testing and statistical regression (Cozby, 1993).

Despite the limitations mentioned above, the study could be described as quasi-experimental as it employed the nonequivalent control group pretest-posttest methodology. Prior to receiving any treatment, subjects were administered the Comrey Personality Scales, the Mini Mult (a short form of the MMPI), and the State-Trait Anxiety Inventory. A brief description of each of these measures is provided, but the authors fail to report any reliability or validity information about these instruments. Following the six to eight week residential treatment program, subjects were re-administered each instrument. Differences between the two groups were assessed using the independent measures *t* statistic and chi-square analysis.

In the results section of the paper, significant pre-post treatment change scores on the Comrey, Mini-Mult, and the Anxiety Measure were reported for subjects in both the psychodrama and the non-psychodrama groups. The State-Trait Anxiety measure indicated that both groups decreased their anxiety levels following treatment, although the instrument did not reveal differences between groups. An interesting finding was the discovery of greater movement away from denial by the psychodrama group as measured by the K scale of the Mini-Mult. The pre-treatment Comrey personality scale administration indicated that the psychodrama group scored lower than the other group on measures of response bias, trust, activity, emotional stability and extroversion. However, the post-treatment Comrey scores demonstrated that there were no significant differences between the two groups. The authors suggest that this finding indicated that the psychodrama component of treatment facilitated increased personality development in subjects.

To further substantiate this claim, the authors conducted two additional, albeit confusing comparisons. A sub-sample of non-psychodrama participants ($n = 15$) was matched to the entire psychodrama group ($n = 36$) on pre-treatment Comrey scores, while a sub-sample of psychodrama participants ($n = 15$) were similarly matched to the entire population of the non-psychodrama group ($n = 65$). In support of the initial analysis, Wood et al. (1979) report that "...post treatment Comrey scores indicated that the psychodrama group was significantly more trusting, active and emotionally stable subsequent to treatment than the sub-population of non-psychodrama participants" (p.83). It is unclear, though, as to why the authors did not choose to form equally sized sub-samples from each group matched on their pre-treatment Comrey scores so that only a single post-treatment comparison would be necessary. This procedure would ensure that the groups were equivalent prior to the introduction of the independent variable (i.e., psychodrama) without confusing the reader with two separate data analyses.

A further problem with this study is the fact that the participants were Navy personnel who were ordered to attend treatment by their physician and Commanding Officer. Thus, the findings of the study may not be generalizable beyond this particular population. The authors recognize this limitation and suggest that additional research is required from a variety of alcohol treatment facilities. Overall, the authors deserve credit for attempting the rather formidable task of conducting an empirical study of this domain.

In her dissertation entitled, "Curative Factors in Psychodrama with Substance Abusers," Ramseyer (1982) also conducted an empirical study of this intervention as it is applied to a specific population. Subjects in her study were a group of 19 male felony offenders from the ages of 18 to 42. These individuals were divided into three groups: a

group of eight participants in a psychodrama group, five participants in a short-term theme-centered group, and six participants who had dropped out early from the treatment conditions.

Ramseyer (1982) hypothesized that the psychodrama group would perform better upon pre-to-post assessment of a variety of outcomes measures, including: the development of empathy, improvement in behaviour and impulse control, and the development of thinking ability. These outcomes were associated to behavioural demands and actions that the participants were asked to perform. To measure empathy, the Mehrabian-Epstein Measure of Emotional Empathy was used based on the behavioural demand of role-playing. To measure impulsive behaviour, the average number of weekly rule infractions was calculated and the Self Control scale of the Gough Adjective Checklist was used based on the demand of behavioural rehearsal. To measure creative thinking ability, the Torrance Tests of Creative Thinking were employed based on the behavioural demand of working within a creative medium to give expression to personal concerns.

For the other two groups, Ramseyer (1982) hypothesized that participants that did not drop out of treatment would perform better than drop outs on several outcomes measures that assessed reduction in hostility and improvement in self-esteem. To measure the reduction of hostility, she utilized the Hostility scale of the Multiple Affect Adjective Checklist, based on the behavioural demand of catharsis in the treatment group. To measure levels of self-esteem, she employed the Self Actualizing Value scale of the Personal Orientation Inventory, based on the behavioural demand of participation in valued group roles. It was further hypothesized that the psychodrama group would show better improvement on these measures than the other treatment group and the group of treatment dropouts.

To analyze the data, Ramseyer (1982) used three multivariate analyses of covariance according to the specific pattern of dependent variables predicted by each hypothesis. Covariates were pre-treatment scores corresponding to the outcome variables in each analysis. The results of the study showed that each of the three hypotheses was rejected. In other words, the psychodrama group did not display predicted changes in the areas of empathy and creative thinking. The short-term theme centered group also did not display improvement in the areas of self-esteem or reduction of hostility when compared to treatment dropouts.

Four outcomes variables did produce a pattern, on the other hand, that proved to discriminate the psychodrama group from the group of drop outs in the areas of self-esteem, self-control, behaviour and hostility: ($F = 6.27236$, $df (4,5)$, $p < .03$). Ramseyer (1982) interpreted this finding as offering limited evidence for the notion that psychodrama leads to improvement in the areas of self-esteem, spontaneity, behaviour change, and hostility. She attributed the benefit to behavioural demands of psychodrama, such as the necessity to participate in valued group roles, the experience of working within a creative medium to give expression to personal concerns, to the process of catharsis and behavioural rehearsal. Unfortunately, the use of statistical analysis with such a low number of participants is a serious methodological flaw that leaves the findings of this research indeed questionable. This is not to say that the results should be completely discarded, on the contrary, the hypotheses might have been accepted if there were adequate numbers to detect minute differences across groups. At the same time, the study does give rise to areas for investigation and outcomes measures that could be employed in a larger scale study.

Finally, in her dissertation entitled, "Project Demonstrating Excellence: Psychodrama in the Field of Addictions," Dayton, (1993) presents a handbook for counsellors and therapists that describes the theories and techniques of psychodrama as it is applied to this population. Dayton collected data from various settings from across the United States, such as in university classrooms where she described her techniques as well as in training groups and workshops in South Dakota, Pennsylvania, Virginia, and New York. The writings in this document formed the basis for her book entitled "The Drama Within, Psychodrama and Experiential Therapy" (Dayton, 1994), which provides the basic concepts of psychodrama and offers guidelines for their safe use. Although both of these works are excellent resources for practitioners who wish to use experiential methods for a specific application, they are not systematic investigations of the use of psychodrama with addicted populations. Thus, they do not provide evidence that supports the concepts and techniques presented. The following research was conducted, in part, to help fill in this missing piece and to explore how the techniques and processes of psychodramatic methods are effective in the treatment of addicted individuals.

CHAPTER THREE

Method

Overview

This research employed the method of multiple case study as it is the preferred strategy when “how” or “why” questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context (Yin, 1989). In presenting the adaptive theory of addiction above, this research begins with a fundamental proposition at its outset (Yin, 1989), that is, that an influential aspect of addictive behaviour is the theoretical construct of integration failure. It is this proposition that will provide the link between data and the interpretation of the findings, (several pieces of information from cases investigated in the study will be related to the theoretical proposition of integration failure). In other words, the method of “analytic generalization” will be employed whereby the adaptive model of addiction is used to compare the empirical results obtained from the cases in this study (Yin, 1989).

In terms of overall methodology, this research employed the multiple case study design in order to obtain an abundant supply of data, which in turn, provided more compelling evidence toward the outcome of the study. Owing to this methodological approach, the underlying logic of this study is that of replication whereby each case is considered akin to a single experiment rather than sampling logic, which makes inferences about a general population based on sampled statistics (Yin, 1989).

Context of Researcher

In the tradition of qualitative research, it is considered desirable to openly acknowledge the background, beliefs, and values of the researcher given that his or her presence plays such an integral role in every aspect of the study (Stake, 1995). It is for this reason that I explicate my own experience surrounding this project so that the reader can more fully understand the context in which the study was designed as well as the context in which the data was gathered and interpreted.

At the outset of my post-secondary academic journey, I have primarily focused on the phenomenon of addiction. The main inspiration for my interest in this area comes from the fact I have witnessed some family members and many friends struggle with addictions of one form or another. It has always intrigued me as to how people become overwhelmingly involved in addictive behaviours that have severe negative consequences, but more importantly, I have been motivated to seek out ways of helping individuals find their way back to more healthy ways of being.

Toward this end, I have studied a multitude of interventions over the years that are designed to help individuals overcome addiction. Some of the methods I have examined and employed include, Alcoholics Anonymous, medical interventions, behavioural modification programs, cognitive approaches, various group orientations, and family systems work, to name a few. Throughout my work with addicted individuals and groups in outpatient as well as in-patient settings, I noticed a tendency for many clients to reach a plateau in therapy when engaged only in so-called talking interventions. I myself have experienced this plateau when I have undergone psychotherapy (as a client) as a means of personal and professional development. Upon reflecting on these experiences, it became evident that affect was a

crucial factor that was either absent or difficult to access when myself and other therapists attempted to produce transformative change in our clients. Since many of the addicted clients I have seen have appeared to be emotionally frozen for an extended period (oftentimes years), I yearned for a treatment modality that would address affect while remaining responsive to behavioural and cognitive domains.

I was first introduced to psychodramatic intervention while in the Master of Arts program at the University of British Columbia. As part of my training, I attended a group counselling class where the instructor, Dr. Marvin Westwood, lectured on the topic of psychodrama and presented a short demonstration of the method. I will never forget how extremely moved I was by what I saw. Because I got in touch with my feelings and emotions so naturally and immediately, I knew right then that this was the intervention that I had been waiting for. I began researching this “new” method of helping at a feverish pace.

Over the next two years, I became progressively more involved with the practice of psychodrama through my association with Dr. Westwood and his colleague, Dr. Patricia Wilensky. I began this relationship by attending a workshop that featured their particular approach to psychodrama, which I discovered was termed Therapeutic Enactment. At this workshop, I had the opportunity to participate as a client, which I did in spite of being slightly anxious. The experience was very profound and I emerged feeling like a different person. I was impacted on many levels and by many aspects of the intervention (e.g., through catharsis, cognitive changes, increased self esteem, and a sense of inclusion). My intuitive reaction to this method had been confirmed—I simply had to learn more. I expanded my knowledge and practical training by becoming the organizer of these workshops and eventually learned to provide professional assistance to Dr. Westwood and Dr. Wilensky.

It was at this point that I wanted to bridge the gap between my interest in the treatment of addiction with my passion for the method of Therapeutic Enactment. I remembered that at one of the Therapeutic Enactment workshops, I had met a counsellor who applied the method at his place of work, a residential treatment program for addiction. My dream of combining my clinical and research interests became a reality.

Setting

Overview.

Participants for this study were recruited from the Nechako Treatment Centre, a 27-day residential drug and alcohol rehabilitation facility located in Prince George, British Columbia, Canada. The Centre was founded in October of 1981 on the grounds of the Prince George Regional Hospital. The treatment facility serves both men and women whose lives are negatively affected by their alcohol and drug misuse and who want to begin a recovery and healing process. The facility does not offer one-to-one counselling in its adult residential treatment program, but rather, works with clients in a community (i.e., group) context. Although the total community is coeducational, most of the smaller therapy groups formed in each program are gender specific. A wide variety of therapeutic techniques are employed to facilitate client change, and treatment matching is used to meet the needs of each person.

The first step of this study was to contact the director of the Nechako Treatment Centre in order to obtain permission to conduct the investigation. The director immediately expressed interest in the research and authorized the project to proceed. Since the Nechako Treatment Centre is affiliated with the Prince George Regional Hospital (part of the Northern Interior Regional Health Board) and the principal researcher is affiliated with the University

of British Columbia, a proposal for this study was scrutinized by two ethics review committees (i.e., Northern Interior Regional Health Board Research Review Committee and University of British Columbia Behavioural Research Ethics Board: see Appendices A, B, and C).

Nechako Treatment Centre clientele.

The Centre serves an estimated population of 309, 852. Clients are referred to Nechako by alcohol and drug outpatient clinics, First-Nations alcohol and drug counsellors, Employee Family Assistance Programs, family medicine physicians, social service workers, and hospital detoxification assessment units. It was estimated in 1995 that 4675 people have attended the Centre since its inception in 1981.

As well as serving the city of Prince George, the Nechako Treatment Centre receives referrals from many other parts of the province. The Centre has had clients from Vancouver, Vancouver Island, the Okanagan, the Kootenays, Bella Coola, Williams Lake, Quesnel, McBride, the Peace River Region, the Yukon, and the Queen Charlotte Islands, to name a few places. Many First-Nations reserves from around the province also utilize the services offered by the Nechako Treatment Centre quite often, resulting in a high ratio of First-Nations clientele.

The Nechako Centre treatment model.

In general, the Nechako Treatment Centre utilizes a group therapy model, and serves approximately 20 to 24 clients per 27-day program. More specifically, the Centre has adopted the bio-psycho-social-spiritual model, an approach that has been endorsed by other

Provincial government agencies, such as the Addictions Services Branch (British Columbia Ministry of Health and Ministry Responsible for Seniors 1996). The theory behind the model suggests that substance misuse is the result of complex interactions between biological, psychological, social and spiritual determinants. Some of the main tenants of the model are as follows:

1. Substance abuse embraces a variety of syndromes including dependency syndrome and substance misuse related disabilities.
2. Substance abuse lies upon a continuum of severity.
3. The development of substance abuse follows a variable pattern over time and may or may not progress to a fatal stage depending on the type of syndrome and/or degree of severity.
4. There is no one superior treatment for all substance misuse as the elements in the experience of addiction will differ between individuals.
5. The population of substance misusers is heterogeneous and defies stereotyping.
6. Successful treatment is contingent upon accurate and comprehensive assessment and matching of affected individual to the most appropriate treatment.

(British Columbia Ministry of Health and Ministry Responsible for Seniors 1996).

In addition to regular programming, the Centre periodically offers gender specific programs as well as refresher programs, programs aimed at violent men, and other groups with a specialized focus.

A day in the life of a client.

Clients attend group sessions from 8:30 a.m. to 3:30 p.m. daily (with rest breaks and a lunch break). The first week of the program is devoted to community building and raising self-awareness. To first establish group safety and build group cohesion, clients participate in a variety interpersonal interactions, such as light physical exercise, introduction activities, art therapy, acupuncture, games and other social events, sharing meals, and maintaining the cleanliness of the Centre.

In addition, clients are exposed to several psychoeducational lectures on topics related to addiction. Some of the lecture topics include: group functioning and developing group norms, the process and stages of change, theories of addiction and related interventions, and effective communication. These seminars are sometimes followed by discussion groups where clients congregate in smaller numbers and discuss material presented in the lecture.

The second and third weeks of program are reserved for more intense psychotherapeutic experiences for clients. The participants are divided into two gender specific groups, which are co-led by two counsellors in each group. During this period, group sessions are held each morning and each afternoon and vary from 1.5 to 3 hours in length (with breaks in between sessions).

Several models of therapy are utilized during the two weeks devoted to therapy. The particular mode of therapy that is offered is discussed with each client before it is conducted and can vary from client to client depending on the counsellor's assessment of the client's needs. Agreement of the client for the therapy selected is essential as respect for the clients is one of the values of the program as many clients have been victims of physical abuse, sexual abuse, and traumatic experiences in their families of origin. Therefore, the counsellors at the

Centre believe that it is empowering for the client to have control over what he or she will or will not participate in.

Counsellors each have their own preference for the type of therapy they employ.

Some of the interventions offered include, Gestalt two-chair technique, cognitive-behavioural interventions, Transactional Analysis, Narrative Therapy, Psychodrama, and multiple couple group therapy.

A large group session also occurs each evening from 7:00 p.m. to 9:00 p.m., where clients are exposed to a number of videotapes on addiction (e.g., the physiological effects of addiction to alcohol, marijuana, cocaine, heroin, etc.) and also participate in other activities such as other psychoeducational presentations on subjects related to addiction. The evening sessions conclude with a short debriefing when group members are encouraged to discuss the impact of the session.

The final week of program is devoted to relapse prevention, where clients create future plans for maintaining sobriety. Clients are exposed to more presentations on topics such as effective communication, anger management, values clarification, and identifying relapse triggers and prevention strategies. They also engage in the behavioural practice of drug and/or alcohol refusal as well as participate in various rituals such as letter writing exercises. Each client is encouraged to document concrete plans for achieving a balanced lifestyle in the areas of occupation, leisure, family, and other domains.

On the last day of program, clients attend a catered luncheon followed by a graduation ceremony. Clients typically present speeches, recite poetry, sing songs, and sometimes treat the audience (composed of significant others) to theatrical plays written specifically for the graduation. Each client is also formally presented an official graduation

certificate by the counsellors. This rewarding event is filled with emotional moments for everyone involved and serves as a pleasant rite of passage that sends each client back into the world on a clean and sober path.

Phenomenon Under Investigation

Overview.

There are many variations of classical psychodrama and a plethora of psychodramatic techniques (Blatner, 1996). The formulation known as Therapeutic Enactment described below has also evolved from the classical school (as practiced by its founder, J. L. Moreno and his followers) yet remains firmly grounded in its principles and techniques. It has also already been mentioned that Therapeutic Enactment departs from classical psychodrama in terms of the amount of attention paid to group safety and control, the role of spontaneity, the role of catharsis, and the importance of group process (Westwood, Keats, & Wilensky, 2002). Practitioners of Therapeutic Enactment pay special attention to formally preparing each session to engender a highly circumscribed enactment experience, which results in an increased sense of control and safety for the client. This difference in preparation also changes the role that spontaneity plays in these two methods. In psychodrama, spontaneity is a necessary pre-condition of the process, while in Therapeutic Enactment, the client's level of personal spontaneity becomes one of the products of the intervention. Moreover, the role of catharsis does not end of the session as it does in some psychodrama models, but instead, catharsis marks the beginning of the healing journey. Once catharsis occurs and the individual accepts previously disowned parts of the self, the client can express and integrate these parts in the support of other group members. It can therefore be argued that Therapeutic

Enactment emphasizes group process more than classical psychodrama since clients are encouraged to reach out and reconnect with the social network of the group, thus promoting the integration and transfer of new learning to the client's everyday life (Westwood et al., 2002).

Where Moreno (1946) named five basic elements of psychodrama (i.e., protagonist, director, auxiliaries, audience, and stage), proponents of Therapeutic Enactment describe four key role components that operate during the intervention. First, the role of the "lead" is defined as the individual client who has decided to participate in the method in order to re-enact an important event or series of events from his or her past, present or future. Because the lead chooses what aspect of life or situation to explore in consultation with the therapist, he or she is, in effect, a co-composer of the enactment. The lead has the responsibility to select others from the group (on a conscious or unconscious level) to perform roles in the enactment and to coach selected group members to portray desired roles in an authentic manner (i.e., the lead provides some background and personal style of the significant other that he or she wishes group members to portray). Although the scene or event to be enacted may be from the past, the lead is asked to maintain a "here and now" orientation, and to deal with significant people from the past (being portrayed) as if those symbolic figures were present. It is the here and now orientation that engenders intense affect and often produces new insight into the relationships between the lead and significant others. As the enactment moves from verbal description of the event or scene into action, elements thought to be previously beneath the individual's awareness begin to surface (e.g., fears, fantasies, etc.), thus enabling the lead to modify his or her intra and interpersonal processes by re-experiencing the event differently. The lead controls the pace of the session and determines

what he or she needs in order to fulfill his or her goals. Other group members typically share similar issues, challenges or struggles with the lead, and owing to this universality, may be significantly impacted and also acquire therapeutic benefits.

The therapist (also known as the *director* in classical psychodrama) has three primary responsibilities. Firstly, the therapist must exercise competence in group process and leadership in order to develop safety and trust, ultimately creating a therapeutic group climate. Secondly, the therapist meets with the lead prior to the group session and develops a tentative plan or vision for how the enactment will proceed (i.e., creates a template, schema, or series of scenarios for the session). Thirdly, the therapist directs the enactment by (a) setting up the session (i.e., helping the focal person select and coach the players, set the stage, etc.), and (b) leading the enactment into action (i.e., guiding the focal person, directing the interactions, etc.). Following the enactment, the therapist conducts a debriefing of the session whereby the lead hears key players and witnesses discuss how the enactment impacted them, thus producing new awareness or understanding. Since the goal is to help the lead explore problems or issues, reach new insights, and integrate them in new ways that promote improvement of the individual's life, the therapist must possess excellent clinical counselling skills. The ability to parallel process is also essential as the therapist must attend to many variables simultaneously and be able to draw on the resources of the group to assist the lead during the enactment. With the ability to spontaneously improvise the direction of the enactment while providing structure and meaning, the group leader models a balance between knowledge, experience, and confidence.

Selected others (known as auxiliary egos or simply auxiliaries in classical psychodrama) are defined as any individual who assists the director and/or the lead during

the enactment. These group members assist the lead to become more deeply involved in the experience by portraying significant others in the lead's life, taking roles of inanimate objects, or standing in for the lead as the lead's double.

The remaining members of the group are referred to as witnessing participants and make up the safe arena or "container" where the Therapeutic Enactment occurs. The witnesses watch and listen to the session and are often personally impacted during the enactment. These individuals can benefit vicariously by identifying with the lead or selected others, by gaining new insights and by possibly experiencing an empathic emotional release. The role of the witness is particularly important at the debriefing phase, where these members are invited to provide support and feedback to the lead. In many cases, witnesses relate how the enactment resonated with their own life experience, which can result in transformative learning for these group members as well.

The five phases of Therapeutic Enactment.

There are five phases of Therapeutic Enactment that involve each of the roles of group members outlined above. The contents of each of the phases are depicted in Figure 1 below and described in the following sections.

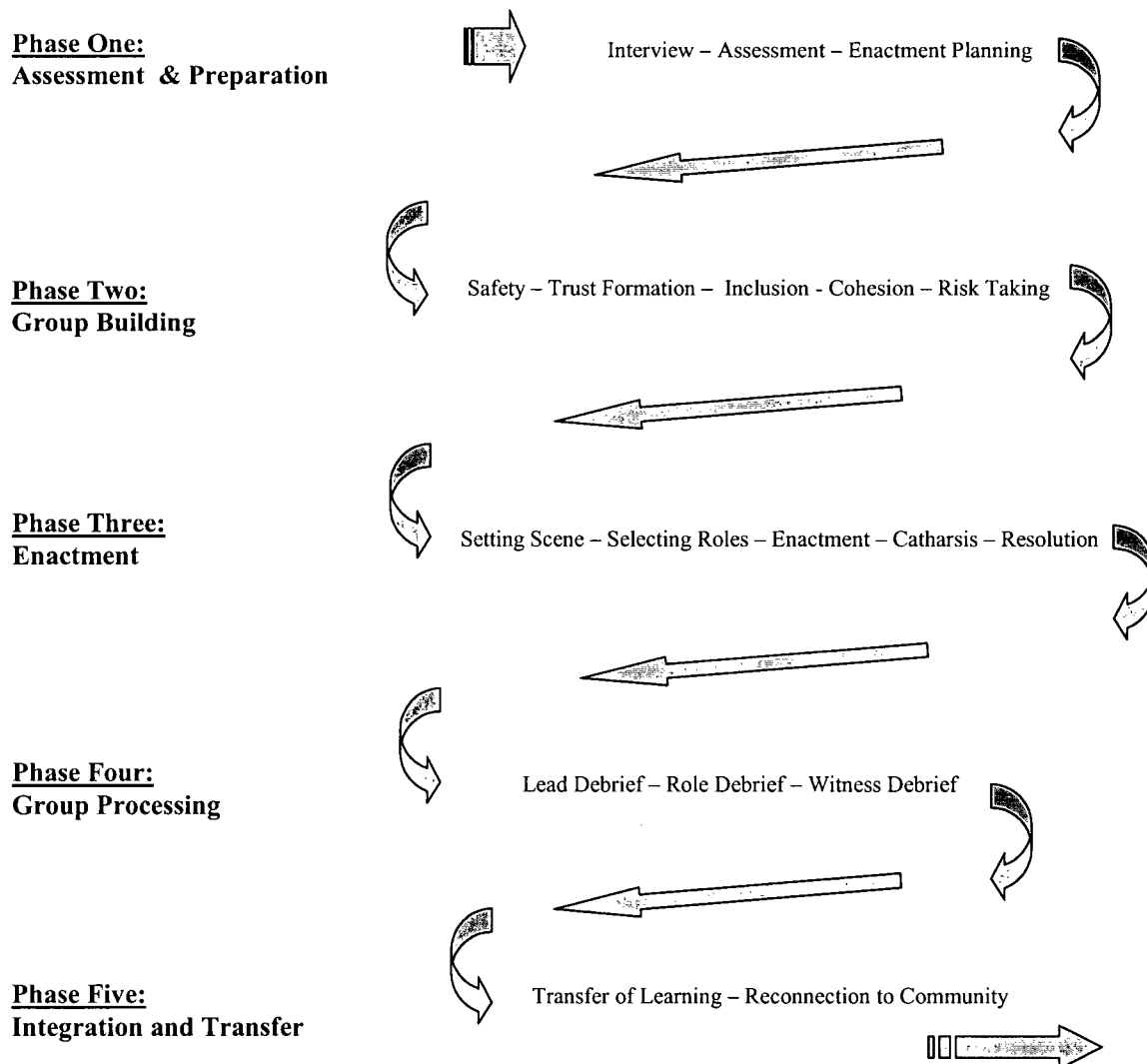


Figure 2 – The Five Phases of Therapeutic Enactment

Phase 1: Assessment and preparation.

The assessment and preparation phase is made up of an interview between the therapist and lead prior to the group meeting in order to assess the client's needs and to develop a detailed outline for the Therapeutic Enactment session. Preparing the client for the enactment process is advantageous because it increases the impact of the intervention and maximizes gains achieved through this process (as opposed to having a protagonist appear spontaneously from the group during session). Based on observations made during the first week (community-building component) of the program, the directors identified clients that were perceived to be willing to participate in intensive group therapy and ready to undergo Therapeutic Enactment in terms of "act-hunger" (Blatner, 1996).

The primary therapist and supporting counsellors held a private consultation with each client to establish scenes and directions for the enactment. The underlying rationale was explained to each client in simple terms. For example, it was stated that Therapeutic Enactment is a method used to break through the problematic feelings that may underlie addictive behaviours. It was explained that Therapeutic Enactment may help clients rid themselves of feelings that lead them to drink excessively or abuse drugs. It was further pointed out that the intervention also brings people back into connection with others through inclusion in a group while encouraging new learning in witnesses.

Clients were then asked to describe a recent or early event that has impacted them significantly or has shaped their life (possibly a traumatic or damaging event). In conceiving of such an event, clients were asked to think in terms of having the possibility to change or correct that event. With the goal of facilitating the re-enactment of event(s) in a way that the

client thinks ought to have occurred, it was hoped that clients would bring session content that would provide them with the opportunity to achieve a sense of control/mastery, or alleviate shame and guilt, (or similar affective and emotional material).

Clients were explicitly asked to describe (a) an event that in their opinion shouldn't have happened, (b) who they would like to be (symbolically) present as well as who they would like to (symbolically) have present as a witness, and (c) what the client would like to do, see or experience (e.g., what it would be like to have a "good father" etc.). In the event that the client conceived of many events, they were asked, "Which event feels best for you?"

Phase 2: Group building.

The group-building phase is an essential component of the intervention, whereby an atmosphere of safety, trust and cohesion is developed among group members. This particular group had already achieved a high level of cohesion by participating in activities and interactions designed to build a supportive climate in the first week of the program. Feelings of inclusion, belonging and spontaneity in group members were evinced by the large number of clients willing to risk participating in the intervention of Therapeutic Enactment in the presence of their peers.

Phase 3: Enactment.

The enactment phase is the critical moment at which the lead moves into action and actually re-enacts the scene(s) from his or her past, present or future. The lead begins by walking with the therapist within the circle of the group, outlining for the group what was said to the therapist during the set-up of the enactment. After the lead has briefed the group

by revealing a part of his or her life, they were encouraged to set up what they felt was the primary or most important scene. In the first enactment studied for this research, a scene that involved lower risk was used so that the group was slowly eased into the intensity of the intervention (i.e., a scene of a child custody battle was favored over scenes of sexual abuse).

At this point, clients are invited to choose other group members to represent significant figures that are important to the enactment of the scene(s). The therapist assists selected others to act as if they were the people whom they've been asked to play, by checking with the lead and asking the auxiliaries to make behavioural adjustments (to help induct the auxiliary into role).

Throughout the various scenes of the enactment, various techniques of psychodrama were employed, a few of which are described below. For example, the technique of role reversal involves having a client switch roles with significant figures from their life, thus promoting raised self-awareness through processes of self-exploration as well as self-confrontation (Blatner, 1996).

The technique known as doubling was also used in this study, whereby the lead was asked to choose another group member to represent him or herself. The double may be brought in to represent the lead if, for instance, the lead has difficulty expressing emotions or inner feelings (Blatner, 1996).

The technique of surplus reality was regularly utilized in the Therapeutic Enactment sessions investigated for this research as well. Blatner (1996) reveals the merits of surplus reality in his explanation of this technique:

The value of this concept is that it validates a dimension of being worthy of being taken seriously and explores those experiences of events that not only have occurred

in the past, and may occur in the future, but also events that never occur—even events that could never happen! —such as an encounter with an unborn child, speaking with a relative who has died, replaying a scene so that one experiences mastery instead of humiliation, or having a dialogue with one’s patron saint or guardian angel (p.76).

As the enactment phase of the intervention unfolds, scenes often evolve sequentially (Blatner, 1996). Scenes may move from some aspect of the client’s present life circumstances to the past or vice versa as there are no rules about the sequencing of scenes. For example, the client was asked, “What is missing?”(e.g., an uncle, aunt, etc.) which sometimes lead to the construction of further scenes.

If a scene becomes problematic or stuck during the enactment process, the enactment is stopped. The client is asked, “Is this feeling right?” to check on the level of awkwardness or whether the client was not experiencing the scene in the here and now (as if it were real). The level of affective experience is monitored during the enactment by asking, “What is going on for you right now?”

At critical moments during the enactments in this study, clients were encouraged to experience affect through the use of the following sentence stems:

“What I am experiencing right now is...”

“What I want is...”

“What I need is...”

“What you took from me is...”

“What I need to get back is...”

“You hurt me by...”

“I’m alone because...”

“What I miss most is...”

“What I regret most is...”

“What I needed to say is...”

“What I want you to do is...”

The therapist sometimes used the technique of amplification to highlight the client's experience by having the client complete these sentence stems louder, more intensely, or by having the client direct statements to symbolic representations of significant people in their life.

This often resulted in a climax of the enactment (catharsis) and led to a conclusion of the scene. The client was asked what he or she needs to do or say to end the scene and complete the enactment. For instance, the client was asked to say, “Now that I have myself back, what I am going to do in the future is...” or “What I have to say or ask you is...” which allowed the client to say what they needed to in order to complete the enactment.

Phase 4: Group processing.

Each enactment was debriefed during the group processing phase by having individuals in the community share their personal reaction(s) to the session. The therapist asked selected others to comment on their experiences as the person whose role they played in the lead's enactment in addition to commenting on how the enactment impacted them as themselves. Individuals were asked to refrain from passing judgment or critiquing the process or outcome of the enactment, but rather, to comment or describe how they were personally affected (e.g., “What was it like for you to play that role? How did this story affect you? As yourself Tom, how did this enactment touch your life or speak to you?”). This

sharing of reactions is designed to facilitate the consolidation of the lead's experience and further develop group cohesion (Westwood, Keats, & Wilensky, 2002).

Phase 5: Integration and transfer.

The integration and transfer phase begins after the lead has heard from selected others and witnesses in the group. In the integration and transfer phase, it is the lead's turn to reflect on his or her experience and the feedback received from others. Soon after the session has ended (within a few days) the therapist follows-through on the personal integration of the lead by conducting a brief post-treatment interview. In the interview, the client is encouraged to apply any new learning gained from the Therapeutic Enactment experience to his or her everyday life. Continued counselling is usually recommended to the client. For the purpose of this study, the integration and transfer phase consisted of each participant being interviewed by the field researcher immediately following treatment and again at three-month follow-up. These interviews permitted each client to significantly reflect on their Therapeutic Enactment experience and to distil therapeutic gains into concise and concrete statements, which could then be applied to the clients' current situations.

Participation in the Study

Upon intake into the Nechako Treatment Centre, all clients of the October 15th to November 9th (2001) program were asked to complete a Consent to Treatment form. In this form, clients are asked for permission to be contacted for participation in research projects. All 21 clients in the program had signed this portion of the Consent to Treatment form, thereby agreeing to being contacted for participation in research. Shortly after the first week

of the program, the entire community was informed about the possibility of participating in this particular research project by the senior clinician at Nechako. The senior clinician described the general nature and procedure of both the intervention of Therapeutic Enactment as well as that of the research project. The voluntary and confidential nature of the research was emphasized. An attempt was also made to screen for individuals who might not have benefited from the experience of Therapeutic Enactment. For example, after the nature and process of Therapeutic Enactment was described, clients were encouraged to reserve the right not to take part in this component of the program if they felt intimidated or anxious, or if action-based group intervention did not fit with their cultural norms or personality style. Bulletins describing the study were also posted around the facility (See Appendix D). Shortly after introducing the study, the senior clinician invited interested clients to obtain informed consent forms from the main reception area (See Appendix E). Of the 21 clients in the program, all consented to participate in the study, and nine expressed a desire to participate as a lead in a Therapeutic Enactment session.

In brief, participation as a lead in a Therapeutic Enactment session for this research involved the following components. First, each client participated in one videotaped session of Therapeutic Enactment with the senior clinician as therapist. Clients then participated in an in-depth interview where they talked about their Therapeutic Enactment experience with a research assistant (See Appendix F). Clients also completed a demographic questionnaire to supply general information for the study's report (See Appendix G). The co-researcher and the client then reviewed the videotape of the enactment to refresh the client's memory of the experience. The co-researcher then presented a short version of the interview. Clients

permitted both transcribed interviews and file data to be used in the study. Finally, clients participated in a follow-up interview three months from completion of the program.

Selection of Participants

According to Creswell (1998), it is important for qualitative researchers to identify sampling strategies and offer rationales for the use of such strategies. Of the nine adults who were recruited as leads in a Therapeutic Enactment session for this study, four cases were selected for rigorous investigation. The sampling strategy began with the criterion sampling procedure, whereby only cases that met certain criterion were eligible for participation in the study. Potential participants had to have undergone all components of Therapeutic Enactment (e.g., completed all five phases, had only one intervention involving all of the therapeutic community as opposed to a gender specific session, etc.) to ensure consistent application of the method. Following this initial criterion, three cases were chosen using the strategy of typical case sampling since they highlighted what was normal or average about the phenomenon of Therapeutic Enactment intervention (Creswell, 1998). A fourth case was selected using the strategy of extreme or deviant case sampling because this case represented an unusual manifestation of the phenomenon under investigation (i.e., where the client confronted the issue of sexual abuse using Therapeutic Enactment), thus offering an alternate perspective and an enriched learning opportunity (Creswell, 1998).

Demographics

All participants chosen for intensive investigation were females living in the Central Interior region of British Columbia, whose ages ranged from 26 to 43 years old. Two of these

women were single, one was divorced and one was in a common-law relationship. With regard to education, three women had completed some college courses, while only one woman had not completed secondary school. These participants had held a wide variety of occupations including secretary, receptionist, youth counsellor, social worker, child-care worker, waitress, bookkeeper, and homemaker. Two women reported annual family incomes of between \$10,000 and \$20,000, one woman reported between \$20,000 and \$40,000, and another woman reported between \$40,000 and \$60,000. In terms of ethnicity, three participants were First Nations and the fourth was Caucasian.

Focusing on the issue of addiction, three women attended the Nechako Treatment Centre in order to obtain counselling for concerns related to both alcohol and drug use, while the other woman was concerned only with alcohol misuse. For two of these women, the Nechako Treatment Centre was the first treatment program they had ever attended in order to deal with their alcohol and drug related problems. The other two women had completed an alcohol and drug treatment program prior to attending the program at Nechako, and one of these women was involved in Alcoholics Anonymous and individual alcohol and drug counselling on an ongoing basis.

Data Collection

As stressed by Yin (1989), “a major strength of case study data collection is the opportunity to use many different sources of evidence” (p.96). Following this rationale, the data for this study were derived from three sources, direct observations, interviews and documented records.

First, I immersed myself in the treatment program and was accepted both as a staff member and as a member of the community. I also videotaped the Therapeutic Enactment sessions, which served as a rich source of data. The direct observations of myself and the other counsellors provided additional information about how the method was applied as well as how clients responded to the intervention.

Secondly, each client participated in an in-depth interview during the final week of the program. The content of the interview questions were developed using the guidelines outlined by Patton (1987) and included experience questions, behaviour questions, feeling questions, knowledge questions, and chronological questions (see Appendix C). An expert in qualitative research was also consulted to improve the interview questions as they were being constructed. The interviews were conducted using a combination of the guided interview approach (which investigates predetermined content areas through the use of a protocol) and the informal conversational style (which relies on the spontaneous generation of questions during the natural flow of an interaction) (Patton, 1987). The interviews were conducted in an office at the Nechako Treatment Centre, which was transformed into a research office for the purpose of this study. A research assistant administered the first part of interviews in an attempt to reduce social desirability responses of clients (in the event that clients might be inclined to please the researcher by giving favorable responses). Then, I reviewed videotaped footage of each client's enactment with the client as a way of refreshing the client's memory of the experience before continuing the interview. Both parts of each interview with clients were audiotape recorded. Three months after the program, clients participated in a follow-up telephone interview, which were also recorded onto audiotape. The audiotapes were used to transcribe interview sessions for later analysis.

Thirdly, documented records were reviewed for use in the study. Among some of the documents included were client journals, letters written by clients to referral agents, and client evaluations of the program.

Data Analysis

Interviews.

This stage of analysis began with a systematic examination of interview transcriptions following Miles and Huberman's (1994) recommendations for sequential qualitative analysis as well as suggestions made by the qualitative methods consultant on the research committee. It is important to note that several efforts were undertaken to increase the trustworthiness of data analysis and interpretation as part of the process of validation.

Keeping the basic research question in mind (i.e., "How is Therapeutic Enactment helpful in addiction treatment?"), I read through all of the interview narratives and underlined every apparent answer—with the single unit of analysis being either a part of a sentence or a multi-sentence chunk (Miles & Huberman, 1984). I then labeled each section of underlined, directly quoted data with codes that described the data. The codes were written in the margins of the transcribed interviews and appeared as summarized notations. In this way, an inductive approach was used, whereby the codes used to classify the data were generated from the data as opposed to coding data according to a prefabricated accounting scheme (Miles & Huberman, 1984).

Next, I re-coded large sections of each transcribed interview again a few days later to test for the internal consistency of analysis (Miles & Huberman, 1984). The following formula was used: Reliability = number of agreements / number of agreements + number of

disagreements. Employing this formula ensured that the same codes were used to code the same blocks of data (or segments of transcribed text). In some cases, definitions of codes had to be adjusted or blocks of data re-coded. When the code-recode reliability exceeded the value of 90% as recommended by Miles and Huberman (1984), the analysis was considered reliable and the data set retained for further analysis. The transcriptions were also given to a colleague experienced in qualitative data analysis that independently coded the data using the same procedure. The code-recode reliability for this second researcher also exceeded the recommended standard of 90%. The coded interview transcriptions were then compared across researchers as an inter-rater reliability check. When discrepancies occurred, researchers discussed, negotiated and made adjustments accordingly (e.g., agreed on the most appropriate code when two looked good, altered codes to become more encompassing or narrow, etc.) (Miles & Huberman, 1984). The same reliability formula was used to ensure that both researchers used analogous codes to code the same blocks of data over 90% of the time.

The coded data was then subjected to the technique of pattern coding in order to identify emergent themes. The coded data was organized into a matrix, following the suggestion of Miles and Huberman (1984), who argue that data displays should be a normal part of reporting conclusions in qualitative research just as they are in the quantitative tradition (matrices for each participant appear in chapter 4). I constructed the matrix according to the frequency in which coded data occurred in the interviews. Miles and Huberman (1984) recommend counting in data analysis as this method allows one to quickly view the content of a large amount of data while protecting against bias and maintaining analytical honesty. The matrix facilitated the analysis of recurring codes across initial and

follow-up interviews, thus providing a gauge for robustness and a means to determine the significance of the data. It was these recurring codes in the matrix display that made up the emergent themes.

The research assistant and I then cooperatively selected lengthy embedded quotes so as to provide additional specific and concrete evidence in support of the themes (Creswell, 1998). Embedded quotes were chosen for presentation according to the decision rules of (a) researcher confidence, and (b) the extent to which the participant's narrative represented exemplars of the code definitions (Miles & Huberman, 1984). Although the embedded quotes were selected from the most frequently occurring themes and the results section presents themes in the order of those containing the highest to lowest number of supporting direct quotes, the quality of relatively less recurrent data was also considered and occasionally presented. Notwithstanding, it was readily apparent that the most consistent codes (i.e., the most reoccurring) were also the most qualitatively valuable as they contained the most relevant and rich embedded quotations.

As another way of verifying the verisimilitude of the analysis, I presented the themes (supported by direct quotes) to the participants for review. I asked participants for feedback on how their interview data was organized into themes and encouraged them to make any changes they desired (i.e., to adjust definitions of themes, or to add or delete direct quotes from the analysis, etc.). Once each client had completed their review and had the opportunity to make changes, they were thanked for their participation in the study.

As a final means of ensuring the trustworthiness of the data and the analysis, I have attempted to supply outside observers with a chain of evidence in this chapter by documenting the methodology of the study in great detail (Yin, 1989). In this way, I have

tried to make the derivation of evidence transparent to readers so as to support the results presented in the following chapter.

Direct observation.

In an attempt to transport the reader directly into the world of the study and to make the writing seem real and alive (Creswell, 1998), a brief summary of each Therapeutic Enactment session was created for each of the final four participants that were selected for investigation in the study. These summaries appear as appendices of this report (See Appendices H, I, J, K). To create these summaries, I reviewed the videotapes and took handwritten notes on how the method of Therapeutic Enactment was applied, and quoted the personal narratives of clients as they responded to the intervention. Although one cannot directly observe the phenomenological experience of participants, it was possible to document behaviours and quotations that support the data collected from the interviews. The directly observed data from each participant's Therapeutic Enactment session was then documented. To increase the reliability of the observational evidence, I presented the videotapes of the sessions to the counsellors of the Nechako Treatment Centre for their review and incorporated their contributions into the direct observations sections for each participant (Yin, 1989). Pseudonyms were used to maintain the anonymity of the participants and other individuals named during their Therapeutic Enactment sessions.

Documentation.

All of the documentary information was generally reviewed in order to attain an overall sense of this data source (Creswell, 1998). Examples of documentary data include referral

information, daily client journals, weekly self-evaluations, clients' letters to referral agents, final program evaluations, and counsellor discharge summaries. Each of these documents was analyzed for content that corroborated or supplemented other research evidence (Yin, 1989). Direct client quotations and/or information written by significant others (e.g., counsellors, referral agents, etc.) were excerpted from these documents and presented for methodological triangulation (Patton, 1987). In addition, clients completed a brief personal information questionnaire (See Appendix G) so that a summary of the participants' demographics could be presented in the final report.

Cross case analysis.

In an attempt to make meaningful comparisons across cases and search for common patterns and themes, a cross case analysis was conducted. I decided to include only the interview data for cross case analysis since these data sets had undergone the most rigorous analysis individually and were therefore considered both reliable and comparable. The analysis began with the creation of a meta-matrix that encompassed all emergent themes from both the initial and follow-up interviews of each participant (Miles & Huberman, 1984). The themes were arranged in rows, while each participant represented a column of data in the matrix. The frequencies of coded data that were categorized according to individual themes appeared in each cell of the matrix. Next, the technique of across-category clustering was used to reduce the data into themes that were common to more than one Therapeutic Enactment session (Miles & Huberman, 1984). The themes were then arranged in order of frequency so that the theme that appeared with the most frequently coded data across cases appeared at the top of the matrix and themes with less frequently coded data appeared below.

Although some themes taken from an individual case analysis had a high frequency of coded data, they were not included in the cross case matrix because the data and theme were exclusive to a particular participant and not common to others. The final cross case matrix provided a sound method of making comparisons across individuals and means to discover ways in which the intervention was useful to more than one participant.

CHAPTER FOUR

Results

Overview

The results section begins by presenting the findings derived from the study of each individual case in accordance with the logic of replication (described above). For each of the four participants, the findings from the interviews are presented first, followed by direct observations, and finally the documentation evidence. Prior to reviewing the results of each case, it is recommended that the reader peruse the summaries of each participant's Therapeutic Enactment session in order to gain a better understanding of what took place during the intervention. The summaries appear as appendices at the end of the report. Pseudonyms are used in the presentation of results and in the summaries to protect the identity of actual persons. After the findings from each case are presented, the chapter concludes with the results of the cross-case analysis of interview data.

Participant Number 1: "Samantha"

Interview data.

The first column in Table 1 (below) displays the seventeen themes that were derived from the initial interview with Samantha. A brief definition of each theme appears in the cell that contains the title of the theme. The frequency of coded data that make up each theme appears in the second column along with short examples of direct quotes.

Ten themes were derived from the follow-up interview with Samantha. Nine themes overlap with the themes derived from the initial interview (and are defined in the first column), while the 10th theme ("Change in Self-Schema") is defined at the bottom of the first

column. The frequency of coded data that make up the themes appears in the third column along with short examples of direct quotes from the follow-up interviews. The fourth column displays the total frequencies of coded data from both interviews that make up each theme.

Table 1: Thematic Results of Interviews

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Self-Awareness <i>Definition:</i> Client became aware of self or behaviours as a result of Therapeutic Enactment.	Frequency: 9 Direct Quotes <i>Examples:</i> "...I realized that I have to stop laughing and that this is serious...because I was nervous and the judge said I wasn't serious...it has ruined my life—disrespecting the judge. I've always done that in bad situations...as a fake thing to hide that I didn't feel comfortable."	Frequency: 4 Direct Quotes <i>Examples:</i> "...my actions and everything...I am aware of...what I can do and can not do, how other people see it, everything."	13
New Experience/Reality <i>Definition:</i> Client reports benefit from new experience in Therapeutic Enactment.	Frequency: 9 Direct Quotes <i>Example:</i> "The new outcome made all of the difference."	Frequency: 2 Direct Quotes <i>Examples:</i> "I find by changing it in the end because I won in the end whereas in real life I didn't. I made me feel better about me...I'm a good mom."	11
Corrective Emotional Experience <i>Definition:</i> Client reports change in emotional state by re-experiencing difficult life situation(s) and working through, letting-go or forgiving previous emotional wounds.	Frequency: 5 Direct Quotes <i>Examples:</i> "I would go and get high automatically because I couldn't deal with how I felt inside. And now, even when I try to think of how that feeling was, I can't find it...ever since [the enactment] it is not the same anymore."	Frequency: 5 Direct Quotes <i>Examples:</i> "I still can't bring that feeling back inside, that total desperation. I can't feel it anymore, it's totally gone. This is what the enactment did for me—it took that away totally—it's gone."	10
Increased Hope <i>Definition:</i> Client reports a renewed sense of hope following Therapeutic Enactment intervention.	Frequency: 7 Direct Quotes <i>Examples:</i> "I just thought that it has given me more faith in myself. It has given me more faith in humankind. And I just believe that anything is possible now."	Frequency: 3 Direct Quotes <i>Examples:</i> "[I am] more positive, about everything. Like making it!"	10
Applying Therapeutic Enactment Independently <i>Definition:</i> Client reports using principles or process of Therapeutic Enactment to help negotiate or cope with life situations.	Frequency: 6 Direct Quotes <i>Example:</i> "...I am going to use it all of the time to make me feel better."	Frequency: 2 Direct Quotes <i>Examples:</i> "Because it helps me feel better whereas before I would never really look at things. I'd always laugh them off and cover. I can look at them and it's o.k. and I can talk myself through it."	8
Experiencing Affect <i>Definition:</i> Client reports experiencing affect or willingness to experience affect as a result of Therapeutic Enactment.	Frequency: 2 Direct Quotes <i>Examples:</i> "And I am forcing myself to feel everything. I want it. I want to get those [feelings]."	Frequency: 5 Direct Quotes <i>Examples:</i> "...cover up all my feelings. Whereas I don't have to do that now...I can feel my feelings. It's O.K. I did learn that from the enactment. I actually wanted to break down and cry and in the enactment I really did break down and cry."	7

Table 1: Thematic Results of Interviews Continued

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Resource Installation <i>Definition:</i> Client draws upon memories of Therapeutic Enactment as a resource that helps with current or future life situations.	Frequency: 3 Direct Quotes <i>Examples:</i> "Just hearing everybody...what they had to say from the jury...to hear all of the different things. Because I've always heard I'm a good mom...I know in my heart that that's me."	Frequency: 3 Direct Quotes <i>Examples:</i> "But sometimes when I get really down or get really hyper and want to get high, I'll remember everything...I just think back and that brings me back to the enactment and how I felt."	6
Reviewing Enactment Videotape <i>Definition:</i> Client reports viewing videotaped footage of Therapeutic Enactment session as being helpful.	Frequency: 1 Direct Quote <i>Example:</i> "...seeing exactly when things happened. Like what set them. What set off the feeling. Like being able to cry...and being able to see what was said before that."	Frequency: 3 Direct Quotes <i>Examples:</i> "I think watching it after...was good because you almost forget what you did a lot of the time you didn't know what you were doing...it showed me on the tape how I was and stuff...how to act in front of a judge."	4
Behavioural Practice <i>Definition:</i> Client reports practicing future life events in Therapeutic Enactment session.	Frequency: 1 Direct Quote <i>Example:</i> "That's another thing I would like to work on is my speech to the judge...it never came out...as strong as I wanted it to be."	Frequency: 2 Direct Quotes <i>Examples:</i> "If I would have acted like I did before I would probably have lost. I probably would not have had [a chance to prove herself] if I wouldn't have gone through that because I would have walked right back in there the way I used to be. This taught me that I can't do that again."	3
Importance of Auxiliaries <i>Definition:</i> Client reports that auxiliaries (i.e., other group members playing a role) were in some way important to her Therapeutic Enactment session.	Frequency: 6 Direct Quotes <i>Examples:</i> "...it just brought me right back to when he [her ex] used to watch me all of the time, and call the cops...it just brought all of that back...no-one else could play that part for me in there."		6
Witnessing Other Enactment Sessions <i>Definition:</i> Client reports benefit from witnessing Therapeutic Enactment sessions of other clients.	Frequency: 4 Direct Quotes <i>Examples:</i> "Every single other enactment brought me to my knees...a lot of stuff I didn't see I kind of see through that. Watching someone else, I can learn so much about myself."		4
Altruism <i>Definition:</i> Client reports feeling more care and concern for others as a result of Therapeutic Enactment.	Frequency: 2 Direct Quotes <i>Examples:</i> "I am thinking about other people. So I know I am growing. I feel compassion for her more than anything...maybe I healed that spot of me."		2
Therapist Support <i>Definition:</i> Client reports benefit from support by therapist.	Frequency: 1 Direct Quote <i>Example:</i> "...it was like [the therapist] was saying good, or it's o.k. or now what...sometimes if someone didn't say anything I was lost. So it was really good for me to have [the therapist] there..."		1

Table 1: Thematic Results of Interviews Continued

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Sense of Empowerment <i>Definition:</i> Client reports gaining some sense of personal empowerment as a result of Therapeutic Enactment.	Frequency: 1 Direct Quote <i>Example:</i> "I am way stronger now, the way I feel."		1
Feeling Safe <i>Definition:</i> Client reports that feeling of safety during Therapeutic Enactment session was important.	Frequency: 1 Direct Quote <i>Example:</i> "I really felt safe. And I knew that no matter what, it would be O.K. I knew that [the therapist] would fix it, kinda, if I couldn't or [the therapist] would push me the right way to fix it."		1
Memories Invoked <i>Definition:</i> Client reports that Therapeutic Enactment evoked memories that led to helpful insights.	Frequency: 1 Direct Quote <i>Examples:</i> When I was eleven I got sexually assaulted...I kept calling my sister and I was crying and she was laughing...I remember laughing...I looked at my sister and she was laughing too."		1
Spiritual Experience <i>Definition:</i> Client reports having some kind of Spiritual Experience as a result of Therapeutic Enactment.	Frequency: 1 Direct Quote <i>Example:</i> "...by going through it, some other power or something came and helps you through that...or something. I don't know what it is. I am scared to dissect it because I always wreck everything. So I am just going to leave it there. It's mine."		1
Change in Self-Schema <i>Definition:</i> Client reports a change in self-perceptions of thoughts, feelings, or behaviours as a result of Therapeutic Enactment.		Frequency: 3 Direct Quotes <i>Example:</i> "Because I lost my kids and then my kids hated me. Because of all this, I got high before. Now I don't have to because I don't think like that now and now I'm trying to be a good mom. I stay home and, yes, maybe I'm not perfect all the time, but at least I'm not bad."	3

The theme entitled "Self-Awareness" was made up of the most frequently coded data from both interviews. Nine direct quotes were coded according to this theme in the initial interview, while four direct quotes were coded in this way during the analysis of the follow-up interview (for a total of 13 direct quotes). Data was coded under this theme if the client reported becoming more aware of some aspect of herself and/or her behaviours as a result of her Therapeutic Enactment experience.

For example, Samantha was asked what Therapeutic Enactment helped her to learn in her initial interview:

What I need to get stronger, I didn't see that. Well I knew when I said it, I knew I wasn't saying it the way I wanted to, like when I was talking about why I deserve my kids. This really enforces that thought. That I really have to work on that and I really have to work on my ex...on asserting myself and being able to look him in the eye like I look at you and say, "Hey, here's how it is." Not, "here...well, you really hurt me." But, "you hurt me!" [In more assertive tone]. And it showed me that I really need to work on communication skills.

[Laughter]...has ruined my life—by disrespecting the judge. I laughed in a courtroom because I was nervous and the judge said I wasn't serious. I've always done that in bad situations...as a fake thing to hide that I didn't feel comfortable or nervous. It's made me think, everytime I laugh, I think, "Was that funny?" And I didn't know the difference before, I thought everything was funny and everything was a joke.

An elevated level of self-awareness is also evident in her follow-up interview, when Samantha comments:

It [the Therapeutic Enactment session] was strictly to do with my court case and just my actions, like how I've always acted and how other people have always seen me act. And even though that's not what I wanted them to see, that's what they saw. But now I'm aware of it.

The theme labeled "New Experience/Reality" was made up of the second most frequently coded data from both interviews. Nine direct quotes were coded according to this theme in the initial interview, while two direct quotes were coded under this theme during the

analysis of the follow-up interview (for a total of 11 direct quotes). Data was coded under this theme if the client reported benefits from experiencing a new reality—that is—an experience during her Therapeutic Enactment session that was different than actual real-life events.

In her initial interview, Samantha talked about the therapist's intention to set up a new trial:

And then I thought, why I'd want to do it. I didn't understand why he would want to do it to me again. I didn't realize he was changing it. I just presumed I'd be doing the same thing again.

I: Was it helpful when you did this and had a new outcome?

S: The new outcome made all of the difference.

Samantha also reported benefiting from the experience of an alternate reality in her follow-up interview:

I find by changing it in the end because I won in the end whereas in real life I didn't. That to me was [winning] and hearing everybody, 'cause he had the jury come in...and hearing that made me realize that – Yes, that is how it is. It made me feel better about me too. I am a good mom.

The theme called "Corrective Emotional Experience" was made up of the third most frequently coded data from both interviews. Five direct quotes were coded according to this theme in each of the initial and follow-up interviews, for a total of 10 direct quotes. Data was coded under this theme if the client reported a change in her emotional state as a result of re-experiencing difficult life situation(s) and working through these event(s) during the Therapeutic Enactment session. The change in emotional state can refer to the client

achieving a feeling of peace, a sense of forgiveness of people or events, or letting go of previous emotional wounds.

In her first interview, Samantha described how Therapeutic Enactment helped to change the difficult feelings she carried following the loss of her court case:

I think...it's because every time I think about driving home in the car, it didn't matter where I was, I would go and get high automatically because I couldn't deal with how I felt inside. And now, even when I try to think of how that feeling was, I can't find it. And that's really weird, like I don't cry when I think of it, and you know...I can still know the whole story, but I am not sad, like I don't have that feeling in my chest now because ever since it is not the same anymore.

This change in her emotional state also surfaced in her follow-up interview:

I still cannot remember the feeling I felt when I drove home from my court case when I first lost. The devastation when I had to go home and tell my kids they had to go be with their dad. I still can't bring that feeling back inside. That total desperation. I can't feel it anymore, it's gone. This is what the enactment did for me, it took that away totally, it's gone. Even to this day, I can't bring it back if I try to think about driving home, I still can't find that feeling. This is wonderful. I truly believe it now especially because I can't bring that feeling back. And that feeling was killing me before and now I can't even find it. That's why I say [Therapeutic Enactment] works.

The theme entitled "Increased Hope" was comprised of the same overall frequency of direct quotes in both interviews as "Corrective Emotional Experience." However, seven direct quotes were coded according to this theme in the initial interview and three direct quotes were coded in this way after analysis of the follow-up interview (for a total of 10

direct quotes). Data were coded under this theme if the client reported a renewed sense of hopefulness following her Therapeutic Enactment Session.

Samantha's statements in her first interview indicate that Therapeutic Enactment raised her optimism about her up-coming trial, as she declared, "It made me feel that I can win and this is all worth it. And if I don't win this time, then I will win eventually." She also states, "I just thought that it has given me more faith in myself. It has given me more faith in humankind. And I just believe that anything is possible now." In addition, she asserted, "Yeah, and I just have so much faith and hope that there are people that are going to listen and know that I am not lying."

Samantha's statements made in her follow-up interview also support the supposition that Therapeutic Enactment raised her sense of hope:

I'm more positive. In my mind I think that because I'm going to win, I can't mess up and I guess nothing is as intense now and what was killing me before was the thought of the loss of my kids...even though I didn't and it was joint custody...but in my mind, to me, that's losing.

The theme entitled "Applying Therapeutic Enactment Independently" was made up of the fifth most frequently occurring coded data from both interviews. Six direct quotes were coded according to this theme in the initial interview, while two direct quotes were coded in this way during the analysis of the follow-up interview (for a total of eight direct quotes). Data was coded under this theme if the client reported using Therapeutic Enactment principles or processes on her own as an aid to cope with or negotiate life experiences.

It was interesting to hear in Samantha's first interview that she planned to use the method of Therapeutic Enactment to help her with her recovery in the future:

Because now I know that no matter what happens in my life, I might not be able to do it when it's happening, but eventually, I know I can always go through an enactment in my head and change it when I am ready to do so. I am going to use it all of the time to make me feel better.

Additional evidence of Samantha's use of Therapeutic Enactment principles appears in her follow-up interview. In response to the same question about how Therapeutic Enactment will help in her recovery, she reasons:

Because I can keep applying it to my life in certain circumstances. I can do my own re-enactments. By myself. So if something devastating comes up or something I've done, then I can still go back to that and try go over it and through it...it helps me feel better whereas before I would never really look at things. I'd always just laugh them off and cover. I can look at them and it's O.K. and I can talk myself through it.

The theme entitled "Experiencing Affect" was made up of the sixth most frequently coded data from both interviews. This theme contained two direct quotes taken from the initial interview and five direct quotes taken from the follow-up interview (for a total of seven direct quotes). Data was coded under this theme if the client reported either experiencing affect or having a willingness to experience affect following intervention with Therapeutic Enactment.

In her initial interview, Samantha talked about how—prior to her experience with Therapeutic Enactment—she often felt uncomfortable when feelings arose. However, after the intervention, she seemed to be able to handle feelings better (perhaps even desiring them) asserting that, "...I am forcing myself to feel everything. And doing the enactment is feeling.

Anyway...and even today, no matter how it feels, if I sit through it, it is going to be O.K.

Afterwards, it is going to be O.K.”

In her follow-up interview, Samantha seemed to be willing to give herself permission to experience affect, which even appeared to have implications for her behaviour in a formal setting. She stated that before her Therapeutic Enactment she tended to:

Cover up all my feelings. Whereas I don't have to do that now because I don't have to show the whole world my feelings. I can feel my feelings. It's O.K. when I'm in a professional place, like the court case—they don't have to see that. I did learn that from the enactment.

The theme called “Resource Installation” was constructed of the seventh most frequently appearing coded data from both interviews. Three direct quotes were coded according to this theme in each of the initial and follow-up interviews (for a total of six direct quotes). Data was coded under this theme if the client reported using memories of her Therapeutic Enactment experience as a resource to help her in current or future life situations.

In her initial interview, Samantha referred to how she was impacted by the statements made by the jury members:

Because I've always heard I'm a good mom, but I never believed it. And I need a bunch of addicts sitting around saying, you know, you are. Addicts that aren't using. You know, because that's who I usually base my thoughts on because that's who I live with more or less. Well not with, but around me. And I go by what they said. So to hear them say to me, I'm O.K...just hearing everybody...what they had to say

from the jury. Because I know in my heart that that's me. And it made me feel that I can win and this is all worth it.

At her follow-up interview, it is clear that Samantha used her experience with Therapeutic Enactment as a resource at a recent court appearance:

I was a total different person after going through that than what I was before when I would go to court like a total nut and then after doing the Therapeutic Enactment, like I sat there and it was almost like [the therapist and auxiliaries] were sitting on either side of me still even though I was in a court room. So I was really mellow and quiet instead of shooting my mouth off like I always do, so it was good.

Later in the follow-up interview, Samantha reported how she used her experience with Therapeutic Enactment as a resource when she faced her ex-husband in the courtroom.

This time in court I looked him in the eye the whole time. I refused to look down. It was like [the therapist and auxiliaries] were sitting there still even though [the therapist and auxiliaries] weren't—in my mind I just portrayed that they were and so I found it helpful.

“Reviewing Videotape” was the name of the theme that was made up of the eighth most frequently coded data from both interviews. This theme contained one direct quote derived from the initial interview and three direct quotes derived from the follow-up interview, for a total of four direct quotes. Data was coded under this theme if the client reported viewing videotaped footage of the Therapeutic Enactment experience as being helpful or important.

From her initial interview, it appeared that Samantha appreciated having the chance to review her tape, analyze it, and learn more about herself. In discussing the analysis of her feelings after Therapeutic Enactment, she remarked:

The biggest—seeing exactly when things happened. Like what set them. What set off the feeling. Like being able to cry. And they could tell that I was just heart-broken and stuff at one point. And to be able to see what was said before that. That's what set it off.

Similarly, in her follow-up interview, Samantha reported reviewing the videotape as being a particularly helpful part of the intervention.

I think watching it after, what you did and how you acted and stuff. I guess that was the biggest thing for me. Doing the enactment is you have to do it in order to watch it, but I think watching the enactment after it was over, how much space before I saw it, I think that was good because you almost forget what you did and a lot of the times you didn't know what you were doing. So watching it was good for me because I didn't know how I reacted in real life. It's helpful because I had to go back to court, so I knew how to act in front of the judge.

The theme entitled "Behavioural Practice" was made up of the ninth most frequently coded data from both interviews. One direct quote was coded according to this theme in the initial interview, while two direct quotes were coded in this way during analysis of the follow-up interview (for a total of three direct quotes). Data was coded under this theme if the client reported that the Therapeutic Enactment session was a useful opportunity to behaviourally practice future life events or anticipated experiences.

After viewing the videotape of her Therapeutic Enactment session in her initial interview, Samantha recalled how she had been dissatisfied with her testimony at her real-life court appearance, saying, "I wrote it down, over and over, different things, but it never came out what I was saying, as strong as I wanted it to be." Samantha then criticized her testimony in her Therapeutic Enactment session, and identified this area as one needing further improvement, stating, "That's another thing I would like to work on is my speech to the judge."

It appears that the opportunity to practice her courtroom behaviour in the Therapeutic Enactment session actually helped Samantha in real-life. According to her follow-up interview, being in the courtroom was a critical part of her Therapeutic Enactment experience.

If I would have acted like I did before I would probably have lost. Whereas now, they are giving me a chance to prove myself. I probably would not have had that if I wouldn't have gone through that [Therapeutic Enactment] because I would have walked right back in there the way I used to be. This taught me that I can't do that again. When I'm in a professional place, like the court case, they don't have to see that [emotional upset]. I did learn that from the enactment.

In considering themes containing direct quotes derived exclusively from the initial or follow-up interviews, three embedded quotes will be noted here. First, the theme entitled "Importance of Auxiliaries" was made up of six direct quotes coded from the initial interview. Data was coded under this theme if the client reported that auxiliaries (i.e., other group members playing a role) were in some way important to her Therapeutic Enactment

session (such as by engendering a more genuine re-experiencing of the scene or by being influenced by comments made by the auxiliary).

Samantha implied that auxiliaries were important in producing a more genuine re-experiencing of the scene. For example, "It was almost like it was really happening. And a couple of times I would lose my concentration and I'd laugh, and it was like this is... And then when I got back to the jury, I was brought right back to being right in it again."

Secondly, the theme entitled "Witnessing Others' Enactments" was made up of four direct quotes derived from the initial interview. Data was coded under this theme if the participant reported some benefit from witnessing the Therapeutic Enactment sessions of other clients. Samantha was emotionally affected by witnessing others' Therapeutic Enactment Sessions and seemed to arrive at personal insights as well.

S: Every single other enactment brought me too my knees.

I: Because it brought up stuff for you?

S: Yeah. Oh, I always had my own show.

I: So watching other enactments has brought up a lot of your own issues.

S: A lot!

I: And has that been helpful?

S: Yes. Because a lot of stuff I didn't see I kind of see through that. Because I couldn't find me so I couldn't bring it up until you start watching someone else's and then it's like...whoa!! It's just amazing. I feel so much stronger because watching someone else, I can learn so much about myself.

Lastly, the theme entitled “Change in Self-Schema” was constructed of three direct quotes taken from the follow-up interview. Data was coded under this theme if the participant reported a change in self-perceptions of thoughts, feelings or behaviours.

In offering a rationale for her addiction, Samantha described how Therapeutic Enactment helped her to change the way she sees herself:

Because I lost my kids and then my kids hated me. Because of all this, I got high before. Now I don't have to because I don't think like that now and now I'm trying to be a good mom. I stay home and, yes, maybe I'm not perfect all the time, but at least I'm not bad.

Direct observation.

A review of Samantha's Therapeutic Enactment session yielded directly observed data that corroborates the findings from her interviews. For a full summary of her Therapeutic Enactment session, see Appendix H.

The most abundant observations relate to the theme entitled “Experiencing Affect.” The first sign of Samantha's experiencing of intense feelings occurred when she disclosed to the group that she had lost legal custody of her children. Samantha fought back tears as she told the group about her drive home from the courthouse, a journey she dreaded because she was forced to inform her children that they must live with their father.

Samantha also collapsed into tears during the re-creation of the custody battle, where she addressed the court and informed the witnesses about the impact of the previous decision (i.e., her loss of custody) on the children and her relationship with them. And although she regained her composure while confronting her ex-husband in court, she experienced intense

emotions once again after her ex-husband hurled insults at her to the point where he was removed from the courtroom.

Fortunately, Samantha's painful experience shifted to her expressing tears of joy when the jury returned with the verdict. As each juror addressed Samantha and awarded her custody of her children, her experience of intense affect was evident in the combination of tears, smiles, and whimpering sobs.

Later in the session, Samantha murmured, "I love you guys very much and want you to come home," in a shuddering voice with tears welling up in her eyes. It was clear that being re-united with her children and sincerely embracing them in her arms emotionally moved Samantha.

She also arrived at an important insight that supports the theme entitled "Self-Awareness" at the outset of the session. When she was introducing her ex-husband to the group and the therapist asked her to address her ex-husband directly, Samantha began to laugh nervously. The therapist pointed out her behaviour, which seemed out of place, and invited her to consider why she was laughing. Samantha pondered the situation and then announced that she thought she used laughter as a way of avoiding emotional upset. She also recalled how she had laughed in the courtroom while on the stand and realized how the judge's perception of her might have impacted her case. This awareness was important insofar as it motivated Samantha to change her behaviour in formal situations.

In addition, it was noted that some of Samantha's behaviours support the theme called "Sense of Empowerment." For instance, when the judge invited Samantha to respond to her ex-husband after he had assaulted her with a barrage of insults, she exclaimed, "You're not going to win...I'm gonna' get my life together and get a job!"

The therapist encouraged her to amplify her voice.

“You’re mean to [the children] and I’m not going to let you hurt them anymore! I’m a winner, I’m going to get my kids back!” she cried.

It was very evident at this point in the session that Samantha had moved from speaking with a meek voice to possessing a tone of conviction that challenged her ex-husband with a new sense of vigor.

Data that support the theme entitled “Increased Hope” was observed as well. For example, during the period while the court was in recess, Samantha appeared to become overwhelmed with a sense of renewed optimism, stating, “I think I won. It was so real! I think I won already! I want to get my kids back!” Her hopefulness about the future with her children resurfaced at the end of session, when she claimed, “This gives me something to hope for because there are decent people here. These people could have said I’m a phony, but they didn’t. They said I deserve my kids because I love them. I do have hope.”

The theme entitled “New Experience/Reality” also finds support in Samantha’s spontaneous shift into the processing phase at the end of the session where she began to compare her Therapeutic Enactment with her experiences in real life. She claimed that she achieved a sense of relief from the outcome of the session and experienced a feeling of calmness as a result of Therapeutic Enactment.

Lastly, her closing statements transcribed below support the themes entitled “Behavioural Practice” and “Resource Installation” respectfully.

Samantha: “It was a good test for real life,” (“Behavioural Practice”). “Every time I think of court I don’t have to get angry...especially with the ignorant things that my ex says,” (“Resource Installation”).

Documentation.

As part of the intake process at the Nechako Treatment Centre, each client must complete a portion of a referral information package. One of the questions in the package asks the client to indicate the behaviours or attitudes that he or she would like to change. Samantha's response to this question implied an important relationship between her addiction and her child custody battle:

Q: What are some behaviour/attitudes you would like to change?

A: Anger Management (denial) – anger towards my ex-husband – three-year court battle – childhood issues – negative attitude – self esteem issues.

Moreover, clients must keep a daily written journal of their experiences during their stay at the Centre as part of the program's requirements. To help stimulate introspection and reflection, the Centre provides paper on which the following questions are printed:

1. Today, what I learned about me was:
2. The feeling I had most often today was:
3. Today, what I really appreciate about myself is:
4. What I still need/want to work on is:

Four days before her Therapeutic Enactment session, Samantha stressed the importance of her children and the on-going custody battle. In her response to question number four, she wrote, "Anger, I have so much anger and resentment towards my ex-husband in regards to my children and what he's done, doing, and going to do. I can't afford to lose it in any way, shape or form."

On the day of her Therapeutic Enactment session, Samantha attached an additional page to her journal entry, thanking the counsellors of the Nechako Treatment Centre. To the

therapist who directed the Therapeutic Enactment, she wrote, "Thank you for your patience and knowledge, your soft, caring voice, and your energies and strengths that helped me walk through fire today and step in water. I will never forget where I went, I will live forever going there."

In describing the auxiliary who played her spouse in the Therapeutic Enactment Session, Samantha wrote, "...my spouse made it so comforting and gave me strength...[his] words will be in my head for a long, long time...I will never forget what that did for me."

Six days following her Therapeutic Enactment session, Samantha indicated the following areas for future work:

Is to be able to lift my head and speak with confidence and power when talking to my ex-husband. I also need to not only believe but to look believable when talking about my own good (good mom, good person). I pray if I keep practicing, I won't have to be in doubt. I'll know and I'll speak these words and it'll show on it's own.

In the last week of the program at the Nechako Treatment Centre, clients write a letter to their referral agents and provide a progress report. Samantha specifically mentioned how Therapeutic Enactment will help her cope, "The enactment work has given me one of my greatest coping skills that I will carry through my life and I will use on a daily basis so things don't become bigger or added to."

On another document (called Going Home Plans), Samantha wrote, "My goal regarding family/relationships is to repair the emotional effect I've had on my children and spouse." She outlined three steps that she would take to achieve those goals: (a) "I will always look at myself when I'm hyper or negative," (b) "I will practice good communication skills," and (c) "I will be accepting and forgiving."

Each client also completes an evaluation sheet and rates each component of the program along a four-point Likert scale (poor, fair, good, excellent). Samantha rated the Therapeutic Enactment intervention as "Excellent."

Finally, Samantha's primary counsellor at the Nechako Treatment Centre also made reference to her Therapeutic Enactment session in the discharge summary:

It was wonderful to witness the transformation that Samantha underwent after participating in Therapeutic Enactment and small group therapy work. What struck me in watching Samantha's journey of self-discovery here at the Centre was how she became visibly brighter, more relaxed, and seemed to possess a great deal more self confidence and self-worth after she was able to let go of the guilt and shame she carried from her past.

Summary.

From the three sources of data (Interviews, Direct Observation, and Documentation), it is obvious that the battle for the custody of her children played a predominant role in Samantha's life, and consequently, her addictive behaviours.

The findings of this case study reveal nine recurrent themes that suggest that Therapeutic Enactment was helpful for Samantha (i.e., Self-Awareness, New Experience/Reality, Corrective Emotional Experience, Increased Hope, Applying Therapeutic Enactment Independently, Experiencing Affect, Resource Installation, Reviewing Videotape, and Behavioural Practice).

Data from direct observation indicate that Therapeutic Enactment helped Samantha deal with this issue by (a) underscoring the relationship between the custody battle and her

addiction, (b) raising her awareness about how others (especially the judge) perceive her, (c) facilitating the expression of affect, (d) increasing her sense of empowerment and assertiveness, (e) providing opportunity for behavioural practice, (f) permitting the experience of an alternate reality, and (g) increasing her sense of hope.

Document evidence also imply that the child custody battle was related to her addiction and that Therapeutic Enactment was helpful by raising her level of self-awareness, by focusing her on improving her communication skills, and by providing her with the opportunity to behaviourally practice for her forthcoming court appearance.

Participant Number 2: "Gloria"

Interview data.

The first column in Table 2 (below) displays the thirteen themes that were derived from the initial interview with Gloria. A brief definition of each theme appears in the cell that contains the title of the theme. The frequency of coded data that make up each theme appears in the second column along with short examples of direct quotes.

Nine themes were derived from the follow-up interview with Gloria. Five themes overlap with the themes derived from the initial interview (and are defined in the first column), while the other four themes are defined at the bottom of the first column. The frequency of coded data from the follow-up interviews appears in the third column along with short examples of direct quotes. The fourth column displays the total frequencies of coded data from both interviews that make up each theme.

Table 2: Thematic Results of Interviews

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Self-Expression <i>Definition:</i> Client reports expressing previously suppressed thoughts or feelings as a result of Therapeutic Enactment intervention.	Frequency: 18 Direct Quotes <i>Examples:</i> "It brought out a lot of feelings. Feelings that I knew were there but I couldn't deal with them. And now I can deal with them. Letting out all...crying out...finally after twenty years of burying it down deep inside I am letting it out. Finding relief I think. Letting all of that pain out inside of me."	Frequency: 5 Direct Quotes <i>Examples:</i> "Actually talking to someone about it. All these years I've kept it in. People were aware but I was too ashamed to talk about it. I was too ashamed to bring it up. The whole enactment helped. Like the talking, yelling and screaming. It wouldn't have been the same if I wasn't allowed to do that. It wouldn't have been helpful at all and that was really helpful."	23
Corrective Emotional Experience <i>Definition:</i> Client reports change in emotional state by re-experiencing difficult life situation(s) and working through, letting-go or forgiving previous emotional wounds.	Frequency: 13 Direct Quotes <i>Examples:</i> "You know I could say well, this happened to me and I can accept it...and you know...possibly forgive those who are still alive... Confronting the past...and letting go of all of the pain and suffering."	Frequency: 10 Direct Quotes <i>Examples:</i> "Letting all the skeletons out and forgetting them. You know, somebody bottled some stuff up my back for such a long time, and when they did the enactment it was like a relief...a heavy block is lifted off your shoulders and you feel so much lighter and so much happier. You've dealt with that part. I don't have to do that [drinking/drugging] to hide what has happened to me. It's all out now and there is no reason for me to be using."	23
Change in Self-Schema <i>Definition:</i> Client reports a change in self-perceptions of thoughts, feelings, or behaviours as a result of Therapeutic Enactment.	Frequency: 11 Direct Quotes <i>Examples:</i> "I am a survivor now. A survivor of sexual abuse, and life can go on. You can go out there and be happy and not pretend."	Frequency: 4 Direct Quotes <i>Examples:</i> "I didn't have to feel so low about myself. I found some new spirit that's happy. I'm more at peace with myself. I can accept it. I'm more polite, happier, not so angry anymore."	15
Working Through Issues <i>Definition:</i> Client reports that Therapeutic Enactment facilitated ability to engage in psychotherapeutic endeavors.	Frequency: 10 Direct Quotes <i>Examples:</i> "...and facing it—you know— it really helped me. It's so positive.... dealing with it, facing it, and doing something about it."	Frequency: 4 Direct Quotes <i>Examples:</i> "Just dealing with it and confronting the weight that I had. Just confronting that ... Confronting all the stuff that I've been bottling up. The sexual abuse and all the abuses. It's a good thing. It is. It's very helpful. People who don't know how to deal with their problems that they're having...it helps them deal with the problems that they're having. Just by confronting it..."	14
Experiencing Affect <i>Definition:</i> Client reports experiencing affect or having a willingness to experience affect as a result of Therapeutic Enactment.	Frequency: 3 Direct Quotes <i>Examples:</i> "It really brought me in touch with my feelings..."	Frequency: 1 Direct Quote <i>Examples:</i> "I am more aware of my feelings..."	4

Table 2: Thematic Results of Interviews Continued

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Importance of Auxiliaries <i>Definition:</i> Client reports that auxiliaries (i.e., other group members playing a role) were in some way important to her Therapeutic Enactment session.	Frequency: 9 Direct Quotes <i>Examples:</i> "Because I had everybody there, everybody here as support. I knew I was safe and that I could let all of this out and not feel ashamed. I could trust..."		9
Self-Awareness <i>Definition:</i> Client became more aware of self or behaviours as a result of Therapeutic Enactment.	Frequency: 8 Direct Quotes <i>Examples:</i> "I still carried that stuff with me, not knowing what I was carrying... but if I didn't do what I did [i.e., Therapeutic Enactment] I still wouldn't have found myself inside. It...helped me remind myself that it wasn't my fault."		8
Increased Hope <i>Definition:</i> Client Reports a renewed sense of hope following Therapeutic Enactment intervention.	Frequency: 6 Direct Quotes <i>Examples:</i> "It helped me learn that I could go on and uh, get on with my life. I am more positive about my life now."		6
Reviewing Enactment Videotape <i>Definition:</i> Client reports viewing videotaped footage of Therapeutic Enactment session as being helpful.	Frequency: 4 Direct Quotes <i>Examples:</i> "To remind me that I did something about it. I can look at it and sit here and know that I wasn't in the wrong. So it is actually reminding me that I don't have to feel dirty inside."		4
Cognitive Shift <i>Definition:</i> Client reports a change to entrenched cognitions or relief from rumination as a result of Therapeutic Enactment.	Frequency: 2 Direct Quotes <i>Examples:</i> "And not to look at them with hate in my eyes and want to kill them."		2
Memories Invoked <i>Definition:</i> Client reports that Therapeutic Enactment evoked memories that led to helpful insights.	Frequency: 2 Direct Quotes <i>Examples:</i> "Just remembering one incident just opened the book to all of them."		2
Importance of Symbolic Representation <i>Definition:</i> Client reports that the symbolic representation of people places or things enhanced the benefit of Therapeutic Enactment.	Frequency: 1 Direct Quote <i>Example:</i> "Representing each person helped too because I couldn't have, you know, do that to a person and to tell them how they made me feel and stuff...because what I did was hit them with the [foam] bat and stuff...and I didn't want to do that to, you know, a person standing in for the... So the chairs were a good help."		1
Value of New Therapy Technique <i>Definition:</i> Client reports that Therapeutic Enactment was particularly helpful because it was a new and unfamiliar technique.	Frequency: 1 Direct Quote <i>Examples:</i> "It was all very helpful to me because...I could never have thought about that until the therapy, you know, the re-enactment stuff...I couldn't have thought of that to help me deal with my pain and suffering."		1

Table 2: Thematic Results of Interviews Continued

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Behavioural Change <i>Definition:</i> Client reports experiencing behavioural changes as a result of Therapeutic Enactment intervention.		Frequency: 5 Direct Quotes <i>Examples:</i> "I didn't come across...how I used to carry all this stuff around with me and would just snap and things that I didn't want to hear. After the enactment, it was just different. It's a good thing because you don't want to go out and drown your sorrows in all the drugs and alcohol to forget about what happened 'cause you now have dealt with it."	5
Importance of Experiential Component <i>Definition:</i> Client reports that the experiential component of the Therapeutic Enactment intervention was helpful.		Frequency: 3 Direct Quotes <i>Examples:</i> "Sitting and talking about something, is not the same unless you show them how really bad it affected you. And just showing them and doing what I did, it's totally different from sitting and talking because sitting and talking seems like it's just that..._Like if you didn't have chairs or the bat or anything, I don't think it would have affected me the way it had. It wouldn't have been the same. And that was very helpful."	3
Positive Outlook <i>Definition:</i> Client reports experiencing a more positive outlook as a result of Therapeutic Enactment.		Frequency: 2 Direct Quotes <i>Examples:</i> "I'm more positive. Not so negative anymore. Positive about life in general. For example, keeping your chin up. Just being positive about every day life. More optimistic."	2
Improved Interpersonal Interaction <i>Definition:</i> Client reports improved interpersonal interaction as a result of Therapeutic Enactment.		Frequency: 1 Direct Quote <i>Examples:</i> "...and how I treat people. I'm not as cold as I used to be."	1

The theme entitled "Self-Expression" was made up of the most frequently coded data from both interviews. Eighteen direct quotes were coded according to this theme in the initial interview, while five direct quotes were coded this way during the analysis of the follow-up interview (for a total of 23 direct quotes). Data was coded under this theme if the client

reported expressing previously suppressed thoughts or feelings as a result of her Therapeutic Enactment experience.

Gloria initially described the benefit she felt by having the opportunity to express feelings that she had buried for a long time:

Just standing there telling them...giving their shit back to them...telling them how they made me feel and telling them that I'm not carrying their stuff around with them...and that they should take it back...and telling them that they are not going to affect my life anymore.

I: And what was the benefit to that Gloria?

G: A big weight off my shoulders! Now I can smile! It was a real good experience. It brought up a lot of pain and I cried pretty well throughout the whole thing...you know...it did a lot of good for me—a lot of good.

During her follow-up interview, she also talked about the value of expressing her dormant feelings:

Actually talking to someone about it. All these years I've kept it in. People were aware but I was too ashamed to talk about it. I was too ashamed to bring it up. The whole enactment helped. Like the talking, yelling and screaming. It wouldn't have been the same if I wasn't allowed to do that. It wouldn't have been helpful at all and that was really helpful.

The theme labeled "Corrective Emotional Experience" was made up of the same number of coded data as the "Self-Expression" theme. From the initial interview, however, there were 13 direct quotes coded according to this theme, while 10 direct quotes from the follow-up interview were coded this way (for a total of 23 direct quotes). Data was coded

under this theme if the client reported a change in her emotional state as a result of re-experiencing difficult life situation(s) and working through these event(s) during the Therapeutic Enactment session. The change in emotional state can refer to the client achieving a feeling of peace, a sense of forgiveness of people or events, or letting go of previous emotional wounds.

For example, Gloria discussed how Therapeutic Enactment helped her to forgive her father and described how she felt afterward:

I rejected my father...it was a sign of relief. Where I could possibly learn to forgive him and forget about it so I can get on with my life and be happy and not have so much anger in me. Because I think that letting all of that go was actually a relief for me. To let go of all of the pain, the anger, the shameful feeling, the unworthy feeling.

Similarly, in her follow-up interview, Gloria disclosed how she felt relieved from her Therapeutic Enactment experience:

Letting all the skeletons out and forgetting them. You know, somebody bottled some stuff up my back for such a long time, and when they did the enactment it was like a relief...a heavy block is lifted off your shoulders and you feel so much lighter and so much happier. You've dealt with that part. I don't feel hurt. I don't feel all that heavy weight on my heart. It's a good feeling.

The theme called "Change in Self-Schema" was made up of the second most frequently coded data from both interviews. Eleven direct quotes coded according to this theme were derived from the initial interview, while four direct quotes were coded in this way from the follow-up interview (for a total of 15 direct quotes). Data was coded under this theme if the client reported a change in self-perceptions of thoughts, feelings or behaviours.

Gloria explains how she saw her self differently following her Therapeutic Enactment session in her initial interview:

You know, I don't have to feel sick or anything or feel dirty. You know about things that happened to me in my life. I can...say, "I'm fine, I didn't do it. It wasn't me"...instead of me carrying the shame and guilt. I can't believe I am sitting here today, clean and sober, after all I have gone through. It just proves that I am a survivor. A survivor of sexual abuse.

Gloria offered several more accounts of how her self-perception had changed as a result of her Therapeutic Enactment session. For example, in her follow-up interview, she remarked, "I didn't have to feel so low about myself. I found some new spirit that's happy. I'm more at peace with myself. I can accept it. I'm more polite, happier, not so angry anymore."

The theme entitled "Working Through Issues" contained the third most frequently coded data from both interviews. The initial interview produced ten direct quotes to support the theme while four quotes were coded according to this theme from the follow-up interview (for a total of 14 direct quotes). Data was coded under this theme if the client reported that Therapeutic Enactment promoted the exploration of life events or psychological issues. This theme also refers to the client's action of confronting people or events in her life during Therapeutic Enactment.

Gloria described how Therapeutic Enactment helped her to do something about the issues in her life that had been plaguing her:

I had to confront those who have hurt me and uh, tell them, you know, that I'm giving their shit back to them and that I'm not taking this anymore. So I confronted my

abusers. Well now I confronted it...dealt with it...you know...This was part of my life that happened. I am facing reality.

Data that supports this theme also emerged in her follow-up interview, when Gloria stated:

Just dealing with it and confronting the weight that I had. Just confronting that ...confronting all the stuff that I've been bottling up. The sexual abuse and all the abuses. It's a good thing. It is. It's very helpful. People who don't know how to deal with their problems that they're having...it helps them deal with the problems that they're having...by confronting it.

The theme entitled "Increased Hope" was made up of the fourth most frequently coded data from both interviews. Six direct quotes from the initial interview and two direct quotes from the follow-up interview were used to construct the theme, for a total of 8 direct quotes. Data were coded under this theme if the client reported a renewed sense of hope following her Therapeutic Enactment Session.

In her initial interview, Gloria stated, "I can look forward to my life...I can go out there and actually find some happiness...and move on in my life with peace and honesty."

Gloria went on to say in her follow-up interview that, "I'm more positive. Not so negative anymore. Positive about life in general. For example, keeping your chin up. Just being positive about everyday life. Things that you do and what happens. More optimistic."

The theme that was made up of the fifth most frequently coded interview data was entitled "Experiencing Affect." Three direct quotes were coded according to this theme in the initial interview, while one direct quote was coded this way during the analysis of the follow-up interview (for a total of four direct quotes). Data was coded under this theme if the client

reported either experiencing affect or having a willingness to experience affect following intervention with Therapeutic Enactment.

It is clear that Therapeutic Enactment impacted Gloria at an affective level from her comments in the initial interview:

I actually feel. Whereas before I was numbing myself up and you know, the feelings were there but, you know, I'd just push them down deeper. And now I am actually feeling... Whereas before, I just, one after another, I push all the way down and bury it.

Data from her follow-up interview confirm that Therapeutic Enactment brought about helpful change with regard to affect, as Gloria declared, "I am more aware of my feelings..."

We will now consider some examples of data that emerged exclusively from either the initial or follow-up interviews. For instance, the theme entitled "Importance of Auxiliaries" consists of nine direct quotes taken from the initial interview. Data was coded under this theme if the client reported that auxiliaries (i.e., other group members playing a role) were in some way important to her Therapeutic Enactment session (such as by engendering a more genuine re-experiencing of the scene or by being influenced by comments made by the auxiliary).

When asked how other people participated in the process of her Therapeutic Enactment session, Gloria replied:

Oh, a big part—a big part. I couldn't have done it without those roles being there. Like I couldn't have done it, you know, by myself. I know I couldn't have. And with them and with all of their support there...that's how I had the strength to stand up and do it and to fight.

As another example of how auxiliaries were helpful, Gloria described how a group member playing her older brother allowed her to proceed in the session:

He was really good...he always made me feel special. And actually being there saying it was him...it just gave me the courage to go on with it. He always made a point to let me know how important I was. He always showed that he cared.

The theme entitled "Self-Awareness" was supported by eight direct quotes derived from the initial interview. Data was coded under this theme if the client reported becoming more aware of herself and/or her behaviours as a result of her Therapeutic Enactment session.

Gloria seemed to reach a profound self-awareness about the relationship between attributing self-blame and addictive behaviours:

I could sit there and know it wasn't my fault. Because it wasn't! You know, I didn't do anything bad. My whole life I was down and out and feeling that, you know, what they did to me was my fault...that's how I was feeling. That's why I was always drugging and using alcohol and that.

She continued to explain how Therapeutic Enactment helped her to reach higher levels of self-awareness when she claimed:

G: It [Therapeutic Enactment] helped save my life.

I: How?

G: Because it gave me understanding. It reminded me what I was bearing inside, so I blacked it out. It helped me understand why I turned to alcohol and drugs. And now I don't need to cover...I don't need to put up a façade, because of all of that pain and anger and suffering.

I know it's already helped me because I found the answer to what was driving me...or helped me to find the answer to what was driving me to alcohol and drugs. Covering up that shame, that guilt, that dirty feeling.

The theme entitled "Increased Hope" consisted of six direct quotes taken from the initial interview with Gloria. Data was coded according to this theme if the client reported experiencing a renewed sense of hope following her Therapeutic Enactment session.

Some examples of Gloria's statements to this effect were:

Gloria: "It helped me learn that I could go on and get on with my life...I am more positive about my life now."

Gloria: "I can look forward to my life...I can go out there and actually find some happiness."

The theme entitled "Reviewing Videotape" was made up of four direct quotes taken from the initial interview. Data was coded under this theme if the client reported viewing videotaped footage of the Therapeutic Enactment experience as being helpful or important.

After viewing the videotape of her session, Gloria went into great detail of how the intervention helped her to effect change:

It reminds me that I can let it go. It reminds me that I don't need this, you know, I am actually saying goodbye to all of those sick men. Saying goodbye to all those...all those...all those...uh, saying goodbye to all of the stuff that happened to me. You know, watching it now...and I won't ever have to deal with it because I have now dealt with it and let it go. I may not like what I am seeing, but you know, that's the reality...that it happened and I have to accept it and move on with my life. It has brought peace and harmony into my life.

They and my dad just drove me right into alcohol and drugs. After they did that to me I, you know, I just wanted to drown myself more and more. I didn't have the courage or the guts to commit suicide myself so he could feel the dirty shame. Like he should have been feeling dirty and shame, not me. You know I was drinking and drugging up...and I was making myself suffer where he should have been suffering. I couldn't bring myself to commit suicide after what he did to me. So I drowned myself in alcohol and drugs hoping one day that I would do too much and that I would end my life. Because I couldn't tell anybody. I couldn't tell anybody about what he did to me because he was, you know, we don't get along. My cousin is on his side of the family anyway and it would just bring...it just brought more turmoil to my life. It would have just thrown me right over the edge. It was bad enough as it was. That's why I had to keep it in and deal with it. But I wasn't dealing with it because I was just numbing myself up.

The theme entitled "Behavioural Change" consisted of five direct quotes taken from the follow-up interview. Data was coded under this theme if the client reported behavioural changes as a result of her experience with Therapeutic Enactment.

Gloria explained how Therapeutic Enactment helped her to change her behaviours by saying, "It's a good thing because you don't want to go out and drown your sorrows in all the drugs and alcohol to forget about what happened 'cause you now have dealt with it."

Finally, the theme entitled "Importance of Action/Experience" was constructed from three quotes in the follow-up interview. Data was coded under this theme if the client reported that the experiential component of the Therapeutic Enactment intervention was helpful.

Gloria discusses the value of participating in this novel intervention, stating that her experience was quite different than what she had been involved in previously.

Sitting and talking about something, is not the same unless you show them how really bad it affected you. And just showing them and doing what I did, it's totally different from sitting and talking because sitting and talking seems like it's just that...Like if you didn't have chairs or the bat or anything, I don't think it would have affected me the way it had. It wouldn't have been the same. And that was very helpful.

Direct Observation.

Data that support the findings from Gloria's interview were derived from direct observations of her Therapeutic Enactment Session. For a full summary of Gloria's Therapeutic Enactment session, see Appendix I.

There were several direct observations of Gloria's behaviours during her Therapeutic Enactment session that support the theme entitled "Self-Expression." At the beginning of the enactment phase of the session, Gloria was sobbing and was hardly comprehensible as she described the context of her enactment for other group members. By the time she came to express herself and confront her abusers, however, she was visibly more confident and spoke in a strong voice.

For example, toward her first abuser she exclaimed, "Uncle, you are the one that started it all. You were always trying to control me. I hate you even though you're dead! You abused my sister too! Now, I'm giving all of that back to you!"

After striking her uncle (symbolized by a chair) with a foam baton, she cried, "You hurt me!" and then broke down in tears.

Gloria openly expressed herself again when she confronted her second abuser.

I was just a kid! I didn't even know who you were! You took it upon yourself to treat me like I was an adult—you took advantage of me because you are a sick dog! You are a sick person and I'm bringing you here today to tell you that I'm standing up to you and I'm not going to take it anymore!

Gloria's self-expression was also directly observable as she confronted her third abuser.

"You made me lose trust in you, I looked up to you, I thought you wouldn't hurt me. You didn't until that night. You are just as sick as Uncle! (Later, after expressing more emotion toward the abuser, she breaks down and weeps).

Toward her fourth abuser Gloria cried:

You let me down! You were sober and you were doing it when my Uncle was drunk. It's not justifiable what you did to me! I trusted you...I used to play with you when I was a kid. Then you took it upon yourself to get your jollies playing games with my emotions and me! You touched me the way you did. You thought I was having fun but I hated you for it. And you deserve it. Now I'm telling you that I'm giving it back to you. I'm not taking it no more, not carrying it around! (She then broke down again into a crying spell).

Similarly, Gloria expresses her inner thoughts and feelings toward her fifth abuser.

I'm here to tell you that I'm not going to take your shit anymore. I was just a kid...You fooled around with me like I was a doll...You didn't care how I felt. I didn't do nothing wrong, it was you! You knew better because you are older than me.

And you still hurt me. Why don't you just leave me and get out of my life! (Gloria wept for a few minutes).

As she approached her sixth abuser, Gloria began by speaking in a medium volume but soon was shouting, "You were my brother! You were supposed to protect me and not use me like that! What you did to me was wrong, very wrong...you took away my innocence, you hurt me very badly! I was scarred of you all of my life because of that!"

By the time she came to confront her seventh abuser, her voice softened, "You were my family, I looked up to you...I thought you were there to protect me but instead you took my innocence away. I lost trust in you because you hurt me really bad. I was just a kid. I didn't know any better. You took advantage of that! I used to love you and look up to you like my brother. Then you took all of that away from me just that one night!"

Finally, Gloria's self-expression was directly observable as she confronted her eighth abuser.

"I am bringing you here for a reason. You are a sick, demented, sick person. I'm your own damn daughter, the only daughter you've got and you took advantage of me!

Like everybody in my family almost! And you're my father! How could you do that to me? I lost my father because I'm not your daughter anymore. You weren't there to protect me—you hurt me. You hurt me the most...you're a dirty dog!

There were many direct observations of Gloria's behaviour that support the theme entitled "Change in Self-Schema." For example, after her emotional self-expression toward her first abuser, she seemed to reject her old way of taking the abuse and reclaimed herself with a sense of empowerment: "I'm not taking it anymore! I'm not carrying it anymore! I don't need it! I'm taking my life back!"

Similarly, she appeared to change her view of herself as going from helpless child to empowered woman when confronting her second abuser: "I'm going to give it back to you because you took my innocence away...I was just a kid, I was just a little girl! Now I'm a woman and I'm going to give it back to you!"

Toward the same abuser, she made comments that indicate that she shifted her self-schema to place blame for the abuse in the hands of the abuser rather than herself: "You're going to have to live with it now, not me! I'm not going to carry your B.S. around anymore!"

As she confronted her third abuser, Gloria's self-schema appeared stronger and she shifted the placement of blame once again:

"I'm a strong woman now, and I don't need it anymore. I'm giving it back to you so you can carry the guilt and shame around. Because you are the one who should be feeling guilty and shameful—not me! I didn't do anything wrong!"

Later during the confrontation of her third abuser, she took a stand and refused to allow this person or anyone else to harm her again: "You're not going to hurt me anymore! I'm not letting anybody hurt me anymore! I've suffered for twenty years and I'm not going to anymore! I'm telling you now I'm taking my life back!"

Finally, her change in self-schema was observed when she viewed herself as a protector rather than a victim and considered pressing charges against one of her abusers for the first time: "I can protect my niece that way—I will press charges—I'm looking out for her. I will have you arrested!"

There were also three direct observations of Gloria's Therapeutic Enactment session that support the theme entitled "Importance of Experiential Component." First, in corroboration with her interview data, Gloria was observed releasing an enormous amount of

energy and rage against her first abuser when she struck a chair (symbolizing the abuser) repeatedly with a foam baton. Secondly, she repeated her actions with the second abuser, although this time she was less aggressive (as if she had released the majority of her negative energy on the first abuser). Thirdly, Gloria approached her fourth abuser with much less intensity (only lightly knocking the chair over with her foot), also indicating that her aggressive energy had diminished.

With regard to the theme entitled "Importance of Auxiliaries" taken from her interview data, Gloria was observed to be visibly moved at the end of her Therapeutic Enactment session when all other group members gathered around her and touched her with the intent to convey support. Gloria wept as the mass of bodies swayed. She then gave out a huge sigh. The session ended with the clients spontaneously lining up to hug her individually.

Documentation.

In her referral package, Gloria wrote that she had a "really bad attitude" that she wished to change. She also mentioned that she experienced mood swings and desired to be "happy, the way I was before." Her statements on this part of the referral package indicate that Gloria saw herself as a happier person at some point, perhaps before some event or trauma occurred in her life.

Evidence that Gloria had experienced trauma that led to drug and alcohol abuse can be found in the treatment goals that she designed for herself. At the beginning of the second week of their stay, each client creates a set of written goals for the therapy so that progress can be self-assessed at the end of the program. Two of the three goals that Gloria set out for

herself refer to the sexual and emotional abuse she suffered at the hands of men. Her goals are reproduced below in her own words:

2) "I'd like to talk about the sexual abuse from my childhood and my dad as a young adult, [and] the physical abuse from my ex-boyfriend."

3) "I need to express my feelings without anger and have the courage to talk to people without alcohol and drugs because I was hurt and abused by men."

Gloria wrote extensively about her experience with Therapeutic Enactment in her daily journal. Before her own Therapeutic Enactment session, Gloria commented on the impact of another client's work and seemed motivated to participate in the intervention as a result of being a witness:

2. The feeling I had most often today was:

Gloria: "First, I was really sad, mixed emotions today, happy, sad, hurt, then angry and scared. Carrie's enactment brought me to when I was assaulted, so it hurt. Not a good feeling. So I want to put that behind me."

On the day of her Therapeutic Enactment session, Gloria was quite prolific upon reflecting on the impact of her work. The journal entry is reproduced below in its entirety.

1. Today, what I learned about me was:

Gloria: "That all the pain I was carrying was not mine. That I can go on with life loving myself truly because I deserve the best. Respect for myself always."

2. The feeling I had most often today was:

Gloria: "Being free. I've released most of the pain I was running from. Now I'm strong and I feel really good. Happy, not sad. Let a lot of things out. So I do not need to carry it anymore."

3. Today what I appreciate most about myself is:

Gloria: "That I stood up to my childhood, let it go for the first time in twenty years. I took that part of my life back. It feels so good to release and be free from it. Even though I had just realized just twenty-four hours ago what I had to do, it's not blacked out anymore! It's gone!"

4. What I still need/want to work on is:

Gloria: "Physical abuse, being hurt, confronting ex's about how I let them ruin my life, let them bring me down. To stand up for me and my rights to say you will not hurt me anymore—I won't let them."

A few days before the end of the program, Gloria wrote that she had successfully addressed the behaviours and attitudes that she outlined in her referral package. For example, she states that she learned, "...that I'm very happy and proud of the hard work I've done here. It was the best time I've had clean and sober. Happiness and joy!" Having said that, Gloria was still realistic about the need for on-going work, writing, "I still need to work on my sobriety and staying clean and sober. I love it! It feels really great to have a positive attitude and to be assertive."

In addition, in the letter she wrote to her referral agent, Gloria briefly mentioned her Therapeutic Enactment session and how it helped her to address issues from her past:

I'm sure I devoted myself very well in the large group and small group. Even in the enactment therapy I dealt with the most difficult part of my life, which I had blacked out until one night. I remembered everything that I buried deep inside and totally forgot about. So I finally put a closure to that part of my life...In this program I

worked on my sexual abuse that happened to me while I was growing up. I finally faced it, now I don't need to carry that stuff with me anymore.

In her discharge summary, Gloria's primary counsellor also wrote about the courage it took for Gloria to face her past in her Therapeutic Enactment session and how she chose to adopt the stance of being a survivor rather than a victim:

Gloria also served as a positive role model to others through her courage to participate in Therapeutic Enactment, her conscious choice to be a survivor, and her willingness to assist other group members in their therapy work. Gloria was called on more than once to play a role in the Therapeutic Enactments of other group members and she did so without hesitation.

Lastly, on the program evaluation sheet where clients rate each component of the program along a four point Likert scale (poor, fair, good, excellent), Gloria rated the Therapeutic Enactment intervention as "Excellent."

Summary.

It is clear from the three sources of data (Interviews, Direct Observations, and Documentation) that sexual abuse in Gloria's past impacted her significantly and also influenced her addictive behaviours. First, five recurrent themes emerged as findings from this case study which illustrate how Therapeutic Enactment was beneficial for Gloria (i.e., through Self-Expression, Corrective Emotional Experience, Change in Self-Schema, Working Through Issues, and Experiencing Affect). Secondly, direct observations suggest that Therapeutic Enactment enabled Gloria to a) express long held feelings, b) produce a shift in the way she perceived herself, c) to face her past by experiencing it in the here and now,

and d) confront her abusers in an environment of support. Thirdly, document data also confirm that Therapeutic Enactment was instrumental in helping Gloria address difficult events from her past and to gain a sense of closure to this period in her life.

Participant Number 3: "Carrie"

Interview data.

The first column in Table 3 (below) displays the ten themes that were derived from the initial interview with Carrie. A brief definition of each theme appears in the cell that contains the title of the theme. The frequency of coded data that make up each theme appears in the second column along with short examples of direct quotes.

Seven themes were derived from the follow-up interview with Carrie. Six themes overlap with the themes derived from the initial interview (and are defined in the first column), while the seventh theme (Improved Interpersonal Interaction) is defined at the bottom of the first column. The frequency of coded data that make up the themes appears in the third column along with short examples of direct quotes from the follow-up interviews. The fourth column displays the total frequencies of coded data from both interviews that make up each theme.

Table 3: Thematic Results of Interviews

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Self-Awareness <i>Definition:</i> Client became more aware of self or behaviours as a result of Therapeutic Enactment.	Frequency: 10 Direct Quotes <i>Examples:</i> "It's the first time...like I had been digging and digging trying to find where my fear and my anger came from. And that's the first time that I've been able to actually see that—was at the enactment. Because of that fear of being hurt all of the time...seems to be what it was. And with my dad...it was the fear of men. I've never been able to have a long-term relationship ever in my life. Yeah. It has helped me to understand. Now I know why and what I have to do about it."	Frequency: 12 Direct Quotes <i>Examples:</i> "Yeah that reenactment really opened my eyes to my life! Of how much that little scene really affected me. That whole enactment helped me to understand emotions and how much that fear of violence can control a person's whole life. That's what I went through and how it stopped me from being...I'm not saying I am a bad person, but I was a mean person. I never allowed people to get close to me. You see, because before that, jealously controlled me and I didn't even realize it."	22
Experiencing Affect <i>Definition:</i> Client reports that experiencing affect or willingness to experience affect as a result of Therapeutic Enactment.	Frequency: 7 Direct Quotes <i>Examples:</i> "Just talking about it I found that it didn't...I didn't get right in touch with my feelings. But walking through it...re-enacting it helped me to really get in touch with my feelings...my fear and the trauma of what happened to me...it definitely helped me get in touch with my feelings. You see I've always been...I didn't have feelings...I just shut it all down, stayed there...like after I did that re-enactment, I was able to actually feel things and understand and cry."	Frequency: 4 Direct Quotes <i>Examples:</i> "It helped me to deal...like to understand that it's O.K. to feel... By allowing myself to feel, cause I know before I didn't feel."	11
Change in Self-Schema <i>Definition:</i> Client reports a change in self-perceptions of thoughts, feelings, or behaviours as a result of Therapeutic Enactment.	Frequency: 2 Direct Quotes <i>Examples:</i> "I think once I finished the re-enactment...it's like I changed. There was a change within me. And it's still there today. I don't get all bent out of shape and everything anymore. I am more accepting with a lot of things."	Frequency: 8 Direct Quotes <i>Examples:</i> "I used to walk around so rigid. You know now, I am more relaxed. Now I am hugging, I give hugs. Like I can be that loving caring person."	10
Self-Expression <i>Definition:</i> Client reports increased ability to express thoughts or feelings as a result of Therapeutic Enactment intervention.	Frequency: 3 Direct Quotes <i>Examples:</i> "I talk about what people do and how it makes me feel. And I let them know. I'll allow myself to share a little bit of what I have to offer to people in recovery...I am going to share my story with them."	Frequency: 5 Direct Quotes <i>Examples:</i> "Before I never shared my feelings much. Before I did that reenactment. ...it's O.K. to feel and to share my feelings. That I don't have to keep them to myself. I can talk to other people—and people know me."	8

Table 3: Thematic Results of Interviews Continued

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Resource Installation <i>Definition:</i> Client draws upon memories of Therapeutic Enactment as a resource that helps with current or future life situations.	Frequency: 2 Direct Quotes <i>Examples:</i> "I just think about what it did to me as a child to me and drinking. What alcohol did to me."	Frequency: 2 Direct Quotes <i>Examples:</i> "Well I always go back and think when my walls start coming up and my fears...I think about that little girl. You know. It helps me not to have the walls, it helps me to share...and that reenactment...I think about it in my relationships, and my life, trust and communication...I keep thinking about it."	4
Corrective Emotional Experience <i>Definition:</i> Client reports change in emotional state by re-experiencing difficult life situation(s) and working through, letting-go or forgiving previous emotional wounds.	Frequency: 1 Direct Quote <i>Examples:</i> "And going back and looking at it I think it helped me to release and realize that I am not that little girl that has all of that fear. And that I am an adult now."	Frequency: 2 Direct Quotes <i>Examples:</i> "It is fine to talk about it, but to actually go through it and relive it as an adult allowed me—that little girl—to let go of that fear—that little girl in me."	3
Insight <i>Definition:</i> Client reports arriving at some cognitive insight as a result of Therapeutic Enactment.	Frequency: 3 Direct Quotes <i>Examples:</i> "I am glad that I finally went through it to help me to understand what the impact that alcohol has on relationships, the violence that it brings out in people, the vulnerability that a woman has when under the influence...the rage of the jealousy and insecurities that come along with it. Because I never seen any of that with my dad before."		3
Importance of Auxiliaries <i>Definition:</i> Client reports that auxiliaries (i.e., other group members playing a role) were in some way important to her Therapeutic Enactment session.	Frequency: 3 Direct Quotes <i>Examples:</i> "They played the roles really well! Yeah. Especially who played my mom and dad...I think that's what helped really bring me back there."		3
Increased Coping Skills <i>Definition:</i> Client reports that she is able to handle stressful life situations better as a result of Therapeutic Enactment.	Frequency: 1 Direct Quote <i>Examples:</i> "And I don't feel like I have to run. Every time I was faced with anything to do with fear and anger or, not so much anger but fear, I would run. I would just leave the whole situation without looking at it in the face. Now I find I'm starting to deal with the situations in the face."		1
Preparation for Future Intrapersonal Work <i>Definition:</i> Client reports that Therapeutic Enactment prepared her for further psychotherapeutic exploration and personal growth work.	Frequency: 1 Direct Quote <i>Examples:</i> "...after that I was able to get in touch with everything else that followed...like dealing with all of the death. The deaths in my family...and my relationships...my children..."		1

Table 3: Thematic Results of Interviews Continued

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Improved Interpersonal Interaction <i>Definition:</i> Client reports improved interpersonal interaction as a result of her Therapeutic Enactment experience.		Frequency: 2 Direct Quotes <i>Examples:</i> "In the way I communicate with men now. Like with my partner, I am not...I don't control him. I take care of him. I do stuff for him...I treat him like he's supposed to be treated, with a lot of love, compassion and nurturing. . And he does the same thing back to me. And it is different!"	2

The theme entitled "Self-Awareness" was made up of the most frequently coded interview data. Ten direct quotes were coded according to this theme in the initial interview, while 12 direct quotes were coded this way during the analysis of the follow-up interview (for a total of 22 direct quotes). Data was coded under this theme if the client reported becoming more aware of herself and/or her behaviours as a result of her Therapeutic Enactment session.

Carrie reported in her initial interview that her Therapeutic Enactment session helped her to realize how an early childhood experience continued to impact her. As she explained, "But what I think what it did is help me look at where that fear came from. That's the first time...that trauma in my life has controlled me all of my life."

She apparently reached a breakthrough in terms of becoming aware of how she had been behaving and thinking when she stated:

When I went through that re-enactment I realized that I don't have to take care of people all of the time, you know. I don't have need to protect people. And it is O.K. to trust people and allow myself to be in a relationship. It is hard now trying to think

as an adult after thinking as a child all of those years. Yeah, that's what is happening with me!

She also highlighted the importance of her early childhood experience in her follow-up interview and discussed how the Therapeutic Enactment intervention was useful in raising her self-awareness:

...when I went through that reenactment, that's when I realized after it was my dad's footprints walking on that porch that made me afraid because I knew they were drinking and wondered what was going to happen. Yeah that reenactment really opened my eyes to my life! Of how much that little scene really affected me.

Later in the interview, she continued to discuss the impact of the event that was enacted and how the intervention was useful:

C: To help me get in touch with what was causing me to feel that fear. Like I didn't understand it before. But now I do.

I: What was it, can you explain it?

C: Well it was my mom and dad. My dad beating up my mom. That scene, that part was always there.

I: How does that part affect you?

C: My relationships with men...all of my relationships...my first and second husbands—they both beat me up. And the guy I was with five years ago...he didn't physically abuse me, but he emotionally and verbally did. That reenactment helped me to understand the abuse in my relationships—how much my dad's words and my dad's violence controlled my mom and her feelings. That's what controlled me all of my life...when I was in the same kind of relationships.

I: What happened?

C: I would allow them to physically abuse me. And emotionally. And verbally. And I would just take it in and say that it was normal. Now I don't do that.

Carrie also commented on how Therapeutic Enactment raised her awareness of how many emotions affected her behaviours:

Before the walls were still there and I would stay sober for so long and then I would just go drink. And, because of the feeling that I used to have inside of me. The anger, the fear, the shame, the guilt...it would all be sitting inside.

The theme that was made up of the second most frequently coded interview data was entitled "Experiencing Affect." Seven direct quotes were coded according to this theme in the initial interview, while four direct quotes were coded this way during the analysis of the follow-up interview (for a total of 11 direct quotes). Data was coded under this theme if the client reported that experiencing affect following Therapeutic Enactment intervention was helpful.

Carrie mentioned how Therapeutic Enactment helped her to experience affect in her initial interview:

"Just talking about it I found that it didn't...I didn't get right in touch with my feelings. But walking through it...re-enacting it helped me to really get in touch with my feelings...my fear and the trauma of what happened to me."

She expressed how experiencing affect was something she desired and how Therapeutic Enactment helped her to achieve that goal:

C: About ten or fifteen years ago when I was trying to deal with my childhood...I couldn't go there, like they wouldn't let me go there.

I: Who's they?

C: Um, I don't know, my body I guess. Like they say, like the Creator decides when you are ready and how much you can handle. And the counsellors said well maybe I wasn't ready then. Now I am ready and I thought I wasn't gonna' be able to open the doors that I needed to open. But I did! The enactment made it more real instead of just talking about it. Like I would recommend people go through that if they are in a treatment program.

In her follow-up interview, Carrie talked about how she had been unsuccessful in her attempts to get in touch with her feelings. That is, until her Therapeutic Enactment session:

I have gone through spiritual healing for ten years, fasting, sweat lodges, ceremonies, sharing circles...I've gone through counselling, I've done life skills programs—like I did a nine month one dealing with me and that never, ever came up. You know, that's why I say that's what helped me...and that's the only thing that finally broke my walls...Because I can talk and talk and talk but I don't feel anything.

The theme called "Change in Self-Schema" was made up of the third most frequently coded data taken from both interviews. Two direct quotes coded according to this theme were derived from the initial interview, while eight direct quotes were coded in this way from the follow-up interview (for a total of 10 direct quotes). Data was coded under this theme if the client reported a change in self-perceptions of thoughts, feelings or behaviours.

In her initial interview, Carrie explained how Therapeutic Enactment helped her to see herself as more relaxed and less of a caretaker:

“I think once I finished the re-enactment...it’s like I changed. There was a change within me. And it’s still there today. I don’t get all bent out of shape and everything anymore.”

“I am more accepting with a lot of things. There are a lot of behaviours, I am more laid back. Like I’m not pleasing people. Yeah. That would be it, I’m not care taking or people pleasing.”

She later compared her self-perceptions both before and after her Therapeutic Enactment session during her follow-up interview:

Before, I would be pissed off. I would say, “Yeah, go ahead and go” but emotionally, I would be pissed inside. Now I trust him. I don’t feel threatened anymore or anything.

Now, I feel so much freer. Like when I’m talking to somebody now...I am learning to say no.

And how much now...it [fear] doesn’t anymore. Like I can be that loving caring person.

The theme entitled “Self-Expression” was made up of the forth most frequently coded interview data. Three direct quotes were coded according to this theme in the initial interview, while five direct quotes were coded this way during the analysis of the follow-up interview (for a total of eight direct quotes). Data was coded under this theme if the client reported an increased ability to express thoughts or feelings as a result of Therapeutic Enactment intervention.

In discussing how she has changed her relationship with her intimate partner, Carrie noted in her initial interview that:

I talk to him more about how I'm feeling and I'm not afraid to. Whereas before I was always afraid to really say how I was feeling and what was bothering me. And now I just say it even though I get scared but I make myself.

During her follow-up interview, Carrie talked about how Therapeutic Enactment has helped her to continue to express herself:

It helps me not to have the walls, it helps me to share. To talk about my feelings. To deal with what is bothering me at the moment and not waiting. Before I would say "I'll just deal with that another day." But that other day never came. I just put it away again. And that's how come my walls just kept getting bigger and bigger and bigger. Because I was carrying all that garbage all of the time and it just kept getting bigger [Laughter]. The garbage bag! Now, I don't have to do that.

The theme called "Resource Installation" was constructed of the fifth most frequently appearing coded data. Two direct quotes were coded according to this theme in each of the initial and follow-up interviews (for a total of four direct quotes). Data was coded under this theme if the client reported using memories of her Therapeutic Enactment experience as a resource to help her in current or future life situations.

While considering how Therapeutic Enactment might help her with her recovery in the future, Carrie stated in the initial interview that:

I talk about the Therapeutic Enactment a lot. And every time I talk about it I learn something different about myself. Even though it was that one scene, it seems to affect all of me...it helps me to get in touch with myself...that would help me to be strong. That will help me to be able to look at all of my fears of men and fears of life...like fears of people in general.

Carrie explained how she would continue to use memories of her Therapeutic Enactment session in her follow up interview, claiming, "Well I always go back and think when my walls start coming up and my fears...I think about that little girl. You know."

She mentioned this process again later in the same interview, remarking, "...and that reenactment...I think about it in my relationships, and my life, trust and communication...I keep thinking about it."

The theme labeled "Corrective Emotional Experience" was made up of the sixth most frequently coded interview data. One direct quote was coded according to this theme in the initial interview, while two direct quotes were coded this way during the analysis of the follow-up interview (for a total of three direct quotes). Data was coded under this theme if the client reported a change in her emotional state as a result of re-experiencing difficult life situation(s) and working through these event(s) during the Therapeutic Enactment session. The change in emotional state can refer to the client achieving a feeling of peace, a sense of forgiveness of people or events, or letting go of previous emotional wounds.

Data from her initial interview suggest that Therapeutic Enactment helped her to let go of a previous emotional wound. As Carrie put it, "And going back and looking at it I think it helped me to release and realize that I am not that little girl that has all of that fear. And that I am an adult now."

She also offered explanations of how Therapeutic Enactment was healing in her follow-up interview. For instance, in response to the question, "What about enactment did you find to be particularly helpful?" Carrie replied:

Oh man, I don't think that I would be as far as I am in my healing if I didn't go through that enactment. It is fine to talk about it, but to actually go through it and

relieve it as an adult allowed me—that little girl—to let go of that fear—that little girl in me.

I am just glad I got to go through it...that it was a part of the program...because...like I said before...I've gone through so much different therapies and counselling, and art therapy—you name it—and I was never able to release and get in touch with what controlled my life—that fear—I was never able to do that before.

In considering themes containing direct quotes derived exclusively from the initial or follow-up interviews, two themes stand out. First, the theme entitled “Influence of Auxiliaries” was made up of three direct quotes coded from the initial interview. Data was coded under this theme if the client reported that auxiliaries (i.e., other group members playing a role) were in some way important to her Therapeutic Enactment session (such as by engendering a more genuine re-experiencing of the scene or by being influenced by comments made by the auxiliary).

It is clear that Carrie found auxiliaries helpful in making her Therapeutic Enactment experience seem real:

Oh, the roles that they were playing. I think it was really important that they played it the way it was. Especially with [Group Member] when she played my mom. That's the way my mom was, eh, just crying and laying there. The way she was just seemed so real. Then there was my brother cliff...

The theme entitled “Insight” consisted of three direct quotes taken from the follow-up interview. Data was coded under this theme if the client reported arriving at some cognitive insight or awareness as a result of her experience with Therapeutic Enactment. Data coded according to this theme differ from the theme “Self-Awareness,” as the latter theme is

reserved for classifying client statements that refer to personal awareness that are not general in nature.

Carrie seemed to arrive at an important insight about her father (and ultimately herself) as a result of her Therapeutic Enactment session:

I am glad that I finally went through it to help me to understand what the impact that alcohol has on relationships, the violence that it brings out in people, the vulnerability that a woman has when under the influence...the rage and the jealousy and insecurities that come along with it. Because I never seen any of that with my dad before.

I: You never seen any of what?

C: The rage and jealousy. He wasn't like that when he was sober. It might have been there, but I never seen it.

I: So the enactment helped you see jealousy?

C: Yeah.

I: How did it do that?

C: Like with my dad...you know...the men that I've been involved with they are all jealous...they all are. It didn't matter. Everybody that I've been involved with has been a jealous person.

Direct observation.

There were several direct observations from Carrie's Therapeutic Enactment session that buttress the findings from her interviews. Appendix J contains a full summary of Carrie's Therapeutic Enactment session.

With regard to the theme entitled “Experiencing Affect” Carrie was visibly distraught (holding her head in her hands and whimpering) while she described the first scene of the enactment. As she went into greater detail about how her father physically and verbally abused her mother, she openly wept, indicating that she was experiencing intense emotions. Similarly, during the scene where she intervened to confront her father, Carrie’s hands shook as she cried and moaned, signifying the strength of the emotions she felt.

Later, the extreme affect Carrie was experiencing was evident in the tears she shed when she helped her mother to bed and wiped away the blood from her face. Carrie emotionally broke down again when her father apologized for the abuse he had forced her and the rest of the family to endure. Carrie cried one last time during the heartfelt interaction with her mother at the end of the enactment session.

Many direct observations of the session support the theme entitled “Self-Expression.” For the first time, Carrie courageously addressed her abusive father by asserting, “It scares me when you raise your voice at me and mom!” She also expressed long held feelings of resentment when she shouted at her father, “I always feel like I gotta' take care of everybody—I’m just a little girl! I shouldn’t have to take care of everybody!” Later, she expressed the following additional feelings toward her father:

If only you hadn’t hurt them, I wouldn’t have to take care of them! You beat up mom—and I don’t want you to do that anymore! I want you guys to stop! Stop drinking, life is so much better without it!

Carrie’s expressions toward her father were sometimes mixed as she explained, “I love you dad, but I am angry because of all of the violence and all of the accusations against mom. The alcohol and the violence. I hate being angry.”

There is also a significant amount of observed data that supports the theme called “Self-Awareness.” For example, Carrie realized the personal cost of being in the role of parent at such a young age, stating, “...it stopped me from growing—it stopped me from being the person I know I can be. I was always afraid of relationships and I’ve always been taking care of everybody. And I’m angry about it!”

She further became aware of a pattern in her life that seemed to repeat itself:

And in my life, when I was in relationship, I was always afraid. Then I would drink and they would do the same thing to me. And it always happened. In my relationships they always did. And I’ve stayed in them because I thought that was the normal thing to do. And I know it’s not.

Carrie also came to understand her own behaviour in these situations and how she contributed to them:

I did things in my own relationships to bring it [anger] out not just physically but by being manipulative and lying. Or I’d run away from relationships to hurt them emotionally. I would not allow myself to get close to anybody especially men—and women—I thought women were pitiful. And I thought men were abusive, so I’d abuse them and abuse them. I would love them to a certain point and then walk away and laugh about it. It was my way of getting back at the abuse that I grew up with.

Finally, near the end of the enactment, Carrie recognized why she could not express her feelings and decided what she wanted to do about it:

I’ve never been able to be emotionally supportive to a man. I’ve been the way you taught me, to cook and clean and be organized in my home, but I’ve not been able to be emotionally supportive to a man. I feel that what happened between you and dad

stopped me from allowing my feelings to come out—the love that I know I have in my heart, like that gentleness and that kindness—you showed me how to be a woman. But I could never love anybody emotionally. I want to be able to do that!

The theme entitled “Change in Self-Schema” is supported by Carrie’s claim that she regained a part of herself as a result of the Therapeutic Enactment session. An excerpt from the session provides more detail:

Therapist: “What did you get back today?”

Carrie: “Me! I don’t need to be that way anymore! Now I understand that I don’t have to manipulate. I don’t have to be afraid, and I can love!”

Finally, Carrie’s statements made at the end of her session support the theme entitled, “Importance of Auxiliaries.”

Therapist: “Is there anything else that you have to do?”

Carrie: “I also want to thank everyone for being a part of my release.”

Documentation.

In her referral package, Carrie theorized about the issues that seemed to keep her locked into a state of negative addiction. The excerpts from this document (which are reprinted below) also reveal what she had identified as goals for treatment.

5.) What are some behaviour/attitudes you would like to change?

Carrie: “To be in touch with my past traumas and emotions.”

6.) What prevents you from staying clean and sober?

Carrie: “My emotional state.”

7.) What kind of issues have you identified you want to work on while you are at the Centre?

Carrie: "My childhood traumas...abandonment, rejection, love."

Carrie's outpatient alcohol and drug counsellor also completed part of the referral package. As can be seen by his comments below, he concurred with Carrie on some key points:

1.) Does the applicant recognize an alcohol/drug problem? Comment/Describe:

Counsellor: Yes. The use of alcohol is to suppress the pain of childhood issues and grief.

2.) Indicate in detail how you see the problems associated with the applicant's addiction:

Counsellor: Family history, grief, parents...When confronted with her issues or alcohol abuse, Carrie's answer to the problem is to take flight.

Turning to her goal sheet that was completed by Carrie prior to her participation in the therapy component of the program, she wrote the following:

1) The first goal I want to work on during my time at Nechako Centre is:

Carrie: "My childhood (abuse). Violence. Anger."

3) The third goal I want to work on during my time at Nechako Centre is:

Carrie: "Grief and Trauma – guilt."

On the day of her Therapeutic Enactment session, Carrie reflected on her experience by writing in her daily journal:

1) Today, what I learned about me was:

Carrie: "I can get in touch with my feelings of fear by going back to my childhood. And I don't need to carry the guilt I felt all of my life by talking and sharing my childhood traumas and violence."

2) The feeling I had most often today was:

Carrie: "Gratitude! Gratitude for finally having the opportunity to understand my feelings and being able to let them go. At the end of the day session, I felt peace and very exhausted."

3). Today, what I appreciate most about myself is:

Carrie: "My courage to go back to my childhood and not feel like I'm betraying my family for sharing my childhood traumas."

The last document that yielded evidence relevant to the analysis of Carrie's case was her second weekend evaluation form. Upon review of her progress after two weeks of treatment, Carrie again submitted detailed comments about her experience with her Therapeutic Enactment session, writing:

1) The ways in which I made progress toward my small therapy group goals were:

Carrie: "I shared one of my childhood traumas and released the fear and pain from it. I released my anger of abuse by acting it out, and I felt so much lighter and relaxed afterwards. It is teaching me to be assertive, not aggressive."

2) The most important discoveries that I made about myself were:

Carrie: "I no longer have to carry my traumas of my past. My childhood traumas have had control over my life. Now I am free from parts of them. I showed the group the traumatic events that caused my fear, and was able to display it without feeling embarrassed, ashamed and guilty."

3) The new skills that I learned this week at Nechako were:

Carrie: "Acceptance of my hurt and pain. Forgiveness to my mom and dad for the violence I witnessed between them. Relief of showing myself to others when I am vulnerable."

Summary.

From the three data sources (Interviews, Direct Observations, and Documentation), it appears that family violence and dysfunction profoundly impacted Carrie to the point that it influenced her recent behaviours, including addiction. The findings of this case study uncovered six recurrent themes that indicate the way in which Therapeutic Enactment was beneficial for Carrie (i.e., Self-Awareness, Experiencing Affect, Change in Self-Schema, Self-Expression, Resource Installation, and Corrective Emotional Experience). Data from direct observations also suggest that Therapeutic Enactment helped Carrie a) to acknowledge the impact of her violent family of origin, b) to express her emotions and act assertively, c) to realize how she reversed roles with her parents (and became aware of the costs of this responsibility on herself as a child as well as how this influenced her behaviour in intimate relationships as an adult, and d) to produce a change in the way she perceived herself while in the company of supportive group members. Documentation data confirm the importance that Carrie placed on past traumas such as family violence, abandonment and rejection. Her writings in these documents also point to how Therapeutic Enactment helped her to gain relief from feelings of guilt after she revisited her childhood and shared her experience with others in significant detail. Documentation data further revealed how Carrie managed to forgive her parents and gain a sense of acceptance of her psychological pain.

Participant Number 4: "Paula"

Interview data.

The first column in Table 4 (below) displays the twelve themes that were derived from the initial interview with Paula. A brief definition of each theme appears in the cell that contains the title of the theme. The frequency of coded data that make up each theme appears in the second column along with short examples of direct quotes.

Six themes were derived from the follow-up interview with Paula. Five themes overlap with the themes derived from the initial interview (and are defined in the first column), while the sixth theme (Memories Invoked) is defined at the bottom of the first column. The frequency of coded data that make up the themes appears in the third column along with short examples of direct quotes from the follow-up interviews. The fourth column displays the total frequencies of coded data from both interviews that make up each theme.

Table 4: Thematic Results of Interviews

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Cognitive Shift <i>Definition:</i> Client reports a change to entrenched cognitions or relief from rumination as a result of Therapeutic Enactment.	Frequency: 8 Direct Quotes <i>Examples:</i> "Before, every time I thought about all of those people, I don't know, I wanted to get sick...for the people that they are. I used to think about them and let it bug me... Because I wasn't even thinking about them...like usually I do, like think about the girls back home. But after I did this, I just remembered I don't even think about it. I didn't even care."	Frequency: 16 Direct Quotes <i>Examples:</i> "Very negative. Negative thoughts. After I did the re-enactment, it's all gone. And now they don't bother me and I don't have all these bad thoughts in my head. And if they had something bad to say about me, that's their problem and, it helped me so much."	24
Self-Expression <i>Definition:</i> Client reports increased ability to express thoughts or feelings as a result of Therapeutic Enactment intervention.	Frequency: 13 Direct Quotes <i>Examples:</i> "I cried lots. Um, it felt really good just to talk about it and getting it out. And we just basically went...I went from person to person and telling them one other thing what I thought of them, what I wanted to hear from them. It just made me feel better. I thought it was important because I have been holding it in for so long. I have been holding it in for so long! I feel I need to tell them, before I go to a crazy house!"	Frequency: 9 Direct Quotes <i>Examples:</i> "The part that I found helpful was me talking to them. Speaking to the people that hurt me. Having to say what I had to say with them listening. Just getting all this stuff out that I had to say to them. That was the most helpful part. All I can say is that it helped me so much because I got to say all these things and they just stood there and listened and it was the best thing that ever happened to me."	22
New Experience/Reality <i>Definition:</i> Client reports benefit from new experience in Therapeutic Enactment.	Frequency: 6 Direct Quotes <i>Examples:</i> "Saying what I had to say. Actually speaking...them having to listen to me. It was great because there is so much I have to say for how many years...and nobody would listen so I wouldn't bother trying I just sat there and sat there."	Frequency: 1 Direct Quote <i>Examples:</i> "They sat there and listened and in real life they wouldn't listen. They'd be talking back and stuff or ignoring me. It really helped because they sat there and listened. That's the part that helped me the most."	7
Positive Outlook <i>Definition:</i> Client reports experiencing a more positive general outlook as a result of Therapeutic Enactment.	Frequency: 3 Direct Quotes <i>Examples:</i> "I don't feel as negative toward myself. I don't put myself down. I try to give myself positive information."	Frequency: 2 Direct Quotes <i>Examples:</i> "More positive. I think good thoughts now and instead of like when I start thinking negative, I tell myself why bring yourself down, it's not going to help and then I try and do something positive to get it out of my head."	5
Self-Awareness <i>Definition:</i> Client became more aware of self or behaviours as a result of Therapeutic Enactment.	Frequency: 2 Direct Quotes <i>Examples:</i> "If I am going to be heard I have to be a bit more assertive. I have to learn to release some problems. I don't know. Face instead of trying to stuff them down and think it's O.K."	Frequency: 3 Direct Quotes <i>Examples:</i> "I would say that it works and it does help. For me, going to that treatment centre was probably the best thing because I figured out and with the re-enactment, I figured out what was bothering me so much. I think the re-enactment is a really great thing to do."	5

Table 4: Thematic Results of Interviews Continued

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Corrective Emotional Experience <i>Definition:</i> Client reports change in emotional state by re-experiencing difficult life situation(s) and working through, letting-go or forgiving previous emotional wounds.	Frequency: 6 Direct Quotes <i>Examples:</i> I just feel that they...I know that they had no right to do that to a little girl, but I am able to forgive them. It's like peace. I can just let it go rather than carry on this huge thing that had built up inside of me. [sigh] Things before that were huge, and now it's just this thing that is almost forgotten."		6
Change in Self-Schema <i>Definition:</i> Client reports a change in self-perceptions of thoughts, feelings, or behaviours as a result of Therapeutic Enactment.	Frequency: 3 Direct Quotes <i>Examples:</i> "I am more assertive. I feel more assertive. I am not as afraid of people, issues or anything."		3
Resource Installation <i>Definition:</i> Client draws upon memories of Therapeutic Enactment as a resource that helps with current or future life situations.	Frequency: 3 Direct Quotes <i>Examples:</i> "I just thought about the re-enactment and when I'm talking to him. I'm trying to get my point out as clear as possible, using "I feel...When you..." I try to use that. I try not to let go...and think of which way I can speak and how I can speak to him in a way where he can understand me."		3
Witnessing Other Enactment Sessions <i>Definition:</i> Client reports benefit from witnessing Therapeutic Enactment sessions of other clients.	Frequency: 2 Direct Quotes <i>Examples:</i> "That helped a lot. Seeing other peoples' enactments too... Because I didn't know...they asked me to pick one scene which I wanted to do, and I couldn't pick just one scene... And then as I was thinking all of this, I was trying to think, which one? It was like, I wanna' do one with all of them because they are the ones who all hurt me."		2
Physiological Change <i>Definition:</i> Client reports physiological change(s) as a result of her experience with Therapeutic Enactment.	Frequency: 1 Direct Quote <i>Example:</i> "...my chest wasn't so tight and my stomach wasn't turning and I didn't feel like getting sick. Before, every time I thought about all of those people, I don't know, I wanted to get sick...for the people that they are."		1
Authenticity of Re-lived Experience <i>Definition:</i> Client comments on the importance of the authenticity of re-experiencing life events or scenes through Therapeutic Enactment.	Frequency: 1 Direct Quote <i>Example:</i> "When we did that it was just so real, the way everything was set up. I don't know...it was very real, with all of those people there. I don't know the impact, it was just good to be part of it. It was tough to go through...it was really hard. But I felt way better."		1

Table 4: Thematic Results of Interviews Continued

<u>Theme</u>	<u>Initial Interview</u>	<u>Follow-Up Interview</u>	<u>Totals</u>
Behavioural Practice <i>Definition:</i> Client reports practicing future life events in Therapeutic Enactment session.	Frequency: 1 Direct Quote <i>Example:</i> I think that this is a place to practice [assertiveness skills].		1
Memories Invoked <i>Definition:</i> Client reports that Therapeutic Enactment evoked memories that led to helpful insights.		Frequency: 1 Direct Quote <i>Example:</i> “Everything wasn’t as bad as I thought it was and I do remember some good times in my past. The memories are starting to come back. Some of the good times that I did have with some of the people that hurt me and stuff. Like I do have some good memories of them and they are coming back to me now.”	1

The theme entitled “Cognitive Shift” was made up of the most frequently coded data from both interviews. Eight direct quotes were coded in the initial interview using this theme, while 16 direct quotes from the follow-up interview were coded with this theme (for a total of 24 quotes). Data was coded under this theme if the client reported a change to entrenched cognitions or relief from rumination as a result of her Therapeutic Enactment session.

It is apparent that Paula experienced a cognitive shift when she describes how Therapeutic Enactment impacted her thoughts in the first interview:

They are almost all gone! [Laughter] I couldn’t stop thinking when I first came here...just thought after thought...all of those people that were [represented] in the enactment...what they do—judging me—and everybody else around me was judging me. And then I look at a certain person and it’s like, “what if they are talking about me?” If I was alone—if I was alone for a reason—like I was alone for a reason because everyone was talking about me. Now, it’s gone. Yeah, there are no more voices in my head!

In her follow-up interview, Paula referred to how Therapeutic Enactment helped her to perceive her mother from a different perspective:

It made me realize that when she does those things to me it's because she has her own issues and she probably doesn't mean to do that to me but she's got her own problems to deal with. So I'm not as angry with her or anything like that.

She also commented on how Therapeutic Enactment helped to change her cognitions (and subsequent behaviours) regarding other people in her life:

I think it helped me because for the people who made me mad or hurt me or whatever, I used to run to drugs and I don't do that now. Because they don't bother me anymore so I don't run to drugs. And getting it all out and re-enacting it, it helped me a lot.

The theme entitled "Self-Expression" was made up of the second most frequently coded data from both interviews, with 13 direct quotes coded with this heading in the initial interview and nine direct quotes coded in this way from the follow-up interview (for a total of 22 direct quotes). Data was coded under this theme if the client reported an increased ability to express thoughts or feelings as a result of Therapeutic Enactment intervention.

Paula became quite ecstatic in her first interview, describing how important it was for her to express her thoughts and feelings in her Therapeutic Enactment session:

It was scary at first, building up that courage to do it. And speaking, confronting the people that have hurt you or upset you...relief! I feel great after! I let go and I just feel wonderful! It might not have been the real thing, but you feel ten times better inside. You feel so confident about yourself. I can't express how much I loved it. I feel so good inside just being able to do it. I am so glad that I came here to do it!

During her follow-up interview, Paula once again identified self-expression as being a critical component of her Therapeutic Enactment experience:

...talking with my mom—that was the hardest one. It was very important to me because she lives about twenty feet away from me and we never see each other and she always talks about me and stuff. She was a really mean person to me. She still is, but like talking to her was so important to do. And that helped me so much because she doesn't bother me as much now.

She further revealed how effective self-expression was for her and how she continued the practice, stating, “And if she does start to bother me, then I deal with it and I talk about it with my spouse or I talk about it and I don't hold it in until I burst.”

The theme entitled “New Experience/Reality” was made up of the third most frequently coded data from both interviews. Six direct quotes were coded according to this theme in the initial interview, while one direct quote was coded under this theme during the analysis of the follow-up interview (for a total of seven direct quotes). Data was coded under this theme if the client reported benefits from experiencing a new reality—that is—an experience during her Therapeutic Enactment session that was different than actual real-life events.

Paula first described why the surplus reality technique was important to her Therapeutic Enactment session in her initial interview:

P: Yeah, um, they just stood there and listened to me. They looked into my eyes and listened and it felt good.

I: It felt good?

P: Really good because they were paying attention to me. I felt like what I had to say was really important...to be heard.

She went on to contrast her Therapeutic Enactment experience with what she might expect in real-life:

Just saying what I had to say. If it was for real, he'd be like, "no, no, stop, nah-uh"—and he wouldn't give me time of day. Or I'd be talking to his back or a wall. And here I got to speak to his face, with him looking at me. And him really listening and interested in what I said.

She also referred to the alternate reality of Therapeutic Enactment in her follow-up interview, emphasizing how the technique allowed her to express herself as well as be heard, saying, "They sat there and listened and in real life they wouldn't listen. They'd be talking back and stuff or ignoring me. It really helped because they sat there and listened. That's the part that helped me the most."

The theme entitled "Positive Outlook" was made up of the forth most frequently coded data from both interviews. Three direct quotes were coded using this theme in the initial interview, while two direct quotes were coded with this theme in the follow-up interview (for a total of five direct quotes). Data was coded using this theme if the client reported experiencing a more positive outlook on life in general as a result of her Therapeutic Enactment session. This theme is different than the theme entitled "Change in Self-Schema" (below) as that theme refers more specifically to client comments directed at the personal self (i.e., internal thoughts, feelings, or behaviours).

On several occasions in her initial interview, Paula underscored how Therapeutic Enactment helped improve her outlook on life. The following quotes are presented as examples.

“I am just thinking about positive things now instead of negative things. It feels so good!”

“I don’t feel as negative toward myself. I don’t put myself down. I try to give myself positive information.”

“Just proud of myself. I don’t know...it is just great! I feel great! I feel real—that’s the word.”

From statements Paula made in her follow-up interview, it appears that she maintained an outlook of optimism:

P: Because of my involvement with Therapeutic Enactment, I am more aware of the good things that are in my life. The good people that are in my family, a better way of thinking and a better way of dealing with my problems.

I: What is the better way of thinking?

P: More positive. I think good thoughts now and instead of like when I start thinking negative, I tell myself, “Why bring yourself down, it’s not going to help,” and then I try and do some-thing positive to get it out of my head.

The Theme named “Self-Awareness” was made up of the same number of direct quotes taken from both interviews as the theme “Positive Outlook.” Two direct quotes were coded according to this theme in the initial interview, while three direct quotes were coded in this way during the analysis of the follow-up interview (for a total of five direct quotes). Data

was coded under this theme if the client reported becoming more aware of herself and/or her behaviours as a result of her Therapeutic Enactment experience.

It is evident from statements made in her initial interview that Therapeutic Enactment helped Paula arrive at some new self-awareness. For instance, she realized, "If I am going to be heard I have to be a bit more assertive." She also declared that, "I have to learn to release some problems. I don't know...face instead of trying to stuff them down and think it's O.K."

She also claimed that Therapeutic Enactment helped her gain new self-awareness in her follow-up interview, stating:

It was important to me because I was letting all these people get to me. The people that hurt me and I never thought of the people that did love me. All these people that kept hurting me and kept hurting me, I let those people get to me. Realizing that I wasted so much time worrying about them when I could be living my life.

It is interesting to consider data that was derived exclusively from the initial interview as well. Data from some predominant themes are presented below. For example, the theme entitled "Corrective Emotional Experience" was used to code six direct quotes in the initial interview. Data was coded under this theme if the client reported a change in her emotional state as a result of re-experiencing difficult life situation(s) and working through these event(s) during the Therapeutic Enactment session. The change in emotional state can refer to the client achieving a feeling of peace, a sense of forgiveness of people or events, or letting go of previous emotional wounds.

While viewing her Therapeutic Enactment session, Paula noticed that re-experiencing difficult life experiences helped her to achieve a change in her emotional way of being:

I think this is the part that I think really helped. Because I never received anything that was positive said to me before. Right now it is going to be easier to say positive things about myself. You see this part...it took a long time for it to sink in...like people saying all of those things...it was like overwhelming for me...it was like wow! People actually see me like this! Now I feel that way!

The theme entitled “Change in Self-Schema” was used to code three direct quotes in the initial interview. Data was coded with this theme if a client reported a change in her self-perceptions of her thoughts, feelings or behaviours, as a result of her Therapeutic Enactment session. As mentioned above, this theme differs from data coded as “Positive Outlook,” which are comments made by the client that are more general in nature.

Therapeutic Enactment helped Paula to change the way she saw herself. For example, in response to the question, “What did the Therapeutic Enactment help you to learn?” Paula replied:

That I am a strong person and not a sweet little girl. And I don’t need other people’s approval. I don’t need to be running back to them just to be shut down. I don’t need anything like that in my life.

The theme labeled “Resource Installation” was constructed of three direct quotes taken from the initial interview. Data was coded under this theme if the client reported using memories of her Therapeutic Enactment experience as a resource to help her in current or future life situations.

Paula’s Therapeutic Enactment experience provided her with resources to help her recover from addiction, such as thoughts of personal attributes and memories of her experience. For example, she declared, “I think just thinking about what I did in my re-

enactment, like how, I don't know how I got through that...but just the courage that I have. Yeah. It gave me courage—strength.”

The theme entitled “Witnessing Others’ Enactments” was made up of two direct quotes derived from the initial interview. Data was coded under this theme if the participant reported some benefit from witnessing the Therapeutic Enactment sessions of other clients.

Not only did witnessing other Therapeutic Enactment sessions provide Paula with ideas for co-designing her own session, but she also came to some insights as well:

Well, in one of the enactments I saw a woman get beaten up. With all of the yelling and screaming at a little girl that was standing there...my son has seen that before. It was a realization or an awareness for me. That helped a lot.

Finally, the theme labeled “Physiological Change” was used to code one direct quote from the initial interview. Data was coded according to this theme if the client reported a physiological change that resulted from her experience with Therapeutic Enactment.

Paula claimed to experience physiological changes immediately following her Therapeutic Enactment session:

P: ...it was really hard, but I felt way better!

I: What do you mean—how did you feel better?

P: It was...my chest wasn't so tight and my stomach wasn't turning and I didn't feel like getting sick. Before, every time I thought about all of those people, I don't know, I wanted to get sick...for the people that they are...as soon as I talked about it and got it out and told them what I had to say, I relaxed. I really relaxed after that.

I: What about since?

P: I have been feeling better and better and better.

I: So you have maintained those feelings. The feelings of relaxation stayed there?

P: Yes.

Direct observation.

Data that corroborate the findings from Paula's interview were directly observed during her Therapeutic Enactment session. See appendix K for a full summary of Paula's Therapeutic Enactment session.

Perhaps the most interesting direct observations of Paula's behaviours support the theme entitled "Self-Expression," and progressively occurred as her session unfolded. Her progression toward self-expression began with an inability to do so, observed at the beginning of the session when the auxiliaries were first placed in the scene. Paula became emotional when she glanced at the congregation of her family members, but was unable to address them at the request of the therapist. In fact, she became withdrawn, which motivated the therapist to utilize a double so that she could observe from an outside perspective. Still, Paula was unwilling to confront her family members, stating, "I don't even want to look at them!"

When the double berated the family members for their abusive behaviour, Paula was observed watching the scene and becoming increasingly emotional during the castigation. Later, a support person (Paula's uncle) was brought into the scene. Paula was then observed expressing anger and resentment to her supportive uncle by whispering in his ear and stomping her foot on the floor. When Paula's uncle confronted her mother, Paula began to communicate with her mother by passing messages through her uncle.

Oliver: [to Paula's mother] "Do you know what is going on in your family?"

Paula: [whispering to Oliver] "I'm scarred of her."

Oliver: [to Paula's mother] "She's scarred of you!"

Paula: [to Oliver] "She's been turning everyone against me!"

Oliver: [to Paula's mother] "You've been turning everyone against Paula and that's not right!"

Finally, Paula progressed to being able to directly confront her mother on her own when her uncle moved behind her and persuaded her to speak for herself:

Oliver: "Paula, will you tell her? Tell her what's going on inside you."

Paula: [in a soft voice] "You hurt me. You were so mean. All I wanted was for you to love me...and then you talked about me..."

Shortly thereafter, Paula gained confidence and expressed herself more fully, using a strong and powerful voice as she angrily scolded her mother, "Nobody does that to a little girl...you're cold hearted! I want you to stop now, just stop! If you don't you're going to regret not having me around!" she exclaimed.

Paula also became more persistent and thorough at expressing herself. For example, after addressing her mother in detail, Paula stated that she was finished with her and wished to move on. Then, she decided to return to admonish her mother for the impact that her mother's behaviour had on her son.

After confronting her mother, Paula stood up straight and faced the group confidently. She seemed to become more motivated to express herself as well. Her increased motivation became apparent when she no longer had to be guided by her uncle, but instead, led him directly over to her brother for her next confrontation.

Paula also expressed long held feelings toward her grandmother and asked important, yet unanswered questions:

You beat me and you didn't let me have a life. I tried to have friends...you're cold hearted, just like her! You loved her more than you loved me... I want you to know how much you hurt me. You didn't protect me—I want to know why—why didn't you protect me?

Paula then demonstrated enormous strength as she addressed her cousin who had sexually assaulted her. As she expressed herself during this scene, Paula's entire body trembled, and her voice shook as she spoke. This section of the enactment was an intense illustration of Paula's self-expression.

At the end of the session, it was evident that Paula had progressed to the final stage in learning to express herself. Before addressing her partner in the last scene, her uncle Oliver came to her side for support as he had done in each segment of the enactment earlier. This time, however, Paula declined his assistance and stated that she could complete this task on her own. Paula bravely faced the challenge and released many emotions in the presence of her partner, Doug.

There were also many direct observations of Paula's behaviour that support the theme entitled "Self-Awareness." Early in the session, for example, Paula identified a significant source of anxiety and discomfort while she informed the group of a disturbing period in her life. She recalled, "...and everybody just talked and talked and talked...and laughed. And I was the joke of the family. They had nothing better to do than to talk about me. I don't know why. It seemed that I made them feel better."

She came to a similar self-awareness when she described the early days in her intimate relationship:

Then I met Doug...and then...this is my opinion of him when I first met him. He tricked me into loving him because he showed a side that I wanted that I want right now. But then he would fight me and fight me and put me down. And then I was joke to him and his family. And a joke to him and his friends. And a joke...to the whole town. Everybody just laughed at me.

Later in the session, Paula realized that the same issue that troubled her was also negatively affecting her son. Paula recalled, "On top of that, not just Doug and my family were doing it, but they started to talk about my son...my mom was talking about it, then people were telling him things about me that weren't true."

Becoming aware about how this ridicule affected her led to another important self-awareness about what she wanted in her life. Paula cried, "I just don't want to be ignored anymore. I want good attention—positive attention—I want people to stop talking..."

Paula further declared, "I don't want them to humiliate me anymore, and I don't want them to talk about him [her son] either."

Another important moment of self-awareness occurred when Paula confronted her grandmother and realized the cost of her neglectful upbringing:

I just wanted you to love me...and to protect me from that loser. And instead you laughed at me! Like nothing happened, and it did happen! It did happen! He touched me and I didn't like it and I cried to you. You didn't believe me! You didn't believe me. Why would I make something up like that? You're supposed to protect me but you didn't. You hurt me and knowing that you must hold a lot of guilt.

While confronting her partner in the last scene, Paula discovered why she did not leave her abusive relationship.

Paula: [to Doug] "You tricked me when I was vulnerable...you used to fight me and I don't know why you used to fight me, I don't know why. And I couldn't leave you because I thought that's what I deserved."

As the scene came to a close, Paula became aware of what she planned to do if things did not change between her and her partner. Paula warned, "If you don't stop playing head games, if you don't start doing something about it, I'll leave you. We don't need this anymore. This is it. I'll leave you."

There were two direct observations that support the theme entitled "New Experience/Reality." Both observations involved apologies from Paula's family members. First, Paula's brother acknowledged that he was wrong in failing to defend his sister when she was bullied at school, referring to himself as a coward. He then sincerely apologized to Paula, which seemed to impact her significantly as she stared deeply into his eyes for several moments after his apology.

Secondly, Paula also received a genuine apology from her grandmother along with an explanation as to why she did not listen to Paula's cries for help. Her grandmother admitted that she feared being disgraced by the community if sexual abuse in the family was made public. During her apology where she acknowledged that her behaviour was unacceptable, Paula's grandmother displayed a great deal of remorse. This moment in the session also appeared to touch Paula as she embraced her grandmother and cried for several minutes after their interchange.

Finally, the theme entitled “Positive Outlook” found support in the closing minutes of the session when the therapist invited group members to offer Paula positive affirmations and their reflections on her enactment. One after another, each group member approached Paula in the center of the room and presented her with warm sentiments of support. Many positive words were used to describe Paula’s character, such as strong, caring, nurturing, brave, loving, and admirable. The last comments came from her son who turned to her and said, “I saw that I got my mommy back!”

Documentation.

As mentioned earlier, clients and their referral agents provide information such as demographics and substance use history in a referral package that is completed prior to the client’s arrival at the Centre. Comments made by Paula’s referral agent confirm the negative impact that her family and peer group had on her welfare and her addictive behaviours:

Question: Indicate in detail how you see the problems associated with the applicant’s addiction: (family, social, psychological, physical, legal, financial/vocational, etc.).

Outpatient Addiction Counsellor: “Paula has indicated that she needs a new environment—a geographic re-location perhaps. She feels that her options for work have been exhausted here. She also feels that her social network is non-supportive to being drug free. I see Paula’s difficulty with drug use stemming from a lack of supports among family and friends in her community.

Furthermore, when asked to identify goals to be addressed at the Centre, her outpatient counsellor suggested that Paula needed to find and stay connected with supportive people. The counsellor continued, “[Paula] wishes to identify some alternatives to drug abuse

when faced with setbacks from friends. She would like to obtain some philosophical and spiritual grounding in order to resist drug abuse.”

Paula also documented the negative effects of her social milieu in her journal entry the day before her Therapeutic Enactment session. In describing what she still wanted to work on at the Nechako Treatment Centre, Paula wrote, “...my insecurity. People make jokes at home, and they try to make me the joke—people, family—talking about me because I’m not perfect and normal like they are. They make fun of me.”

The next day, after her Therapeutic Enactment session, Paula’s responses to the journal questions were quite different:

1. Today what I learned about me was:

Paula: “I can face my fears! Even though it was scary, I did it!”

2. The feeling I had most often today was:

Paula: “Happy and relieved!”

3. Today what I appreciate most about myself is:

Paula: “My self-awareness.”

In her letter to her referral agent, Paula reflected on her work and described how the Therapeutic Enactment session helped her to shift her perceptions of herself and motivate her to change her social support network:

I get along great with every participant in this program. I made twenty new friends.

The most meaningful and helpful parts of the program were the re-enactments. The issues I worked on most were neglect, and sexual, physical and mental abuse. I saw myself as a hurt and abandoned little girl wanting attention. I learned that I don’t need

negative people in my life. I need positive people in my life to be happy. I need to work on my assertiveness and family relationships.

During the last week of the program, Paula's partner arrived at the Centre to participate in the multi-couple group therapy component. On a document called the couples' planner sheet, Paula's partner declared his goal of, "learning to listen more closely to what Paula is saying and to try to understand her needs more." He also stated that he would achieve this goal by being more open and truthful with her. He was further able to identify the barriers to reaching his goal, realizing that, "friends must change the way they treat Paula." The statements made by her partner represent additional corroborative data that indicate how Paula's partner ignored her and how her social network treated her poorly.

Summary.

The three sources of data (Interviews, Direct Observations, and Documentation) imply that rejection by significant others and a lack of social support played an important role in Paula's way of being in the world, and consequently, her addictive behaviours. The findings of this case study indicate that five recurrent themes were essential to the way in which Therapeutic Enactment was helpful to Paula (i.e., Cognitive shift, Self-Expression, New Experience/Reality, Positive Outlook, and Self-Awareness). Direct observations collected from Paula's Therapeutic Enactment sessions suggest that the intervention enabled her a) to quickly progress in her ability to express herself, b) to become aware of the negative effects of ridicule and certain childhood events, which in turn, motivated her towards taking action, c) to experience constructive outcomes to previously negative events, and d) to produce a shift toward a more positive outlook on life as a result of experiencing social

support and encouragement from others. Similarly, data taken from documents underscore the negative impact of Paula's lack of social support and her intense desire to be acknowledged, accepted, and validated.

Cross Case Analysis

The findings of a cross case analysis of interview data revealed 16 themes that were common across the participants in the study. Table 5 (below) presents the findings as a matrix display. In order for a theme to have been included in the cross case comparison, each theme must have emerged from more than one participant's interview analysis. The frequency in which coded data appeared in each participant's interview analysis served as a means of arranging the themes from most to least prevalent. In other words, themes appear in table 5 according to how often data were coded into a particular category. The text below describes the extent to which themes overlapped across participants' interview data, and provides a précis of how participants related to each theme individually.

Table 5: Cross Case Analysis of Emergent Themes

<u>Theme</u>	<u>Samantha</u>	<u>Gloria</u>	<u>Carrie</u>	<u>Paula</u>	<u>Total</u>
Self-Expression		23	8	22	53
Self-Awareness	13	8	22	5	48
Corrective Emotional Experience	10	23	3	6	42
Change in Self-Schema	3	15	10	3	31
Cognitive Shift		2		24	26
Experiencing Affect	7	4	11		18
New Experience/Reality	11			7	18
Importance of Auxiliaries	6	9	3		18
Increased Hope	10	6			16
Resource Installation	6		4	3	13
Importance of Auxiliaries	6	9	3		12
Reviewing Enactment Videotape	4	4			8
Positive Outlook		2		5	7
Witnessing Other Enactment Sessions	4			2	6
Behavioural Practice	3			1	4
Memories Invoked	1	2		1	4
Improved Interpersonal Interaction		1	2		3

The theme with the highest frequency of coded data was “Self-Expression,” although this theme did not emerge from the interviews of all participants. Based on the frequency of data coded according to this theme, it appears that the theme was extremely important to Gloria, Carrie and Paula. For example, Gloria and Paula both commented on how they felt relieved after expressing intense thoughts and feelings during their sessions. And while Therapeutic Enactment helped Paula to build up the courage to express in session what she couldn’t do in actuality, Carrie claimed that the intervention facilitated her ability to express herself in real life.

The theme with the second highest frequency of coded data was “Self-Awareness.” This theme emerged during the analysis of all four participants’ interview data. Many of Samantha’s comments referred to her raised level of awareness of how others were experiencing her, which in turn, had an impact how they responded to her. Once she was aware of the perceptions of others, she endeavored to change her own behaviours. For Gloria, Carrie, and Paula, it was important to become aware of how personal issues and past life events still seemed to affect them in their present lives. Through becoming more self-aware, Paula even arrived at some conclusions as to how she wanted to change (such as wanting to learn how to be more assertive and not to suppress her feelings).

The theme with the next most frequently coded data, “Corrective Emotional Experience,” also emerged from the analysis of all four participants’ interview data. The intervention of Therapeutic Enactment seemed to free Samantha of some very negative feelings that had dogged her for much of her life. Gloria reported that her session allowed her to let go of a great deal of pain and suffering—that confronting her past was a healing and corrective experience. Similarly, Carrie noted that re-living some earlier experiences allowed

her to let go of fear that had somehow been blocking her emotionally. Paula also described how her Therapeutic Enactment session brought a feeling of peace so that she no longer carried burdensome feelings of resentment.

The theme entitled “Change in Self-Schema” was also common to all participants following the analysis of the interview data. For Samantha, her Therapeutic Enactment session seemed to help her see herself as a loving and responsible mother—which was a major shift from how she had previously perceived herself. According to Gloria, the intervention allowed her to view herself as a survivor of sexual abuse and someone who is no longer angry, but happy and at peace with herself instead. Carrie also reported a profound change insofar as she is no longer rigid and volatile. She now describes herself as a loving and caring person. Paula, on the other hand, claimed that she became more assertive and less afraid of others as a result of her involvement with Therapeutic Enactment.

The theme with the next highest frequency of coded data was “Cognitive Shift,” although the majority of data entries emerged from Paula’s interviews. Therapeutic Enactment helped Paula to overcome entrenched negative cognitions that were a major source of rumination and distress. Similarly, Gloria described how Therapeutic Enactment enabled her to change negative thoughts that had plagued her for many years.

Three of the participants had the theme entitled “Experiencing Affect” emerge from their interviews. Samantha yearned to experience her feelings after being emotionally frozen for many years, and Therapeutic Enactment fulfilled her desire. She further claimed that the intervention taught her how to experience emotion and how to break out of the pattern of stifling her feelings. Both Gloria and Carrie reported similar benefits from the intervention,

as these two women had also claimed to achieve their goal of being reunited with their feelings.

The theme known as “New Experience/Reality” emerged from the interviews of Samantha and Paula. The frequency in which data was coded according to this theme for these two participants was equal to the frequency of coded data in the theme above (i.e., “Experiencing Affect”). Samantha reported that experiencing an alternate reality was critical to her therapy work, and that the new outcome resulted in more positive self-perceptions. Paula was also very enthusiastic about the way that her session ultimately unfolded, and at one point cited the new experience as the most helpful aspect of the intervention.

The theme “Importance of Auxiliaries” emerged from Samantha, Gloria, and Carrie’s interviews with the same frequency of coded data as the above two themes. Although this theme was common to three participants’ interviews, the reasons for why these clients valued the auxiliaries differed. For Gloria, the auxiliaries were significant because they provided a safe and supportive arena where she could engage in psychotherapeutic work without feeling ashamed or embarrassed. For Samantha and Carrie, the importance of the auxiliaries lie in their ability to make characters in their lives come alive, which consequently made their sessions seem more real.

“Increased Hope” was the theme that emerged with the next highest rate of coded data. This theme was common to the interviews of Samantha and Gloria. Both clients remarked about how their Therapeutic Enactment sessions gave them a renewed sense of hope for their futures—a belief that they were now equipped to carry on with their lives. Samantha’s sense of hope extended even further, to having hope for human kind in general, in addition to feeling very positive about achieving her own personal success.

The theme with the next most frequently coded data, “Resource Installation,” emerged from the interviews of Samantha, Carrie, and Paula. Therapeutic Enactment seemed to have instilled a strong memory in Samantha, which she occasionally drew upon to help her remain on the road to recovery. Therapeutic Enactment enabled Carrie to access and retrieve actual childhood memories as well as memories from her session that served as a resource during her struggles with addiction. Paula also utilized memories of her Therapeutic Enactment session to give her strength when communicating with her partner during her attempt to repair her significant relationship.

Samantha and Gloria’s interviews produced the theme called “Reviewing Enactment Videotape”, which had the next highest frequency of coded data. Samantha reported that watching the videotape of her Therapeutic Enactment helped her to see what precipitated her emotional reactions during the session. This process also reminded her of what occurred during the session thus providing her with an extraspective view of her own behaviours. Gloria also felt that watching the videotape was a useful way to observe her own behaviours and to again see that she had done nothing to deserve what happened to her. She further commented that viewing the videotape functioned to validate the fact that she had actually taken steps toward a healing journey.

Gloria and Paula’s interviews produced the theme with the next most frequently coded data, entitled “Positive Outlook.” Both of these participants credited the intervention of Therapeutic Enactment with influencing their current, more positive way of being in the world.

The theme called “Witnessing Other Enactment Sessions” arose from the interviews of Samantha and Paula to produce the next most frequent number of coded data. Samantha

stated that she learned a great deal about herself from watching the enactments of others, and also commented on the intense impact that these sessions had on her. Paula said that watching other enactments helped her to conceptualize her own session, and provided her with ideas for selecting specific issues to work on.

“Behavioural Practice” was the emergent theme with the next most frequently coded data. This theme was common to the interviews of Samantha and Paula. Where Samantha used the session to practice her behaviour for a future court appearance, Paula noted that the session allowed her to practice being more assertive.

The theme entitled “Memories Invoked” was as popular as “Behavioural Practice” insofar as it emerged with the same number of coded interview data. However, the theme emerged from the interviews of three participants, Samantha, Gloria, and Paula. For Samantha, Therapeutic Enactment stimulated the recall of memories that were long forgotten, leading her to an important insight during her session. The intervention produced many memories for Gloria as well, which resulted in the thorough processing of these issues in her session. Paula also reported being helped by the positive memories that she began to recall as a result of her Therapeutic Enactment session.

The last theme that emerged from the interviews of more than one participant was named “Improved Interpersonal Interaction.” Gloria claimed that she was more personable in general toward others after participating in Therapeutic Enactment. Carrie was more specific in discussing how the intervention impacted her behaviour in this regard, stating that she had improved the way she relates to her significant other in their relationship (i.e., being less controlling, yet more compassionate and nurturing).

CHAPTER FIVE

Discussion

Overview

This section begins with a brief discussion of the primary findings of the study. It continues by relating the findings of the study to the adaptive model of addiction, which was described in chapter 1 of this report. Various factors that result from integration failure (the central component of the theory) will be used to conceptualize the findings from each individual case. Next, the implications for clinical practice drawn from individual cases as well as from across cases will be compared to existing work that utilizes psychodramatic methods in the treatment of addiction. The chapter will then describe the implications for future research before concluding with a review of the delimitations of the study.

The findings of this study clearly delineate the process by which Therapeutic Enactment is helpful to individuals in treatment for addiction. The 16 recurrent themes that emerged as findings in this study represent answers to the basic research question (i.e., "How is the intervention of Therapeutic Enactment helpful to clients in treatment for addiction?"). It is interesting to consider that many of the most popular themes in terms of frequency of coded data across participants (i.e., Self-Expression, Self-Awareness, Corrective Emotional Experience, Change in Self-Schema, New Experience/Reality) also emerge with high frequency within individual cases. For example, the theme "Self-Awareness" was made up of the most frequently coded data in both the cases of Samantha and Carrie. The theme entitled, "Change in Self-Schema" was made up of the third most frequently coded data in the cases of Gloria and Carrie. The fact that these themes recur with high frequency both within and

across cases lends support to the proposition that the findings of this study represent the most important ways in which clients find the intervention of Therapeutic Enactment helpful.

It is particularly noteworthy to underscore the thorough and sound methodology used in this study because it provided increased confidence in the reliability and validity of the themes that emerged. For example, the added procedure of reviewing videotaped footage of the Therapeutic Enactment sessions during the initial interviews resulted in clients greatly elaborating on their experience, which then yielded richer data that better supported the themes ("Reviewing Videotape" actually emerged as an independent theme in the cases of Samantha and Gloria). Triangulation across data sources (interviews, direct observation, and documentation) was also used within each case study to buttress confidence in the findings. In spite of the reliability and validity of the emergent themes, it should be mentioned that each participant produced data relating to each theme in a somewhat idiosyncratic way. Nevertheless, the cross case analysis was the final step in confirming the finding that 16 emergent themes represent processes that describe how Therapeutic Enactment is helpful to clients in treatment for addiction.

Implications for Theory

It is also interesting to look at how the findings from this study relate to addiction theory. For example, the cases studied in this research appear to fit particularly well with the adaptive model of addiction (Alexander, 1990). Although the design of this study does not permit the findings to be used as a test of the adaptive model, we can still examine how these cases can be used to illustrate the central tenet of the model—integration failure. Recall that the adaptive model supposes that integration failure can result from a faulty upbringing,

genetic unfitness, or the failure of the environment to meet an individual's needs. Integration failure is experienced as a sense of existential pain by people who fail to achieve things like social acceptance, self-worth, self-efficacy or autonomy. The negative experience of integration failure may then produce other negative emotions and situations, such as family breakdown, self-hate, depression, aggressiveness, economic dependence and selfishness. This state of affairs is thought to motivate individuals to either attempt to attain psychosocial integration or, if unsuccessful, cope with the situation by potentially making choices amongst substitute lifestyles, such as additive behaviours. If the person consistently chooses to cope with their circumstances through a lifestyle of addiction, a negative feedback loop is created whereby harmful addictive behaviour serves to intensify the results of integration failure so that additional family breakdown, self-hate, depression, etc. ensues.

Let us examine the case of Samantha in light of the adaptive theory. From her enactment session, we learned that Samantha was particularly worried about the custody battle over her children and that being a mother to them brought meaning and purpose to her life. When asked about the outcome of her initial court case (where she lost custody of her children) Samantha made comments that appear to relate directly to a felt sense of integration failure and despair. For example, she reported, "I would go and get high automatically because I couldn't deal with how I felt inside."

Other comments made by Samantha support the supposition that she placed a high priority on parenthood and family. In describing herself, Samantha stated, "...I've always heard I'm a good mom...I know in my heart that that's me." Furthermore, it was obvious that she placed a great deal of importance on earning another chance to prove herself as a mother.

Thus, Samantha's psychology (i.e., her sense of despair), her life circumstances (the disintegration of her family), and her addictive behaviours are consistent with the adaptive model. The findings of this study showed that Therapeutic Enactment provided her with increased self-awareness, the opportunity to rehearse for her future court date, and to experience a positive outcome, all of which led to a renewed sense of hope for a positive future with her children. Therefore, at the theoretical level, it can be argued that this intervention addressed some of the components of integration failure, which hopefully would counteract Samantha's choice to remain in an addictive lifestyle.

Turning to the case of Gloria, it appears that self-hate might have been the outcome of integration failure that contributed to her addictive behaviours. In fact, Gloria made several statements that suggest that she once had very low self-esteem. From excerpts of her interviews reprinted below, we can surmise that Gloria experienced a low sense of self worth prior to her Therapeutic Enactment session:

"I didn't have to feel so low about myself. I found some new spirit that's happy."

"...so it is actually reminding me that I don't have to feel dirty inside."

"I am a survivor of sexual abuse and life can go on. You can go out there and be happy and not pretend."

"I'm more positive. Not so negative anymore. Positive about life in general. For example, keeping your chin up. Just being positive about every day life. More optimistic."

Other findings from Gloria's case imply that guilt and aggressiveness might have been additional products of sexual abuse that led to integration failure. For example, Gloria came to a new awareness in her Therapeutic Enactment session, concluding that she was not

to blame for being sexually abused. Once she was free of the guilt and self hate, she moved away from a previous stance of aggressiveness, stating, "...[I no longer] look at them with hate in my eyes and want to kill them."

It is argued that the adaptive model is also an appropriate framework for conceptualizing Gloria's life and addictive behaviours. The fit between this case and the adaptive model is strengthened by Gloria's description of her method of coping when she claimed, "I don't have to do that drinking and drugging to hide what has happened to me. It's all out now and there is no reason for me to be using." By providing the opportunity to confront her abusers, express her buried emotions, and realize that she is not to blame for being abused, it can be said that Therapeutic Enactment served to neutralize things like self-hate, guilt, and aggressiveness. Furthermore, the intervention resulted in an improvement in Gloria's self-concept and prompted her to bring closure to this painful part of her life.

The case of Carrie also provides an illustration of the adaptive model. For Carrie, a faulty upbringing and early childhood trauma could have contributed to integration failure. It is clear from Carrie's statements that the violence she witnessed, coupled with becoming a caretaker for her parents, left her unwilling to engage in intimate relationships and occasionally to become aggressive. For example, during her initial interview, Carrie stated:

I had been digging and digging trying to find where my fear and my anger came from...because of that fear of being hurt all of the time...and with my dad...it was the fear of men. I've never been able to have a long-term relationship ever in my life. Now I know why and what I have to do about it.

As a result of the complex interplay between these factors, Carrie chose to isolate herself, both physically and emotionally, and to drown her desperation in alcohol. Perhaps it

can be said that Carrie's pattern of social and emotional separation represents a classic case of integration failure.

The intervention of Therapeutic Enactment helped Carrie to address some events from her past and gain self-awareness in the process. Carrie claimed that she gained a sense of peace and actually forgave her parents in her session. She further stated that her session produced a positive shift in the way she perceives herself and in the way that she interacts with others. In principle, these events operate to reverse the effects of integration failure, theoretically removing the impetus for addictive behaviour.

Similarly, it can be said that the case of Paula also represents a classic example of integration failure. The fact that Paula was abused and abandoned in her early years points to faulty upbringing as an original source of integration failure. Later, in her early adult years, Paula experienced considerable family breakdown and economic dependence. The most blatant contributors to integration failure for Paula, however, could be the ostracism and humiliation she experienced at the hands of her Grandmother, her mother, her boyfriend, and even her community. The shaming that she experienced is evident in the comments she made during her Therapeutic Enactment session, when she exclaimed, "...he [her boyfriend] would fight me and fight me and put me down. And then I was a joke to him and his family. And a joke to his friends. And a joke...to the whole town! Everybody just laughed at me!"

Given Paula's life circumstances, it is not surprising that she ended up in an addictive lifestyle—if we view her situation using the framework of the adaptive model. Following this line of reasoning, it is proposed that Therapeutic Enactment allowed Paula to counteract some of the forces that fueled her addictive lifestyle. The intervention gave her a supportive

environment where she could tell her story, come to new insights about herself, learn to become more assertive, and increase her sense of self-worth and confidence.

Implications for Practice

The findings of this study stand in contrast to a prevailing criticism levied against psychodrama, which states that there is no universally agreed-upon statement of therapeutic objectives in the psychodramatic method (Kellerman, 1987). In fact, this study revealed some therapeutic processes that were specific to individuals and several common themes that emerged from across the four separate cases. To lend support to the argument that therapeutic objectives can be specifically identified and addressed through psychodramatic methods, we will consider how the findings from this study relate to the therapeutic objectives provided by Dayton (1994).

In her book, “The Drama Within: Psychodrama and Experiential Therapy,” (1994) Dr. Tian Dayton lists 19 clinical issues that are frequently encountered when treating people who suffer from addiction. After describing each of these clinical issues, she discusses them in terms of therapeutic objectives by offering explanations as to how psychodrama can be employed to help clients work through and overcome these matters. The clinical issues that Dayton submits as being often shared by addicts are listed below in no particular order of importance.

- Shame
- Isolation
- Unresolved grief and mourning
- Developmental distortion

- Post Traumatic Stress Reaction
- Sober vs. Non-sober thinking and behaviour
- Emotional numbness
- Disorganized thinking
- Distorted internalized family system
- Distorted parental role models
- Difficulty in forming empathic bonds
- Incomplete separation from parents
- Parentified children
- Internalized marital dysfunction
- Inflexible ego structure
- Physical and sexual abuse in childhood
- Dissociation
- Grandiosity
- Difficulty clarifying needs

While an examination of each of these clinical domains is beyond the scope of this discussion, the findings of this study support Dayton's (1994) claim that these issues are common in the treatment of addiction—and that psychodramatic methods are effective in producing positive change in many of these areas. Some of these issues will now be considered in relation to each case from this study.

In the case of Samantha, the issues of inflexible ego structure and unresolved grief appear to be applicable to her work in Therapeutic Enactment. Dayton (1994) argues that when individuals are entrenched in an addictive lifestyle, rigid and inflexible roles also get

developed. To maintain homeostasis even within a dysfunctional and addicted way of being, a person tends to defend their lifestyle and avoid challenges to their behaviours. Dayton postulates that addicted individuals begin to lead double lives, whereby serious discrepancies come to exist between their intrapsychic and outer worlds. Once rigid and inflexible roles are developed, "Even fun and humor have an unnatural intensity about them because they are used as much to release painful feelings or to control through sarcasm masquerading as humor as they are for enjoyment" (p.227).

The clinical issue of inflexible ego structure is pertinent to the case of Samantha, since we learned how inappropriate humor and laughter had undermined her in the actual custody battle for her children. It can be argued that Samantha's flippant attitude in the courtroom functioned as a defense mechanism that buttressed her state of psychological inertia and her lifestyle of addiction. Dayton (1994) suggests that psychodrama groups provide a safe forum for individuals to examine ineffective ego roles from a new perspective, to work through such conscious and unconscious processes, to learn new roles, and to practice new behaviours. In her Therapeutic Enactment session, Samantha did, in fact, become aware of how inappropriate laughter had worked against her during the actual custody battle for her children. She also worked through this issue via the processes of behavioural practice, experiencing a new outcome of the case, and being instilled with resourceful memories as well as an increased sense of hope.

The issue of unresolved grief and loss is also pertinent to Samantha's case, since she was obviously suffering profoundly from the loss of her children as a result of being addicted to drugs. Dayton (1994) believes that a primary task of psychotherapy in situations where a client has experienced grief and loss is, "to provide a safe arena in which [clients] can

undergo a process of mourning in a supportive, emotionally connected group” (p.216).

Dayton explains that, unlike other forms of psychotherapy, psychodramatic methods:

...offer an opportunity to speak what needs to be spoken and do what was left undone. [Clients] can finish old business in the context of an enactment. The final goodbye, the thing we never had a chance to say, the love that went unspoken, the tears that were never shared, the anger that was held in quivering silence—all can be role-played psychodramatically so that we can work through the unresolved loss, bring it to satisfactory closure and move on with our lives.

In her Therapeutic Enactment session, Samantha’s statements and her moments of emotional breakdown clearly showed how the loss of her children had left her in a state of grief. The session allowed her to explain the impact of losing her children and to express her feelings of injustice. She also took advantage of the opportunity to demonstrate her love for her children through language and behaviours, which resulted in a corrective emotional experience that helped her work through the grieving process.

The issues of shame and sexual abuse stand out as being relevant therapeutic objectives in the case of Gloria. Dayton (1994) describes shame as a basic attitude internalized by the self that manifests in, “a lack of energy toward life, an inability to accept love and caring on a consistent basis, or a hesitancy to move into self-affirming roles” (p.214). Consistent with adaptive theory of addiction, Dayton believes that individuals will use alcohol, drugs, food, sex, or work in compulsive ways in an attempt to moderate the feelings of emotional pain that shame often brings. She contends that psychodrama permits clients to give back to the perpetrator the shame that he or she has internalized as their own.

In this study, we saw a lucid example of this process in Gloria's enactment. Gloria made copious statements that indicate she had experienced shame as a result of being sexually abused (e.g., statements about low self esteem, feeling dirty inside, and not being herself). In her enactment, Gloria was able to fully understand the origins of her shame, to bring shame to life, and to give it back to her abusers with enthusiasm and vigor. Thus, Gloria was able to work through shame in Therapeutic Enactment through the processes of experiencing affect (getting in touch with her feelings), self-expression (letting her feelings out), and going through a corrective emotional experience (confronting the past and putting closure to these events in her life).

Sexual abuse was another central issue in Gloria's enactment. Dayton (1994) addresses the impact of sexual abuse on a child, stating that, "A deeply internalized sense of helplessness, defeat and terror results from being subjugated in such ways by an authority figure or a parent...and trusting the self is equally difficult because the victim may feel a deep sense of guilt or complicity..." (p.228). She insists that a critical component to healing process in sexual abuse cases is the individual's acceptance that he or she was innocent and truly a victim. She also asserts that traumatic memories are left unresolved or frozen in the psyche of the victim. Psychodrama is effective because it brings these memories to the surface where, "The story can be told and the frozenness can be walked, spoken, acted, cried, raged and worked through" (p. 229). In addition, psychodramatic methods result in new awareness for clients, which in turn, can lead people from a place of helplessness to empowerment.

In accordance with Dayton's (1994) theorizing, the method of Therapeutic Enactment engendered the all-important moment of self-awareness in Gloria—that is—she realized and

acknowledged that she was not responsible for what had happened to her. Her awareness did result in a change in self-schema whereby she came to characterize herself as a survivor rather than helpless victim. In sum, Therapeutic Enactment helped Gloria to overcome shame and sexual abuse through the processes of facing her issues, experiencing affect, raised self-awareness, self-expression, a change in self-schema, and experiencing a corrective emotional experience.

Turning to the case of Carrie, the primary clinical issues relevant to this case appear to be emotional numbness and difficulty forming empathic bonds. Dayton (1994) discusses emotional numbness in the context of children from dysfunctional homes who learn how to numb emotions in efforts to escape painful feelings. Consistent with the adaptive model of addiction, Dayton submits that children (and adults) can escape painful feelings through the use of substances or by learning how to cut themselves off from emotional experiences. While becoming emotionally cut off can be effective in reducing psychological pain, it can also block the individual from experiencing a multitude of other genuine feelings. The unfortunate result of this process is the negative state of feeling isolated and disconnected. To address emotional numbness in therapy, it is necessary for clients to experience emotions even though the process may be frightening and confusing. Because psychodramatic methods encourage involvement in emotional experiences for clients, this approach actively counters the process of emotional numbing and reintegrates the self, thus allowing individuals to feel whole once again.

In her Therapeutic Enactment session, Carrie returned to a painful childhood scene that contributed to her emotional numbness. The intervention produced self-awareness about how she came to be emotionally numb and to what extent this childhood event impacted her

adult life. Carrie reported that one of the most significant benefits of her session was her renewed ability to experience affect—a change that no other intervention she participated in was able to accomplish. By permitting the thawing of frozen emotions, Therapeutic Enactment further promoted the accompanying process of emotional expression.

Carrie also reasoned that early childhood experiences contributed to her difficulty in forming empathic bonds with others. Dayton (1994) surmises that when children do not receive satisfactory nurturance from caregivers the development of self is left incomplete. When individuals have a sense that their needs have not been met, they may find it difficult to become empathically and intimately engaged with others. As Dayton describes this situation, “...it becomes difficult for them to give from what feels like an empty place” (p.223). Psychodrama can access early pain (such as abandonment, rejection, or neglect) and allow the client to work through painful experiences and the defenses that may have been established to block pain. Dayton claims that psychodrama heals the self by presenting the client with the experience of empathy and nurturance. Once empathy is integrated into the self, the client is then able extended it to others and to form intimate, fulfilling attachments.

The experience of Therapeutic Enactment first enabled Carrie to become aware of the source of feelings like fear and anger that persisted into her adult life. This realization led to a further understanding of her behaviour in intimate relationships and her tendency to keep men at arm’s length emotionally. The intervention also produced a change in her self-schema and improved her interaction with others, so that she viewed herself as a less angry and more caring, loving person.

Lastly, the case of Paula was similar to Gloria’s because shame was a central issue throughout her Therapeutic Enactment session. Paula was shamed by many people who were

close to her and worked through this issue in her session via the processes of self-awareness, self-expression, cognitive shifts, and corrective emotional experiences. For example, through the process of self-expression, Paula gave back the shame with which she had been burdened to several people during her session. Paula emphasized the importance of this process, stating, "The part that I found helpful was me talking to them. Speaking to the people that hurt me. Having to say what I had to say with them listening. Just getting all this stuff out that I had to say to them." This process of expunging shame led her to have a more positive outlook (while not feeling as negative toward herself) and brought into her awareness the need to assume more self-affirming roles (e.g., "If I am going to be heard I have to be a bit more assertive").

Another major issue that seemed to characterize Paula's life was that of isolation. Dayton (1994) presents the issue of isolation as a common phenomenon that arises in addicted populations. In discussing isolation in the context of the addicted family, Dayton explains how family members often end up isolated because there are no avenues for receiving empathy, support, or validation. She contends that when it is not safe or possible to express genuine feelings, individuals suppress emotions and become trapped or isolated in their own suffering. Psychodramatic methods function to counteract this process because it draws individuals out of isolation and propels them into supportive interaction, sincere self-disclosure, and the experience of meaningful connectedness.

Paula was able to come out of a place of isolation in her Therapeutic Enactment session through the process of experiencing a new reality. Paula described how she had been isolated in her life while she extolled the benefits of Therapeutic Enactment:

Paula: "It was great [having particular people listen to her] because there is so much I have to say for how many years...and nobody would listen so I wouldn't bother trying, I just sat there and sat there."

Paula: "They sat there and listened and in real life they wouldn't listen. They'd be talking back and stuff and ignoring me. It really helped because they sat there and listened. That's the part that helped me the most."

Having people acknowledge, listen and validate her was the key to releasing her from emotional isolation. The intervention also helped to produce a cognitive shift, whereby she no longer weighted the importance of others' perceptions and words as heavily, asserting, "After I did the enactment it's [negative thoughts] all gone. And now they don't bother me and I don't have all these bad thoughts in my head. And if they had something bad to say about me, that's their problem...it helped me so much."

Thus, the findings of this study support Dayton (1994) in her contention that there are specific therapeutic objectives that can be pursued using psychodramatic methods. The findings are also consistent with researchers and clinicians studying gender differences in addiction treatment who have found that women enter treatment with different areas of concern than men, such as issues of parenting, issues around social support, low self-esteem, and sexual as well as physical victimization (Comfort, Zanis, Whiteley, Kelly-Tyler & Kaltenback, 1999; Dodge & Potocky, 2000; Grella, Polinsky, Hser & Perry, 1999). The women in this study did present with these problems and found help from the intervention of Therapeutic Enactment. Furthermore, the application of Therapeutic Enactment in this study also complies with recommendations published in, "Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems" (Minister of Public Works and

Government Services Canada, 2001). Not only does this document recommend that women focus on experiential learning during treatment, but it also espouses the exploration of family of origin issues because this kind of therapeutic work can significantly impact several life areas, such as parenting.

Delimitations

Despite the utility of using qualitative methodology to obtain accurate and detailed descriptions of the phenomenological experiences of clients participating in Therapeutic Enactment, the qualitative research tradition has certain limitations. According to Miles and Huberman (1994), researchers can overcome many limitations that are inherent in qualitative studies by operationalizing ways of testing and confirming findings. Although this study employed several tactics to overcome limitations and improve the validity of the research, certain limitations must be noted.

First, the extent to which the findings could be validated and generalized are limited due to the small number of participants in the study. The method of selecting participants was used to address this limitation and enhance the validity of findings. Three typical cases were selected (to examine normal or average aspects of the intervention) as well as one extreme case in an attempt to enrich the amount of data gathered. In addition, replication logic was used to compare findings across individuals and heighten learning opportunities.

Secondly, the issue of methodology raises another limitation of the study, that is, the problem of consistency of treatment across individuals. To address this potential problem, efforts were taken to ensure that the application of Therapeutic Enactment adhered to

standardized guidelines so that treatment effects can be assumed to be attributable to the intervention rather than the particular therapist or context.

Thirdly, the potential bias that results from researcher effects represents a further limitation of the study. Remaining cognizant of this potential bias, I attempted to strengthen the trustworthiness of the findings by acknowledging my own values and beliefs in the opening of the methodology section. I also took steps to avoid researcher effects on the site, such as, a) ensuring that the mandate of the study was clear to informants (through posters and verbal explanation), b) spending considerable time on the research site so as to fit in and reduce intrusiveness, and c) using unobtrusive methods (e.g., documentation) when possible (Miles & Huberman, 1984).

A related problem is the issue of social desirability bias. The clients in this study may have been attempting to please the researcher by telling me what I want to hear in order to confirm the effectiveness of the intervention. Thus, the study may be limited by the nature of the relationships between the clients and researcher. Although it is common in the qualitative tradition for the researcher to become immersed in the context of the study, it is possible that the clients perceived me as a friend whom they wanted to please. As a means to protect against social desirability bias, a research assistant was employed to conduct the initial interviews. Hopefully, this methodological precaution served to negate the potential effects of informants presenting biased data as a result of personal dynamics.

Moreover, one can assume that demand characteristics would not be operating given the ground up nature of this research and the fact that there was no hypothesis for participants to predict (Cozby, 1993). On the other hand, it was not easy to find disconfirming evidence—that is—evidence that explains how Therapeutic Enactment might not be helpful. In response

to the interview question that asks how the intervention might not be helpful, clients did not provide any data. This lack of disconfirming evidence may have been a function of social desirability bias and/or the relationship of the researcher to the participants. Still, it seems that even potentially disconfirming evidence was not found in this study. Examples of potentially disconfirming evidence could be a) if clients did not report any benefit from participation in Therapeutic Enactment, b) if clients were more distressed following intervention with Therapeutic Enactment, or c) if participants experienced a major psychological break down during the Therapeutic Enactment session. Since none of these outcomes occurred, it is submitted that no overt disconfirming evidence was found in this study.

Forth, the issue of self-reporting has been controversial in addictions research and therefore presents a potential limitation of this study. This limitation is lessened by the findings of other researchers who have discovered that participants accurately describe their experiences with addiction if interviews are thoughtfully created and conducted in a careful manner (Vaillant, 1983, cited in Alexander & Schweighofer, 1988).

Fifth, it is noted that some of the processes reported here might not have been a result of Therapeutic Enactment intervention exclusively. Clients at the Nechako Treatment Centre are involved in many other program activities outside of Therapeutic Enactment, such as gender-specific small therapy groups. It is entirely possible that the change processes experienced and reported by each client may have partially resulted from interventions other than the one under investigation in this study.

Finally, it is important to mention a limitation of the intervention of Therapeutic Enactment as it is applied to addictive populations. As mentioned previously, it is essential

that a skilled therapist who possesses formal training in Therapeutic Enactment deliver the intervention. Equally important is the readiness of the client, who ideally should have attained a significant period of sobriety prior to engaging in Therapeutic Enactment. It is further emphasized that group safety must be established before conducting Therapeutic Enactment sessions. Having identified these important preconditions, it is argued that Therapeutic Enactment is an ideal brief therapy to be employed in residential addiction treatment settings, where group intervention is commonplace.

Implications for Future Research

The findings of this qualitative study has produced a better understanding of how Therapeutic Enactment facilitates the recovery process and also serves as the foundation from which future research can be conducted. Future research could extend the findings of this study by using quantitative methods in a rigorous outcome study of Therapeutic Enactment intervention as it is used with addictive populations.

For example, a true experimental design could be employed whereby matched participants could be randomly assigned to experimental and control groups (e.g., clients that undergo Therapeutic Enactment, clients who are involved in all aspects of a treatment program except Therapeutic Enactment, and a no-treatment wait list control group). At the outset of the study, subjects could be administered a pre-treatment clinical interview and battery of quantitative psychological tests (e.g., measures of self-esteem, shame, addiction severity, stage of change, depression, family relationships, etc.) prior to the commencement of any components of treatment. At the end of the treatment program, subjects could be re-administered the battery of instruments and interviewed again. The data would be subject to

an assortment of analyses in an attempt to discover evidence that supports the efficacy of the Therapeutic Enactment component of the program as well as to obtain the best set of composite predictors of variables associated with a reduction in addictive symptomatology. Longitudinal data could also be obtained where subjects could be re-administered the instruments in order to examine whether or not treatment gains are maintained.

Based on the results of the present study, it is hypothesized that subjects who undergo Therapeutic Enactment intervention will differ from subjects in the other two groups by producing significantly different scores on the quantitative measures. It is further predicted that the data produced by this future research endeavor could contribute to the empirical testing of the adaptive model of addiction (Alexander, 1990), and potentially expand the theoretical knowledge base of this debilitating health problem.

In summary, future research could improve the delivery of health care by (a) contributing evidence for the use of Therapeutic Enactment as an effective, empirically validated brief intervention for treating addictive populations, (b) replicating previous research and providing additional evidence for targeting particular symptoms, which in turn, has implications for treatment planning, (c) further developing a concise treatment manual that documents the administration of this intervention, and (d) supplying data that could be used to test a comprehensive model of addiction. In addition, since the Nechako Center treats a large number of First-Nations clients, a future study conducted at this site may also contribute to theory and practice in cross-cultural counselling for addictions as well.

Conclusion

While the reader of this work must bear in mind the limitations of this study, the findings of this research are very positive with regard to the treatment of addictions using Therapeutic Enactment. Themes that came out of the analysis of the transcribed interviews were supported by other data sources collected during the investigation, thus strengthening the trustworthiness of the emergent themes. The themes from each case were, in turn, distilled into a list of common themes from across participants. The emergent themes support the therapeutic objectives presented in the literature and can be conceptualized as processes by which Therapeutic Enactment successfully addresses such therapeutic objectives. By supporting concepts and methods in the literature, this study forms the basis for future research that can be conducted to empirically validate the intervention. In conclusion, this study demonstrates the curative processes of Therapeutic Enactment and exemplifies an important intermediate step in the journey towards developing and validating an effective, efficient treatment for the serious problem of addiction.

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Appendix A

The University of British Columbia
Office of Research Services and Administration
Behavioural Research Ethics Board

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	NUMBER
Westwood, M.J.	Educ & Couns Psych & Spec Educ	BO1-0463
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT		
CO-INVESTIGATORS:		
Chan, James, Educ & Couns Psych & Spec Educ		
SPONSORING AGENCIES		
TITLE:		
Therapeutic Enactment and Addiction: Investigating the Process of Recovery		
APPROVAL DATE	TERM (YEARS)	AMENDMENT:
Oct 03, 2001	1	
AMENDMENT APPROVED:		
CERTIFICATION:		

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval of the Behavioural Research Ethics Board by one of:

Dr. Paul Hewitt, Chair
Dr. K.D. Srivastava, Director Pro Tern, Research Services

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures

Appendix B

The University of British Columbia
Office of Research Services and Administration
Behavioural Research Ethics Board

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	NUMBER	
Westwood, M.J.	Educ & Couns Psych & Spec Educ	BO1-0463	
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT			
CO-INVESTIGATORS:			
Chan, James, Educ & Couns Psych & Spec Educ			
SPONSORING AGENCIES			
TITLE:			
Therapeutic Enactment and Addiction: Investigating the Process of Recovery			
APPROVAL DATE	TERM (YEARS)	AMENDMENT:	AMENDMENT APPROVED:
01-10-03	1	20 November 2001, consent form	Nov 29, 2001
CERTIFICATION:			

The protocol describing the above-named project has been reviewed by the
Committee and the experimental procedures were found to be acceptable on ethical
grounds for research involving human subjects.

Approval of the Behavioural Research Ethics Board by one of:
Dr. Paul Hewitt, Chair
Dr. K.D. Srivastava, Director Pro Tern, Research Services

This Certificate of Approval is valid for the above term provided there is no change in
the experimental procedures

What is Required:

- 1) *Videotaping:*** You are being asked to consent to having your Therapeutic Enactment counselling session videotaped. The videotape of your enactment will serve as data to support the findings of the study. The videotapes are for research purposes only and will not be shared with any other persons or institutions. Only James Chan will have access to the videotapes, which will be kept in a secure place and coded to protect your identity (see Confidentiality section below).
- 2) *Interview:*** You are being invited to participate in one interview with James Chan and Desne Hall (Counsellor at Nechako and Research Assistant) in which you will be asked to talk about your experiences with the intervention. This interview will take place at the offices of Nechako and may take from thirty minutes to no more than two hours of your time. During the interview, you have the right to refuse to answer any question(s). At the end of the interview, you will be asked to complete a brief personal information questionnaire so that a summary of the participants' demographics can be given in the final report of the study. The information you provide will be kept completely confidential and you will not be personally identifiable in the study's report (see Confidentiality section below).
- 3) *Videotaping and Transcribing of Interview:*** You are being asked to provide permission for the interview to be videotaped and transcribed so that an accurate record of your description of your experiences can be created. The videotapes and transcripts are for research purposes only and will not be shared with any other persons or institutions. Only James Chan will have access to the videotapes and transcripts of the interview.

- 4) **File Data:** You are being asked to give James Chan permission to view information in your file and to use it as data in this research. The file information includes, but is not limited to, your self-evaluations while at the Nechako Treatment Center, paper and pencil measures that you completed while you were attending the program, as well as information provided to the Nechako center by your referral agent. The file information is for research purposes only and will not be shared with any other persons or institutions.
- 5) **Follow-Up Contact:** You are being asked for your consent to be contacted to participate in a follow-up telephone interview approximately three months from your initial participation in the study. Providing permission to be contacted later is not a commitment to participation in the follow-up telephone interview. If you agree to being contacted, the voluntary and confidential nature of the interview, along with other aspects of ethical research practices, will be explained once contact is made. At that time, your consent to participate in the follow-up telephone interview will be required before the interview can proceed.

Confidentiality: All of the information that you provide will be kept completely anonymous and confidential. Videotapes, paper and pencil measures, and transcripts will be given code numbers instead of personally identifying information. In other words, in order to protect your personal information, your full name will not appear on any documentation other than this consent form. All data, such as videotapes, measures, and transcripts will be kept in a secure locked filing cabinet. This informed consent form will be kept in a secure locked filing cabinet at a separate location.

Once the study is complete, a report will be produced. Any information that you offer in terms of your interview transcript, file data, or your follow-up telephone interview will be summarized in the study's report, and therefore, your comments will be kept anonymous and will not be personally identifiable. This report (which summarizes the results of the study so that individual participants cannot be identified) may be submitted to a professional journal for publication. The videotapes will be erased and destroyed once they have been viewed and transcribed. All other data obtained will be kept for five years in a secure location (with coded transcriptions kept separate from personal information). With your permission, all transcripts, consent forms, and any other data will be shredded and destroyed five years after the completion of the study.

Right to Decline or Withdraw: Your participation is completely voluntary and you may choose to withdraw at any time during the study without penalty of any kind. If you decide to withdraw at any point before the study is complete, the information that you have provided thus far will be destroyed. Your choice to withdraw from this study at any point will have no effect on the medical care or services you are receiving or are about to receive from the Nechako Treatment Center.

Potential Risks and Benefits: No direct risks are anticipated from participating in this research. However, it is possible that you may experience mild emotional distress as a result of talking about your experiences. If you do have this experience, you will be debriefed and offered support (see Debriefing section below). As a result of participating in this research, you may benefit by further integrating the therapeutic effects of the intervention through the consolidation of personal learning and psychological growth.

Informed Consent

I have read the above information concerning the study entitled "Therapeutic Enactment and Addiction: Investigating the Process of Recovery." I have had adequate opportunity to consider the information in the document, to ask questions pertaining to the study, and I understand the conditions of my participation. I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time without penalty of any kind.

I have received a copy of this consent form, and my signature indicates that I agree to participate in the study.

Name: _____

Signature: _____

Date: _____

Witness: _____

Telephone Contact Number: () _____

Appendix F

Interview Questions

*Remind client that they may ask for clarification or have questions repeated to them.

Pre Video Viewing Questions:

1. I would like you to think of your work with Therapeutic Enactment at Nechako and tell me about your experience. What impact did Therapeutic Enactment have on you?
2. What happened in your enactment?
3. Who were the important participants in your enactment?
4. How did the other people (that is, people playing roles) participate in the process?
5. What important part did the role have?
6. What is the story that can be told of your experience(s)?
7. What about Therapeutic Enactment did you find to be particularly helpful?
8. What about Therapeutic Enactment did you find to be unhelpful?
9. What did Therapeutic Enactment help you to learn?
10. In what way did Therapeutic Enactment impact your behaviours?
11. In what way did Therapeutic Enactment impact your thoughts?
12. In what way did Therapeutic Enactment impact your feelings?
13. What insights about your past have you become aware of since your participation in Therapeutic Enactment?
14. How do you think Therapeutic Enactment will help you with your recovery in the future?
15. What part did Therapeutic Enactment have in the treatment at Nechako?
16. What else would you like to say about your experience(s)?

Post Video Viewing Questions:

Now that you've had a chance to review your enactment tape and have been reminded of your experiences, I would like to return to a few questions.

1. What about Therapeutic Enactment did you find to be particularly helpful?
2. What about Therapeutic Enactment did you find to be unhelpful?
3. What did Therapeutic Enactment help you to learn?
4. What insights about your past have you become aware of since your participation in Therapeutic Enactment?
5. How do you think therapeutic enactment will help you with your recovery in the future?
6. What does recovery mean to you?

Thanks for participating!

Appendix G

Demographic Questionnaire

Thank you for your participation in this study. Would you please complete these final questions regarding general statistics:

1. Your Age: _____
2. Your Sex: Male _____ Female _____
3. Your Marital Status:

Single _____	Married _____
Common Law _____	Divorced _____
Separated _____	Widowed _____
Other _____	
4. How many sessions of group therapy did you attend where Therapeutic Enactment was used? _____
5. How many sessions did you participate in as the "protagonist" or focal person and enact a significant scene(s) in your life? _____
6. How many sessions did you participate in as an "auxiliary ego" whereby you role-played an "important person" in another client's enactment?

7. How many sessions did you participate in as a witness or member of the audience? (i.e., you were not the protagonist and were not selected to play a role in another person's enactment).

8. Did you attend counselling for concerns related to:
 - A. Alcohol use _____
 - B. Other drug use (specify) _____
 - C. Combination of alcohol and other drugs _____
9. A) How many other treatment programs for drug and/or alcohol related problems were you involved in before coming to Nechako? _____
 B) (If involved in other programs) Did you complete these programs? _____

10. Where were you born? _____
11. Where have you lived most of your life? _____
12. How long have you lived in the area indicated in question #11 above?

13. What is your current occupation? _____
14. What other occupations have you held? _____
15. What is your approximate yearly family income?
- | | |
|----------------------|-----|
| Under \$10,000 | ___ |
| \$10,001 - \$20,000 | ___ |
| \$20,001 - \$40,000 | ___ |
| \$40,001 - \$60,000 | ___ |
| \$60,001 - \$80,000 | ___ |
| Over \$80,000 | ___ |
| Prefer not to answer | ___ |
16. What is the level of your education?
- | | |
|----------------------|-----|
| Grade 8 or less | ___ |
| Some high school | ___ |
| High school grad | ___ |
| Some college | ___ |
| College grad. | ___ |
| Some post grad. | ___ |
| Masters | ___ |
| Ph.D., M.D., etc. | ___ |
| Prefer not to answer | ___ |
17. What is your ethnic background?
- | | |
|--------------------------|-----|
| Caucasian/White | ___ |
| Asian Canadian | ___ |
| First Nations / Native | ___ |
| Hispanic/Latino Canadian | ___ |
| African Canadian/Black | ___ |
| Other (Specify) | ___ |
| Prefer not to answer | ___ |

Thank you once again for your participation in this study, your input was very helpful!

Appendix H

Participant Number 1: "Samantha"

The therapist began the enactment by having Samantha talk about a significant part in her life that she felt was related to her addiction. Samantha told the group of her tumultuous relationship with an extremely abusive alcoholic man. After five years of marriage and two children, she separated from him and insisted that he leave the household, which he did. Samantha admitted that she turned to heavy drug use and drinking soon after the couple's split. After finding out about her substance misuse, her ex-husband initiated court proceedings in an attempt to gain custody of their children. Samantha told the group how her ex-husband often tormented her by calling the police to her house and accusing her of child abuse in order to strengthen his position in the custody battle.

Samantha reported that on the day of her court case, the judge told her that she did not deserve her children and awarded custody to her ex-husband because he thought that her ex-husband would make a better parent. This appeared to be extremely difficult for Samantha to disclose, as she fought back tears while telling her story. Samantha stated how much she dreaded the drive home from the courthouse as well as the fact that she had to tell her children that they had to live with their father. Samantha claimed that this event had such a severe impact on her that it "baffled her mind" and precipitated hospitalization for her substance abuse.

Samantha and the therapist decided to re-enact the courtroom scene so that she could express her felt sense of injustice and tell about the impact that the court decision had on herself and her children. The therapist had Samantha select other group members for her enactment scene and to place them in the room, which was transformed to resemble a

courtroom. She selected a person to play her ex-husband, another to play her current partner, and two to play her children. The therapist suggested that Samantha also include her parents as support, and she agreed to have them symbolically represented by chairs.

Samantha then walked with the therapist in a circle around the room and told the group about her ex-husband. When the therapist stopped her and asked her to address her ex-husband directly, Samantha began to laugh nervously. The therapist asked her why she was laughing and Samantha took a few moments to ponder the question. Samantha then stated that she thought she used laughter as way of avoiding emotional upset. The therapist asked her how she learned to use laughter to mask intense emotion. Samantha recalled how her mother threatened to abandon her when she was young in an attempt to shock her into behaving and also recalled how she responded with nervous laughter instead of tears. Samantha seemed to reach an important insight at that moment, remembering that she had laughed in the courtroom while on the stand and realized how she must have been perceived.

The therapist asked her what she might say to the judge after having that realization. Samantha began a soliloquy:

I didn't deserve to lose my children, I didn't do anything wrong! I was sober, I didn't do any drugs, I was with them all of the time. My doctor even wrote a note three pages long stating that my kids should never be taken from me. My doctor cried when I lost my kids because he knew my ex-husband. Everyone but the right people knew my ex-husband. And it's unfair—he's still hurting them! And there's not a thing I can do about it! I can cry, I can report it...and I still get hurt!

Samantha went on to address her children (saying how sorry she was) and then her ex-husband (scolding him for attempting to pit her children against her). This initial part of

the scene climaxed as Samantha admitted to her children that she had attempted suicide because of all she had been through.

After Samantha had calmed down, the therapist directed her into the set up of a new trial. Samantha selected group members to play the judge, jury members, and her lawyer. The Judge was placed behind a desk and the jurors were seated in a row along one side of the room. Samantha was seated with her lawyer and her current partner on either side. Her ex-husband was seated across from them.

The lawyer began the proceedings by announcing that Samantha did not have a voice at her last court appearance and that there were many things she wished to say. At the lawyer's invitation, Samantha spoke:

I just want to say that I've made mistakes in the past. But my children and myself shouldn't be punished forever because of it. I'm a good person and I deserve my children back! I tried to kill myself the same night that they [the children] went to their dad's but it didn't work. I stayed high for a year after that. Then I sobered up for a year and took my ex back to court and you still must have thought that I just laughed everything off. Six months after the trial, the kids told me how much they hated me because I made them go and live with their dad.

At this point, Samantha broke down in tears. She sobbed for minutes before regaining her composure. She went on to describe how she had lost another attempt at regaining custody of her children. She told the court how she sedated herself for two months and attempted suicide again because she had lost hope of ever winning her children back.

The therapist motioned for the ex-husband to speak.

“I’m winning and you’re losing!” he exclaimed. “You’ll never get them away from me!”

The judge called for order in the court and the therapist invited Samantha to respond.

“You’re not going to win...I’m gonna’ get my life together and get a job. You’ll always be a bum!” She blurted out.

The therapist encouraged her to amplify her voice. “You’re mean to them...I’m not going to let you hurt them anymore! I’m a winner, I’m going to get my kids back!”

By this time, Samantha had moved from speaking with a meek voice to a tone of conviction, challenging her ex-husband as if she had renewed energy. Her ex-husband continued with put-downs, claiming that she would never win. At the therapist’s direction, the judge put a stop to the exchange, and ordered a group member appointed to the role of bailiff to remove the ex-husband from the courtroom. Samantha began to weep once more. The jury left the room to deliberate.

After a moment of silence, Samantha began to speak. “I think I won. It was so real! I think I won already! I want to get my kids back.”

The jury returned to the room a few minutes later. The foreman of the jury reported that each jury member wished to address Samantha individually. One by one, the jury members ruled in favor of Samantha receiving custody of her children. All of them stated that they perceived Samantha to be a compassionate and loving mother. Some jurors, however, imposed the conditions that Samantha must complete her treatment program and continue with drug and alcohol counselling. Other jurors acknowledged that the ex-husband had been vindictive in trying to get the children to hate Samantha, and despite deserving visitation rights, argued that the father should seek counselling for his alcoholism as well.

With tears rolling down her face, Samantha was visibly moved by the decision and comments made by the jurors.

The therapist then brought the ex-husband back into the courtroom for his closing remarks:

Samantha, we have spent many wonderful years together and I don't know what went wrong. But those kids are both ours, and yes, I have used them as pawns against you and I am sorry for that. But I love them just as much as you do. They are a part of me too. I would never hurt them. What I would like to do is to have them live with you until I seek counselling and I am fit enough to be a part of their family again. You and I may never be together ever again, but they are our kids and they should have a father too.

Samantha watched her ex-husband intently and seemed to nod in agreement.

The therapist then provided the children the opportunity to speak. Samantha's young son spoke up. "We love our dad, but we'd much rather live with mom because we miss our mom."

His younger sister concurred, "I love dad but would rather go with mom."

Samantha's eyes filled with tears of joy. After a few moments, she dried her eyes and the therapist invited her to approach her children.

"And what do you have to say?" the therapist asked.

In a shuddering voice and with tears welling up, she murmured, "I love you guys very much and I want you to come home."

Samantha embraced her children and they returned a very sincere hug. It seemed a heartwarming resolution of the scene.

To close the enactment, the therapist had the judge announce that the children would be awarded to Samantha according to the conditions stipulated by the jury. The case was closed.

Samantha spontaneously shifted into the processing phase, and began to compare this experience to her experiences in real life. She claimed that she achieved a sense of relief from the enactment and experienced a feeling of calmness:

It was a good test for real life. Every time I think of court I don't have to get angry...especially with the ignorant things that my ex says. I pray that he will be like he was here today. This gives me something to hope for because there are decent people here. These people could have said I'm a phony, but they didn't. They said I deserve my kids because I love them. I do have hope.

The group went on to process and debrief the session.

Appendix I

Participant Number 2: "Gloria"

The therapist began the enactment by inviting Gloria to share with the group some of the events that they had discussed at a prior assessment and preparation meeting. In her private consultation with the therapist, Gloria claimed that some distant memories had returned to her conscious awareness after witnessing and participating in the therapy component of the program thus far. Gloria wished to re-visit some of those past memories and confront particular individuals in her Therapeutic Enactment session.

As Gloria and the therapist slowly walked around the inner perimeter of the circle, she immediately began to talk about her life when she was about ten years of age. She was already visibly upset and her voice quivered as she told how her mother used to leave her alone with her Grandmother on a regular basis. Gloria fought back tears as she went on to describe her first experience of sexual abuse. She talked about how her uncle used to motion her to come toward him, how she would run away, and how he would chase her even though she screamed for him to leave her alone. The therapist remarked how courageous Gloria was to resist and stand up to her abuser at such a young age.

Gloria skipped to describing her next experience of sexual abuse that occurred while she baby-sat at the home of her mother's friend. Her voice was timid and sometimes inaudible at this point. However, she managed to speak out about how this abuser dragged her from her bed, sexually assaulted her, and then returned her to her bed. By the end of her description, she started to sob and shuddered with every breath. Gloria completed her description of this assault by mentioning how unprotected she felt because nobody—including her Grandmother—stood up for her.

Her next memory was of her first Christmas at a new house that her family moved into one year. This time, Gloria disclosed how her brother came in while she was sleeping, abused her, and then quietly left as if nothing had ever happened.

The therapist invited her to set up the scene that they had planned together, but Gloria had more of her story to tell.

She launched into a description of her brother's housewarming party and the heavy drinking that took place there. The next thing that Gloria knew, all of her clothing had been removed and she had been sexually abused again. She told how she ran away from the house completely naked and how her uncle (the abuser) had come looking for her. Fortunately, her uncle was so intoxicated he fell unconscious and Gloria managed to escape.

Without stopping, she began to tell about another incident of sexual abuse perpetrated against her. This time, it was her cousin who forced himself on her. Gloria's cousin acted as if it were a game, but when she resisted, he picked up a rock and struck her in the eye. As soon as Gloria spoke these words, she broke into a fit of tears, crying uncontrollably.

When she collected herself enough to speak once again, Gloria had one more story to tell. She told the group of a man who made her touch him sexually and then offered her money afterwards. Gloria was unable to fight him off, as he forced himself on her, hugging...touching...

And then Gloria abruptly stated that she had blocked these people out of her life. That is, until she remembered that her own father had done this to her as well.

"You've been carrying this for a long time," the therapist responded. "And now you say the memories are returning."

Gloria nodded in agreement.

“And just so the group knows, you couldn’t tell anyone?” the therapist confirmed.

Gloria again nodded.

“You couldn’t tell your mom, and you couldn’t stop them,” he said. “And you were moved from place to place and yet somehow you managed to survive it. And now you’re getting to talk about it.”

Gloria nodded, sniffed and wiped away her tears with tissue.

“And you have brought some pictures as support?” he asked.

“Yeah,” she replied and set them on the mantle of the fireplace in the room.

“You also talked about bringing in your brother as a support,” the therapist queried.

Gloria motioned to a group member and asked him if he would play this role in her enactment. The group member agreed and the therapist had Gloria describe her brother and place him in the room. She talked about how protective her brother was and how he made her feel safe, and how much she revered him. Then she placed him right beside her, informing the group how much her brother cared for her.

The therapist then described how he and Gloria had planned to have some of the men in the group stand in as the people who abused her in her life. He explained to Gloria that they would be symbolically silenced so that her voice would be heard and so she wouldn’t be interrupted.

He then invited her to represent some of the abusers with chairs, and at Gloria’s request, four chairs were set in place in front of her. The arms and legs of the chairs were wrapped with masking tape to symbolize the silencing of the abusers.

The therapist suggested that real people be used to represent some significant abusers, such as her brother and her father, while chairs be used to represent those that abused her

when she was very young. Four male clients had already been asked to stand in as the abusers and sat patiently in the circle waiting to be called upon. Gloria nodded her head confirming that she had agreed with this arrangement.

Cueing Gloria to move into the action phase of the enactment, the therapist invited her to move toward the first group of four abusers (symbolized by chairs). As Gloria stepped forward, the auxiliary acting as her supportive brother followed closely. Gloria immediately began to weep, and after a few moments, initiated her soliloquy in a strong voice:

I was so small...I didn't know what you were doing to me. I didn't know if I was doing the wrong thing or not. You guys took advantage of me—you took my childhood away! I was just an innocent child; I didn't do anything to you! You hurt me and took away my innocence!

Gloria paused to take breaths in between sobbing. The therapist invited her to focus in one abuser and to speak in the here and now:

Uncle Joey, you are the one who started it all. You are always trying to control me, I hate you! Now, I'm giving all of that back to you! You hurt me and my sisters and I'm giving back to you now! I'm not taking it anymore, I'm not carrying it anymore! I don't need it! I'm taking my life back!

As she cried, Gloria reached for the foam baton. Then, with a sudden spurt of energy, she rushed toward the first chair and struck it with intense emotion three times. In between blows, she shouted, "I hate you! You hurt me!"

Gloria collapsed into the arms of the therapist and wept. Her brother and the therapist comforted her. Gloria regained her composure and the therapist led her back to the first chair.

“What would you like to do next?” the therapist asked.

Gloria used her foot to push the chair over, and moved back toward the safety of her brother and the therapist.

After a few moments had past, Gloria decided to approach the next abuser. Once again she exploded with emotion, berating the abuser in the here and now:

Jonathan, I was just a kid! I didn't even know who you were. You took it upon yourself to treat me like I was an adult...you took advantage of me because you are a sick dog! You're a sick person! And I am bringing you here today to tell you that I'm standing up to you and I'm not going to take it anymore! I'm going to give it back to you because you took my innocence away too... I was just a kid, I was just a little girl. Now, I'm a woman and I'm going to give it back to you. I didn't deserve to be treated like that! I was just a child and I didn't know what you were doing to me but I knew it was wrong... I'm taking my power back and I'm gonna' take my life back. You are not going to hurt me anymore. I'm not carrying it around with me anymore. Twenty years is too damn long to carry your bullshit around with me. I hope someone treats you the way you treated me!

Gloria finally slowed her speech and calmed herself down.

The therapist intervened in an attempt to modify her tendency toward retaliation, “Your justice will be done but not through me...” he remarked.

Gloria appeared to accept this idea, stating, “You're going to have to live with it now, not me! I'm not carrying your bullshit around anymore!”

She then walked over to the chair. This time, however, Gloria was much less aggressive and did not violently strike the chair as she had done before. Instead, she knocked it over using the foam baton and quickly turned away, walking back toward the therapist.

It appeared as though Gloria was returning to the therapist and her brother as a secure base where she could regain her strength and composure before venting her emotions on her abusers. There were two more chairs used to symbolize abusers in the enactment session. Gloria approached these two last chairs and expressed the thoughts and feelings she held in for so many years. At times, she would speak as though she was still a child, talking to the abusers in the present tense and using less sophisticated language. Gloria would always return to her adult voice, vocabulary, and past tense language as she assumed a position of strength and power while chastising the abusers.

For the last scenes of the session, actual persons from the group were brought in to represent sexual abusers that were Gloria's close family members. The therapist directed other counsellors to bring in each abuser individually and placed them on their knees facing the opposite direction of Gloria. The abusers had their hands tied and their mouths covered to indicate to Gloria that they could not interrupt her and that she would be heard. As her two cousins and her brother were brought before her, Gloria openly described the abuse that she was forced to endure. She also described other ways that these men had hurt her, for example, by betraying her trust, by failing to protect her, and by sexually abusing her instead. At some points, Gloria exploded in anger, and screamed at the abusers—forcing them to hear how she had been affected by the abuse. When prompted by the therapist to state what she wanted in the present, Gloria replied that she wanted them to hear how she was affected and how she wanted them to stay out of her life forever. After she had expunged these awful

memories and feelings publicly, the abusers were taken out of the room and out of Gloria's sight.

The last scene of the enactment occurred when Gloria confronted her final abuser, her own father. He was brought into the room cloaked in sheet that was used to symbolize shame. Gloria immediately broke into a lengthy soliloquy:

[Father] I am bringing you here for a reason. You are a sick, demented, sick person. I'm your own damned daughter—the only daughter you've got—and you took advantage of me! Like everybody else in my family almost! And you're my father! You're the one that brought me into this world—you were with my mother! How could you do that to me... I didn't mean anything to you but a sex object...I also lost my father because I'm not you're daughter anymore. You weren't there to protect me—you hurt me. You hurt me the most! You're a dirty dog!

With each statement that Gloria screamed, her father cowered and sunk closer to the ground. Gloria broke down in tears and wept as her brother comforted her. Her catharsis was an emotionally charged climax to the session. The therapist motioned for the other group members to gather around Gloria. The therapist then placed a mat on the floor and eased Gloria down to lay on the floor. Many people reached out and touched Gloria to support her as she wept. The group held each other and swayed back and forth in sync with Gloria's sobbing. Several minutes passed and Gloria let out a huge sigh of relief. One by one, the group members took turns hugging Gloria.

The group then moved to the processing phase.

Appendix J

Participant Number 3: "Carrie"

Carrie began her session by walking with the therapist within the circle and explaining to the group how she would like her enactment to proceed. The therapist encouraged Carrie to describe the people she wanted to be present in the session. Carrie had already approached individual group members who agreed to participate. She introduced and described her parents and siblings to the rest of the group.

The therapist then asked her to describe the scene from her childhood that she wished to re-visit. Carrie proceeded to describe a traumatic scene of domestic disturbance. She told the group about a turbulent night when she and her siblings were home alone and asleep in their bedroom while her parents were out. The therapist asked Carrie to pause as he directed other counsellors to re-create Carrie's bedroom by laying mats down on the floor to represent beds. The therapist then had Carrie bring her siblings into the scene and place each of them in their own beds.

Carrie's voice began to quiver as she went on describing the events of that particular night. She talked about how she awoke to her parents returning home from the local cabaret, drunk, as was typically the case with them.

She continued, "When we woke up and there was fighting going on and I could hear my Dad hollering...Francis goes into the closet and they shove me outside."

With her hands on her head and visibly distraught, she motioned for the scene to shift into action.

"My mom was on the floor right there and my dad was over there...I came out of the bedroom..." she remembered.

Suddenly, Carrie started to cry uncontrollably and hesitated.

Moments later, with tears rolling down her face, Carrie sobbed, "My dad was kicking and hitting my mom...He's got her by the hair and he's kicking her! And they told me I have to come out and stop the fighting!"

Carrie was visibly shaking and appeared to be experiencing the scene in the here and now. She screamed toward her father, "Please don't hit her anymore!"

She rushed over to her mother who lay on the floor and repeated her plea. Carrie then shifted back to describing the events of that evening from the perspective of the third person and explained how her father stopped the physical abuse and went into the kitchen. At first, she followed her father into the kitchen but then soon returned to check on her mother in the master bedroom. The therapist handed Carrie a towel to wipe her mother's face and a gown to wrap her in. He then invited her to speak in the here and now once again. Sobbing, Carrie wiped the imaginary blood from her mother's face and draped the gown around her before helping her to move from the floor to the bed.

Carrie sat at the edge of the bed and started to console her mother, "Things will be O.K." she said as she stroked her mother's back. He is not going to hurt you anymore."

She assured her mother that this wouldn't happen again and told her that she wanted to check on the other children and to talk to her father. Her mother nodded. Carrie then walked over to the bedroom, and, noticing that her youngest brother was missing asked, "Where's Frank?"

Her youngest brother Frank crawled out from the area that represented the closet and Carrie hugged him and put him back into bed. She turned and hugged her other siblings and assured them that their parents would not fight anymore.

The therapist stopped the scene and invited Carrie to reconstruct the events of that night, however this time, she would be more in control by having the power to stop the action and make changes whenever she desired. Carrie agreed.

The therapist then directed all of the players in the enactment to return to where they were before the parents returned home. He also had Carrie coach the group members who were standing in as her mother and father to act as her parents actually did that night.

Finally, the therapist asked Carrie to select a person from the group to double as herself so that she could stand outside the scene through parts of the enactment. She chose a person that somewhat resembled herself. The therapist also requested that she select another person to play a supportive figure from her childhood. Carrie chose a man from the group to be her older brother, Mike. When the therapist asked her why she would like him present, Carrie explained that Mike would have intervened to stop the fighting and physical violence between her parents. The therapist reminded her that things could happen in a way that was desirable to her during this session before directed the scene into action again.

Carrie's father crashed into the front door of the house and immediately began shouting at her mother. The therapist stopped the scene and turned to Carrie.

"Is that how it was?" he asked, checking the accuracy of the auxiliary's behaviour.

"No," she replied. "I just realized that he would not start yelling until the door was shut."

At that moment, Carrie realized that her father kept conflict a secret and that nobody in her family was ever allowed into her house. Acknowledging this insight, the therapist returned the scene to action.

Again her father came into the house with a crash, but this time waited until the door was closed before he started to curse at her mother and accuse her of an infidelity. The person playing Carrie's father was very convincing and intimidating as he screamed expletives and threatened her mother.

The therapist prompted Carrie to talk about what happened next. She explained how the children all awoke to the fighting that was going on and how they urged her to confront her parents. The therapist asked the person playing Carrie to speak.

The auxiliary cried, "I don't want to go out there...I won't go!"

After hearing the double's response, the therapist asked, "What do you feel right now, Carrie?"

"I feel better!" she replied.

"What do you like about this?" the therapist queried.

Carrie immediately responded, "It's that I don't have to go out and see! I don't have to go and protect her anymore!"

Following her reflections, Carrie was overwhelmed by a wave of tears and sobbing.

"Yes, it's over. You don't have to do that anymore," the therapist confirmed.

Then he turned to Carrie's double and instructed her to call out for her older brother. The double cried out for her brother Mike, telling him that their parents were fighting again. Mike rushed to intervene with the conflict between his parents and addressed them with a firm voice.

"What the hell is going on here? Get away from her!" he commanded as Mike pushed his father out of the room. "Go away!"

Mike then crouched by his mother and comforted her. He helped her to stand up and carefully walked her to the bedroom and lay her down. Carrie watched intently, and then spoke up to explain how her father would usually go out to have a cigarette after an outrage. The therapist invited Carrie to speak to anyone in the scene.

Carrie asked Mike to check on the younger children. Mike walked into the children's bedroom and touched each of them as he ensured that they were safe and sound.

"Do you have anything to say to anyone at this time?" the therapist questioned.

"My dad." Carrie stated.

The therapist walked with Carrie over to the kitchen and sat her down at the table where her father was having a cigarette. After a moment, Carrie began to speak:

It scares me when you raise your voice at me and mom. I wish you guys would not drink anymore—things are so much better when you're not drinking—and I don't want you guys to hang around all of these people. That's when you get mad and you get mad at mom all the time over these guys. And they say that they're your friends but you always get mad and you bring it around here all of the time. I just don't want you to get mad anymore.

"Tell him how that affects you," said the therapist.

Carrie began to cry and her voice sounded childish as she continued:

It makes me afraid...I always feel like I gotta' take care of everybody. I'm just a little girl; I shouldn't have to take care of everybody. I shouldn't have to take care of them when they're hurting. It stopped me from growing. It stopped me from being the person I know I can be.

Carrie's voice shifted from being soft as a child's to strong and loud like an adult's, as she declared, "I was always afraid of relationships and I've always been taking care of everybody else...and I'm angry about it!"

Her emotional state changed once again, moving from anger to sadness as she started to cry:

I was only a little girl! Why did I have to take care of everybody all my life? If only you hadn't hurt them, I wouldn't have to take care of them. You beat up mom and I don't want you to do that anymore! I want you guys to stop! Stop drinking! Life is so much better without it!

With the therapist encouraging her to continue, Carrie arrived at important insights: I was always afraid when I would go to bed when you guys were out. And in my life, when I was in relationship, I was always afraid. Then I would drink and they would do the same thing to me. And it always happened. In my relationships they always did. And I've stayed in them because I thought that was the normal thing to do. And now I know it's not!

"See if this fits...Dad I love you but I'm angry," the therapist questioned.

Carrie completed the sentence and arrived at more self-awareness:

I love you dad, but I am angry because of all of the violence and all of the accusations against mom—the alcohol and the violence. I hate being angry. And I did things in my own relationships to bring it out, not just physically, but manipulative and lying. Or I'd run away from relationships to hurt them emotionally. I would not allow myself to get close to anybody, especially men. And women...I thought women were pitiful. And I thought men were abusive, so I'd abuse them and abuse them. I would

love them to a certain point and then walk away and laugh about it. It was my way of getting back at the abuse that I grew up with.

“And what did you get back today?” the therapist asked.

“Me!” She said. “I don’t need to be that way anymore. Now I understand that I don’t have to manipulate, I don’t have to be afraid. I can love!”

The therapist motioned for the father to respond. Carrie’s father spontaneously responded with validation and taking responsibility for the abuse that he had put the family through. He also tried to explain his own feelings of jealousy and insecurity that motivated his behavior. He concluded with a sincere apology and an expression of love for his daughter, which produced tears in Carrie’s eyes. The two hugged for several moments.

The therapist asked Carrie what she would like to do next. Carrie explained how her mother would always apologize to the children following the father’s abuse, often making excuses for his behavior. At the therapist’s invitation, Carrie agreed that she would like to address her mother and walked over to the bedroom where her mother still lay on the bed. She took a seat on the edge of the bed and her mother began to apologize.

Before her mother could excuse her father, Carrie interrupted:

Mom, I know when dad hit you it affected me. And now I’m thinking about how it’s affecting me. It has by me being a server to them all of the time. Like, I am a good person; a good wife...I cook and I clean...laundry...I provide everything except emotional support. I’ve never been able to be emotionally supportive to a man. I’ve been the way you taught me, to cook and clean and be organized in my home, but I’ve not been able to be emotionally supportive to a man. I feel that what happened between you and dad—that stopped me from allowing my feelings to come out—the

love that I know I have in my heart. Like, that gentleness and that kindness...you showed me how to be a woman but I could never love anybody emotionally. I want to be able to do that!

With the last statement, Carrie became emotional and started to cry. "I want to be able to show my love to a man. I want to be married and happy. I don't want to be cold all the time. I want my daughter and sons to be loving like me."

Carrie's mother was also emotionally moved by the words being said. When it was time for her to speak, her mother first apologized to Carrie and then tried to explain her perspective on things:

I'm sorry that I didn't show my emotions, but I was afraid that if I did show my emotions I would get beat up again. That's why I kept it all in and I didn't teach you how to love, how to show your emotions and how you care for someone. I taught you the value of being in a family but not how to take care of your heart. And I'm sorry for not teaching you the right way. I did the best I could, I was always afraid that if I showed my emotions I'd get beat up worse. I wasn't there for you guys. So now I'm saying to you that I am sorry.

Carrie cried throughout her mother's reply. When her mother had finished speaking, Carrie reached out and hugged her mother for several minutes. The entire group watched patiently and many group members appeared to be entranced by the depth of this connection between mother and daughter. Eventually, the two separated from their embrace.

The therapist turned to Carrie and asked, "Is there anything else that you have to do?"

Without speaking, Carrie went over to the group members that were standing in as her siblings and held them in her arms one after another.

“Now I want to go back home and thank my real brother for how he helped me...I want to tell him,” she revealed. “And I also want to really thank everyone here for being a part of my release. Thank you.”

Her words served as a natural end to the session and the therapist called for a break before the group would continue with the processing phase. As the group broke, many witnesses from the group came over to Carrie and hugged her.

Appendix K

Participant Number 4: "Paula"

The therapist began this session by announcing to the group that the session would begin as usual, by giving Paula the chance to tell the group about a part of her life while walking in the inner circle. Paula decided to start by describing a section of her early childhood and recalled how her mother had given her to her Grandmother when Paula was only a little girl. Although this was supposed to be a temporary arrangement, it seemed that Paula frequently went back and forth between living with her mother and Grandmother. Paula also remembered that her mother physically assaulted her each time she went back to live at her mother's house. She circled the room and continued to hastily divulge significant events from her life, such as how her brother also began beating her around that period. The therapist interrupted Paula and asked her to slow down and provide more details.

Paula took a deep breath. Then, she briefly stated that her uncle had molested her shortly after her brother started beating her. After this announcement, Paula whimpered as she told the group how it was at this time that she realized that her mother really didn't want her, especially because her mother kept proclaiming love and promising to take her back—but never did.

To make matters worse, even her Grandmother began beating Paula after she had tried to reveal that her Grandfather had been touching her in inappropriate ways. But it wasn't the sexual or physical abuse that seemed to bother Paula the most. It was the fact that people had begun to gossip about her, saying very terrible things. Nobody would believe Paula's cries for help.

In a condescending voice, Paula imitated examples of what people were saying around that time. "How could he do that...he's a preacher...he goes to Church...he's a Christian...Look at him—he's so innocent!"

The therapist used empathy to validate Paula, "So it seemed everyone was against you."

Paula replied by telling the group that there was only one person who did try to help her, unfortunately, this friend moved away to attend a distant school, which again left Paula alone.

She began to sob:

Then everyone just talked and talked and talked and then laughed. And I was the joke of the family. They had nothing better to do than to talk about me. I don't know why. It seemed that it made them feel better!

The therapist summarized:

We talked about making those people central to the enactment. So far, I'm hearing about your cousin who was abusing you, your mother who abandoned you, and your brother who beat you, and the rest of the family that ridiculed you. Is there anyone else?

"That's it, those are the people who hurt me the most," Paula declared.

The therapist suggested that her current partner also be present during the enactment. She agreed, but had more of her story to tell.

Paula went on to describe how her Grandmother wanted to send her away because she thought that Paula was getting out of control. She suddenly began to weep. "That's when I

got pregnant and moved to [a nearby town]. And then that loser left me! 'It's not my kid', he said!"

At this point, Paula was very upset and walked with her head in her hands and tears dripping from her face. "That's when I met Danny and he tricked me into loving him because he showed me a side I wanted...but then he would fight me and put me down..."

Paula cried as she walked, underscoring her core issue to the group:

And I was a joke to him and his family. And a joke to him and his friends. And a joke to him and his girlfriends. And the whole town! Everybody just laughed about me! I just don't want to be ignored anymore...I want good attention—positive attention! I want people to stop talking!

The therapist interjected, "That's what is happening right now...people are listening...and that's what you want more of."

Paula nodded then qualified his statement, "But I don't know what they are thinking...they must think I'm a loser."

The therapist acknowledged Paula's concerns about what others thought of her and commented how her family of origin experience had impacted her negatively. He then asked her to look into the eyes of other group members so that she could know that she was no longer alone. Paula looked around the room and found comfort in the attentiveness of the group.

Suddenly, she returned to disclosing events from her troubled past. "To top it off," she cried, "they started to talk about my son...and to tell him things about me that weren't true!"

The therapist noted the pattern of gossip and slander that was occurring. Paula emphasized how she was tired of being humiliated and how she didn't want her son to be dragged into the negativity.

"So you're ready to put a stop to that pattern for both of you," the therapist stated.

"Yes!" Paula cried.

"Then we should start to select some people to stand in for today," the therapist suggested.

Immediately, Paula began the process of going around the room and soliciting group members to participate in her enactment. She had already approached individuals to represent key figures in her family, such as her mother, her abusive cousin (Roy), her Grandmother, her helpful Uncle (Oliver), her boyfriend (Doug), her brother (Billy), and her son (Donny). All of the group members whom she had previously selected confirmed their willingness to participate.

The therapist then revealed the plan to have Paula confront the original constellation of individuals who had ultimately robbed her of confidence and self-worth. He also suggested representing Paula's supportive uncle Oliver in the session as well as her son Donny at appropriate points during the enactment. Paula was invited to create the scene.

Paula immediately turned to the group member who was asked to stand in as her mother. The therapist asked her to place her mother in the room and to describe her in a few words. Paula placed her mother in the center of the room and depicted her as a cold, angry woman with crossed arms and who wore a frown. Next, she brought up her Grandmother and placed her beside her mother, but facing the opposite direction (indicating a rift in their

relationship). She then placed her uncle Oliver (a positive influence on her life) at the perimeter of the circle, looking in on the family.

Paula became visibly distraught and exclaimed, "He did see it, he did try to help me—he was watching and did try to help—but this was more than he could do!"

"About what?" the therapist queried.

Paula walked over to the group member who was to represent her abusive cousin but paused as if she was unsure where to place him.

The therapist prompted her, "What do you want to do?"

"Strangle him!" she whispered.

"He was your mother's sister's son," the therapist pointed out, "and if your mother knew something about this, where would you place him?"

Positioning him in front of her mother and Grandmother, Paula asserted, "They did know...but they loved him."

With the help of the therapist's direction, Paula brought her brother and her boyfriend into the scene and then stood back to survey the family. All of a sudden, she broke into tears and cried, "Just look at them!"

Staying in the moment, the therapist urged Paula to comment on her emotional outbreak:

Therapist: "Address what just happened."

Paula: "And say what?"

Therapist: "Say, 'look at you!'"

Paula: "I don't want them looking at her!"

Therapist: "Tell them."

Paula: "No, because they are just going to keep looking at her!"

Paula became quiet, apparently unable to express her inner feelings. The therapist encouraged her to select a double to stand in so that Paula could simply observe. Paula began to cry out loud as she watched her double express anger toward the family.

"Look at her...two-faced!" the double exclaimed. "Quit looking at her...she's a two-face...why do you look up to her...don't you see what she is like?"

The therapist asked if this was an accurate representation of her feelings and Paula agreed. He then suggested that her helpful uncle Oliver join her as a support. Paula acquiesced.

As soon as her uncle came by her side, Paula embraced him and began to weep profusely. After a few moments, the therapist prompted her to speak.

"Oliver, they were all so mean and horrible," she sniffed. "I didn't do anything to them...I didn't do anything!"

Paula stomped her feet in anger as she spoke to her uncle. The therapist directed the double to replicate her thoughts and feelings:

I didn't do anything! Why are you guys so mean? You guys hurt me and you know he hurt me! How could you do this? And then you guys talk about me! And you're hurting me and my son now! And I won't take it anymore. And I'm here today to tell you guys that! You've hurt me long enough!

Paula cried intensely in the background as she watched her double castigate her family members. Shortly thereafter, she regained her composure and asked Oliver for his help to stand up to her family.

"Are you ready to tell them?" Oliver questioned.

Paula nodded and the therapist led her over to take the place of her double opposite her family. Paula sheepishly pushed Oliver in front of herself, explaining that she was afraid that they would not hear her and start talking about her again. The therapist instructed Oliver to confront her family in Paula's defense. Paula pointed to her mother and whispered in Oliver's ear.

In turn, Oliver communicated Paula's message:

Lisa [Paula's mother] will you look at me and pay attention? Do you know that your daughter feels like a rat and that she is scarred of you? It's time you listened to her. You need to look around and see what is going on in this family. You know what is going on don't you?

Oliver turned and asked Paula to speak.

Paula replied, "She's turning everyone against me!"

Oliver repeated the accusation.

Paula began to open up to her mother in a soft voice, "You hurt me. You were so mean. All I wanted was for you to love me. And then you talked about me. I just wanted you to love me. I'm your only daughter—that's all I wanted."

The therapist added, "What I needed was..."

Paula continued. "What I needed was your love and support. I needed it so bad. And you and Doug just laughed and said I deserved it."

Her voice became stronger and she started to shout, "I want to hurt you the way you hurt me—you're sick. Nobody does that to a little kid, nobody!"

Paula expressed intense hostility toward her mother, calling her “cold” and “hard” until she finally warned her mother that she would leave if she did not stop the hurtful behaviour. Paula took a break to blow her nose.

The therapist recommended that her son join her and Paula motioned for Donny to be placed behind her.

She continued, “You’re not going to hurt me anymore. You won’t. And I won’t let you do that to Donny. I won’t let you do that to him—he’s my son. I won’t let you hurt him like you did me.”

Paula claimed to feel better after rebuking her mother and seemed to possess a renewed sense of strength. She told her son to sit down in the corner while she went on to confront the next member of the family. She reached over to link arms with her uncle Oliver. This time, however, she walked directly toward her brother with Oliver in tow rather than having to be coaxed by him. With a stern tone, she began her tirade:

I’m angry and mad! I’m so pissed off at you...you’re such a loser, picking on girls. You had everyone on your side. You knew you had mom on your side...because you’re the baby. I didn’t do anything to you. I used to play hockey and baseball with you...you think you are so good now! You’re not! You’re an alcoholic. At least I’m trying...but all you can say is ‘look at her, she needs help.’ Well, you let me down! You let me down when I was in school...all of those kids were laughing at me for being an Indian and you were in my class and all you did was laugh at me. You let them do that to me—you’re my brother and you’re an Indian too! You let them fight...and pick on me—I thought you were gonna’ protect me. You didn’t protect me from anybody!

The therapist intervened, "All I want you to do is..."

"All I want you to do...all I would like from you is to say sorry," she said. "I want you to say sorry to me!"

Paula's brother stared into her eyes for a few moments before presenting her with a sincere apology. He later added an explanation—that he was a coward—and should have stood up for her. Paula accepted his words and turned away. Leading Oliver by the hand, she walked over to her grandmother.

This time, Paula sounded timid as she started to address her Grandmother. She reminded her Grandmother how strict she was as a parental figure and how she wasn't allowed any friends. As tears came to her eyes, she also compared her Grandmother with her mother:

You're cold hearted, just like her. You loved her more than you loved me. I just wanted you to love me. I just wanted you to love me and protect me from that loser. And instead you laughed at me! Like nothing happened—and it did happen! It did happen! He touched me and I didn't like it and I cried to you—you didn't believe me! Why would I make something up like that? You're supposed to protect me but you didn't. You hurt me and now you must hold a lot of guilt. I want you to know how much you hurt me. I want to know why...why didn't you protect me?

Before apologizing, her Grandmother explained that she ignored the abuse because she was afraid that if others found out, the family would be disgraced. She admitted that the abuse did occur, which seemed to give Paula a sense of relief. Paula's Grandmother then offered a heart-felt apology and approached her for a hug. The two women embraced one

another and cried for several minutes. Finally they broke away and Paula returned to Oliver's side.

With only two family members left in the scene, the therapist suggested that Paula address her abusive cousin, who lay on the floor behind her. Since her cousin is now deceased, the therapist represented him in a grave, covered by a linen sheet. Slowly Paula approached the gravesite, growing more distraught with every step. With her hands partially covering her face and her body shaking, Paula spoke out:

Where you are is where you belong. You were a loser who likes to touch little girls and you had your little cover-up, that you were a preacher and a Christian. I know you did that to your daughters too because they told me—you did it to me! You wrecked my life and put everyone against me too! Nobody believed that you touched me. I felt so unwanted! Nobody wanted me! What you did was wrong—you were wrong! I want you to know that's why I didn't go to your funeral. And everyone knows why I didn't go! They buried you like a warrior—you're not—you're just a child molester! People knew you did that! You're not a hero and I just won't let you get to me anymore!

Paula abruptly turned and walked away. She then took a few moments for some deep breaths and to blow her nose before looking around the room for her son. She walked over to Donny and took him by the hand. Oliver followed and reached for her other hand, but Paula did not welcome his support, preferring to complete this last confrontation on her own. In a trembling voice, she called out for her partner to face her. When Doug turned around, Paula began to weep.

“You tricked me when I was vulnerable,” she moaned. “You used to fight me and I don’t know why...and I thought I couldn’t leave you because that is what I deserved.”

With her last statement, Paula appeared to arrive at an important insight and shifted to adopt a different stance vis-à-vis Doug. She went on:

And then you would talk about me—and you still do! Donny hears all of this and I don’t like it! I’m trying...I don’t want your mind games—you mess with my head all of the time! Stop playing head games with me, it hurts...and you do this in front of Donny, he doesn’t need to see that. We argue and I try not to argue with you and I don’t want him to see it. Sometimes, I don’t know why I’m with you...then we have our little moments that make me want to stay with you and I think somewhere inside that you will love me, that you’ll actually show me. I’ve got this picture of us, of when we first started going out—you were such a beautiful man—you wanted me so much and you accepted my son and loved us both so much and now he’s seen something different. I don’t want him to be confused.

The therapist invited her to conclude. “So what I am going to do...”

Paula completed the sentence stem, charging:

If you don’t stop playing head games, if you don’t start doing something about it...I’ll leave you. We don’t need this anymore. This is it. I’ll leave you. I don’t know why you’re doing it; you’re just as bad as they are. And I won’t start fighting with you again.

Paula hesitated and rocked back and forth as she held her son. After a period of silence, the therapist asked if she had anything else to say. Shaking her head, Paula declined.

To bring the session to a close, the therapist had Paula take a chair in the center of the room with her son seated on the floor in front of her. He then invited the group members to approach Paula individually and to honor her with a positive affirmation and some reflections of the session. One group member hurried to her side and announced his thoughts:

What I saw at the end when you stood holding your son was a woman with courage and dignity—her chin lifted up—her eyes looking into the distance of a future holding her son strongly, almost like a tree. You are strong and have dignity and I wanted you to know that.

One after the other, each group member approached and acknowledged Paula, describing her with supportive words such as nurturing, brave, admirable, and loving.

The last comment came from her own son, as he turned to her and said, “Today, I got my mommy back!”

The group recessed before progressing to the processing phase.