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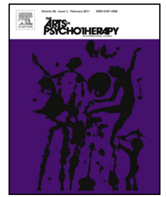

The effect of drama-based group therapy on aspects of mental illness stigma☆

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ABSTRACT

This study examined the effect of drama-based group therapy on the self-esteem and self-stigma of five participants with mental illness and on the public stigma of seven university students without mental illness who participated in the same group. ABA single-case experimental design was utilized to systematically assess change across 14 time points. We used visual analysis to inspect change as well as hierarchical linear modeling that allows the aggregation of single-case results to the population level. To study the effect of the treatment, contrasts were examined, comparing scores at baseline, treatment, and follow-up. The findings for all measures indicated a significant difference between scores in the baseline phase compared with scores in both the intervention and the follow-up phases. Significant differences were not detected between scores in the intervention phase and the follow-up phase. Interpretations of findings are provided, followed by a discussion of possible change processes, limitations, and future directions.

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Introduction

Mental illness stigma is a worldwide phenomenon that has a range of negative effects on people with mental illness: from objective effects such as unemployment, income loss, social ostracism, and reduced recovery orientation to subjective psychological effects such as increased depression and reduced hopefulness and self-esteem (Drapalski et al., 2013; Hinshaw, 2007; Link & Phelan, 2001). Using a single-case design, this study examined the effect of drama-based group therapy on the self-esteem and self-stigma of five participants with mental illness and on the public stigma of seven university students without mental illness who participated in the same group. As we demonstrate below, while previous studies examined stigma reduction and increased self-esteem, and a small number of studies examined the impact of drama therapy and psychodrama on people with mental illness, virtually no intervention studies examined the effect of drama-based therapy that assembles people who have mental illness and people who do not have mental illness in the same group. First, we review the literature on stigma, focusing on public stigma and self-stigma and their relationship to self-esteem. Then, we briefly review the theoretical framework of psychodrama and drama therapy, followed by a brief account of treatment research in these modalities. We then describe the treatment examined in the present study, report the results, and provide a discussion that it is hoped will stimulate further research.

Stigma

In his seminal work, Goffman (1963) defined stigma as "an attribute that is deeply discrediting" (p. 3). Since then, various conceptualizations of stigma have been offered in the literature. Link and Phelan (2001) offered a sequential conceptualization of stigma that is not restricted to mental illness, according to which stigma exists when the following interrelated components converge: human differences are labeled; stereotype is formed when dominant cultural beliefs link labeled people to undesirable characteristics; labeled people are seen as an out-group, as "them" and not "us"; and labeled people experience status loss and discrimination that leads to unequal consequences (p. 367). A different conceptualization suggests that stigma refers to problems of knowledge (ignorance or misinformation), attitudes (prejudice), and behavior (discrimination) (Thornicroft, Rose, Kassam, & Sartorius, 2007). Another model proposes that stigma consists of different cognitive, emotional, and behavioral aspects: *Stereotype* refers to negative beliefs about the targeted group; *prejudice* refers to agreement with these negative stereotypes and/or reaction to negative emotions as a consequence; and *discrimination* refers to behavior response to prejudice (Rüsch, Angermeyer, & Corrigan, 2005). In this model, stigma is categorized as either public stigma or self-stigma, with each consisting of the above-mentioned elements of stereotype, prejudice, and discrimination (Rüsch et al., 2005). We focused on both public stigma and self-stigma because they are most pertinent to the treatment examined in this study.

Public stigma

Public stigma refers to society's endorsement of prejudice and the manifestation of discrimination toward people with mental illness (Corrigan, Watson, & Barr, 2006). Studies indicate that individuals with mental illness are often perceived as unpredictable and dangerous and as people who are unable to follow accepted social roles, who are culpable for their conditions, and whose illness or disability is difficult to treat (Angermeyer & Matschinger, 2005). Thus, on top of the illness itself, society's reaction to individuals with mental illness has an equally harmful impact on their well-being. Public stigma leads to

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the exclusion of people with mental illness from society, through their rejection by society and their own social distance because of fear of rejection. This exclusion may lead to depleting social networks, forcing these individuals into solitude and further undermining their chances of recovery (Link & Phelan, 2013; Yanos, Roe, Markus, & Lysaker, 2008). However, in some cases, the reactions to stigma are positive and lead to personal empowerment, such as through active engagement in treatment and in the promotion of improved psychiatric services in the community (Corrigan & Watson, 2002). Still, public stigma also has serious consequences for the internalized self-stigma of people with mental illness.

Self-stigma

Self-stigma, also referred to as *internalized stigma*, is the conscious or unconscious process of internalizing public stigma that leads to personal "shame, blame, hopelessness, guilt and fear of discrimination associated with mental illness" (Brohan, Slade, Clement, & Thornicroft, 2010, p. 2). Past research shows that self-stigma is related to reduced hopefulness, self-efficacy, and social functioning (Boyd, Adler, Otilingam, & Peters, 2014a; Yanos, Roe, Markus, & Lysaker, 2008), as well as to a loss of previously held, or hoped for, identities such as self as student, self as worker, self as parent, etc. (Yanos et al., 2008).

Self-stigma is also linked with reduced self-esteem. We follow Rosenberg's (1965) *widely accepted definition of self-esteem* as a favorable or unfavorable attitude toward the self (p. 15). Evidence of a negative link between internalized self-stigma and the self-esteem of people with mental illness is prevalent in the literature (Boyd, Otilingam, & DeForge, 2014b; Corrigan et al., 2006). The significance that people with mental illness attribute to their illness not only affects their self-esteem but also has a decisive impact on their recovery process in terms of leading to low involvement in rehabilitation and the tendency to adopt strategies of social withdrawal (Roe, 2003; Yanos et al., 2008).

Drama and therapy

Both psychodrama and drama therapy use dramatic techniques and processes for therapeutic change, and both are primarily known as group therapies but have also been applied with individuals, couples, and families (for comparisons of the two disciplines, see Kedem-Tahar & Kellermann, 1996; Leveton, 2001).

Psychodrama (PD) takes place in what J.L. Moreno, its creator, has called *surplus reality*: the reality beyond everyday reality, an extended realm of dramatic action wherein clients actively explore their feared and hoped-for past, present, or future. Within this fail-safe reality of play and pretend, clients can explore different ways of coping with problems "without risking serious consequence or disaster, as they might in life itself" (Moreno & Moreno, 1975/2012, p. 19). Moreno believed that people have the innate capacity for *spontaneity and creativity*, twin concepts referring to two positive human qualities that are essential for adapting to life's inevitable changes and challenges. In the PD context, spontaneity is distinct from uninhibited impulsivity in that it is intentionally induced. It is a state of readiness that catalyzes creativity; it propels "the individual toward an adequate response to a new situation or a new response to an old situation" (Moreno, 1953/1978, p. 42). Furthermore, Moreno believed that human potential comes to full actualization not in isolation but in relation to others (Moreno, 1949, p. 238). This notion is reflected in his concept of the *encounter*: a deep interpersonal communication that involves the mental reversal of roles with others and the meeting of one's self and others directly and authentically, with all strengths and weaknesses, to deeply consider their viewpoints and experiences (Moreno, 1960, 1969). The PD technique of *role reversal* is the concrete dramatic manifestation of the encounter, enabling clients to take on the role of others and "stand in their shoes."

Unlike PD, drama therapy (DT) does not refer to one theory or a set of techniques created by one person. Rather, it has multiple theoretical and clinical approaches that were created by different originators (see Jennings, 1994; Johnson & Emunah, 2009). Nevertheless, Jones (2007) defined the following nine core processes (i.e., therapeutic factors) that are at the heart of therapeutic change in all DT and are not confined to one approach: dramatic projection, therapeutic performance process, dramatherapeutic empathy and distancing, role playing and personification, interactive audience and witnessing, embodiment, playing, life-drama connection, and transformation. Of these nine processes, we focused on two that are most notable in our work with people with mental illness and therefore served as lenses through which we observed the intervention: witnessing and playfulness. *Witnessing* typically refers to the role of the audience as a witness to the drama being enacted. The experience of being witnessed can be experienced as being acknowledged, validated, and supported, which is particularly relevant when working on stigma and self-esteem with people who have mental illness. Witnessing in DT not only involves witnessing others but also witnessing oneself by the use of mirroring, doubling, role reversal, or objects that represent aspects of the self. Clients may develop an inner witness to themselves that may enhance their ability to guide their actions and shape their inner experience. Jones explained that a DT client is a participant observer who can experience both the audience and performer roles that may change from moment to moment. *Playfulness* refers to a state "characterized by a more creative, flexible attitude toward events, consequences and held ideas" (Jones, 2007, p. 88). DT invites clients to enter a playful state to be able to experiment more freely with new roles and attitudes toward themselves and their life experiences. Unlike solitary play activities, playing in DT may facilitate a client's awareness of others through playful interactions in a realm of flexible time, space, and everyday rules and boundaries. Thus, we posit that playful interactions are important for reducing self-stigma and public stigma. To summarize, surplus reality, spontaneity and creativity, encounter, role reversal, witnessing, and playfulness are core concepts that we revisit in the "Discussion" section of this paper.

Drama-based intervention studies

Academic research on the therapeutic effectiveness of PD and DT is relatively limited compared with research on other methods of treatment. Throughout the years, the focus has mostly been on describing and explaining processes through anecdotal experiences, clinical vignettes, and case illustration reports. In the PD literature, three systematic reviews of research have been most widely cited. In Kellermann's (1987) review of 23 outcome studies in classical PD (published between 1952 and 1985), he concluded that "psychodrama is a valid alternative to other therapeutic approaches, primarily in promoting behavior change with adjustment, antisocial, and related disorders" (p. 467). Kipper and Ritchie (2003) conducted the first meta-analytic study of psychodrama research that focused on the effectiveness of using specific PD techniques in 25 experimentally designed studies (published between 1965 and 1999). The analysis revealed "an overall effect size that points to a large size improvement effect similar to or better than that commonly reported for group psychotherapy in general [and] the techniques of role reversal and doubling emerged as the most effective interventions" (p. 13). Most recently, Wieser (2007) descriptively reviewed 52 studies on the treatment effects of PD, concluding that "there is still a need for basic research into the effectiveness of psychodrama therapy" (p. 282). Since then, although no systemic review has been published, researchers continue to examine the effectiveness of PD on, for example, aggression and violence (Karatas & Gokcakan, 2009; Smokowski & Bacallao, 2009), painful emotional experiences (McVea, Gow, & Lowe, 2011), coping with HIV/AIDS (Karabilgin, Gökengin, Doğaner, & Gökengin, 2012), treatment of sexual offenders (Hollander & Craig, 2013), and parental psychopathology (Vural, Akkaya, Küçükparlak, Ercan, & Eracar, 2014).

Past studies have also examined the effectiveness of DT on a range of disorders and populations (for detailed literature reviews, see Chapman, 2014; Yotis, 2006). A systematic review of DT studies on schizophrenia and schizophrenia-like illnesses concluded that because there was too little extant research to execute a full systematic review, there are no conclusive findings on the benefits or harms of the interventions (Ruddy & Dent-Brown, 2007). In a two-part article, Jones (2012a, 2012b) examined factors that affected the development of DT research, advocating for training in a range of methodologies, for interdisciplinary collaborations, and for publications in formal and informal outlets, in local as well as in international peer-reviewed journals.

We searched scientific databases (ProQuest, Scopes, ISI, PsycNET; 1980–2014) to identify studies on drama-based treatment groups that brought together individuals who have mental illness with individuals who do not. One study was identified wherein people with mental illness and community members jointly participated in DT groups of therapeutic theater (Emunah & Johnson, 1983). The rationale for assembling these groups was to foster the integration of recovering psychiatric clients "into the community by providing them with a normative social experience" (p. 23). The authors concluded that direct, onstage dramatic disclosure of their illness-related struggles, rather than indirect and symbolic disclosure, was most empowering for the recovering psychiatric clients. Finally, a different line of studies in the literature suggested that drama-based educational interventions, wherein children and adolescents participated in role-plays and/or watched theater performances, increased their awareness and reduced their stigma regarding mental illness (see Essler, Arthur, & Stickley, 2006; Roberts et al., 2007; Sakellari, Leino-Kilpi, & Kalokerinou-Anagnostopoulou, 2011).

Study purpose and hypotheses

The purpose of this study ($N = 12$) was to examine the effect of drama-based group therapy on the self-esteem and self-stigma of five participants with mental illness and on the public stigma of seven university students without mental illness who participated in the same group. We posited the following hypotheses: (1) Throughout treatment, self-stigma will decrease in participants with mental illness; (2) Throughout treatment, self-esteem will increase in participants with mental illness; and (3) Throughout treatment, public stigma will decrease in student participants.

Method

Participants with mental illness

The five individuals with mental illness were members of the "Amitim Program" sponsored by the Israel Association of Community Centers and the Ministry of Health. The Amitim Program was established under Israel's Rehabilitation in the Community of Persons with Mental Disabilities Law, which was enacted in 2000. The

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