ANGLIA RUSKIN UNIVERSITY

STILLBORN TO REBORN: A DRAMATHERAPY JOURNEY

FROM POST TRAUMA TO RECOVERY

By Rachel Bar-Yitzhak

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This thesis is dedicated to the memory of my dearly beloved husband

Yair without him it would never have been completed

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Abstract

This research explored the role of extra-therapeutic variables contributing to recovery from chronic Post Traumatic Stress Disorder (PTSD). Within the context of dramatherapy treatment, those variables were identified as three crucial concepts: *'Client, Post Traumatic'* (C.PT), '*Imaginary Existence Zone'* (IEZ) and *'Time Adjusted Encounters'* (TAE). Together they created the notion of a *Curative Zone* (CZ). Establishing and understanding the significance of these new concepts helped the researcher to explain the PTSD recuperation phenomenon.

The research was conducted within the qualitative–naturalistic paradigm, and based on real-life dramatherapeutic occurrences. The choice of an inductive case study approach and design was possible due to the fact that a single individual was willing to participate in this research as an active partner by contributing her reflections on the therapy, four years after its termination. Iris, the client and the collaborating respondent was a childless woman aged 43, who suffered from chronic PTSD for three years following stillbirth of her baby daughter and the repetitive failure of fertility treatments.

The findings reveal a direct linkage between: the neurological system and its activation, and the cardinal role of the C.PT during TAE, working through prolonged engagements in the IEZ facilitated by dramatherapy. These processes gradually integrated and synthesized to create the CZ, a development which explains this instance of recovery from chronic PTSD.

The conclusions are: the chronic PTSD recovery was a holistic body-mind cure phenomenon. It resulted from the interaction between the extra-therapeutic variables, combined with the curative characteristics of the dramatherapeutic nonverbal imaginative language and activities, which compounded a new synergetic constellation. The research findings contribute to the theory and practice of dramatherapy as a discipline; additionally, the model developed by this research can be potentially applied as an appropriate treatment of PTSD. These conclusions challenge valid psychotherapy knowledge regarding effective therapeutic factors that contribute to successful outcomes. However, in this case they verified credible, dependable and transferable attributes features this naturalistic research. Therefore, they make a contribution to knowledge in the dramatherapy field.

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Personal Prologue

This thesis reflects two paths, the personal and the scholarly. In some mystical way they coincided and had a tremendous impact on the lives of two people – Iris and me. It had to be written in order to lighten the burden of other distressed women. In this prologue I would like to give you an idea of my personal and professional journey over almost four decades; a journey marked by traumatic experiences which have had a profound and lasting effect on my life. Above all, I hope that taking part in Iris' journey of recovery and the fact that I was able to complete this long term study will assist me to live in peace with myself in the future and achieve my own cure.

First Way Station

At the age of 24, my first pregnancy ended in the fifth month with a 'pathological placenta' and no foetus. Molar Pregnancy is the medical term for this rarity. I was advised to avoid pregnancy for a year, advice which, like my entire treatment, reflected purely medical considerations. No one addressed the emotional implications this traumatic experience had for me. I was overwhelmed, angry, sad, guilty, and depressed for a long time. In vain I tried to understand why this had happened to me while I simultaneously mourned my losses – my pregnancy, my baby, my hopes, and the role of a mother.

As soon as the year was over, I was determined to become pregnant again and for two more years I was subjected to tests, medication and other medical interventions — to no avail. In addition to this frustration I underwent an intrusion into my most intimate life – I had to take my temperature daily, check my ovulation and have intercourse accordingly. A spontaneous natural act turned into a project. It was absolutely not my image or hope of a romantic loving marriage and intimate relationship with my husband.

A long honeymoon was replaced by a physical ordeal. My sense of humour, optimism, and openness gave way to bitterness, stress and tension. At one point I even experienced a 'false pregnancy', which shows just how anxious I was to

become pregnant. In fact, it was only the work for this research that brought back the memory of this very uncharacteristic episode: I had actually managed to forget it.

Second Way Station

Eventually, with hormone treatment, I did become pregnant again. The news had an almost magical effect on my entire existence. I felt I had walked out of the dark and into a zone of light. Then, after nine months of healthy normal pregnancy during which I felt blessed, the darkness caught me again. The happiest and most meaningful event in 27 years of life— giving birth to my first son — was also one of shock, devastation and trauma. My son was born with a 'clubfoot', a severe leg deformity. Alone, without my husband, I cried the whole day. I felt my world was falling apart. Two doctors brought Amir to me and showed me his little tiny legs in a cast. I felt helpless and terrified in face of my lovely baby's unknown future. One of the doctors offered me comfort with a sentence that I shall never forget: *'Be happy that the defect is in the leg and not in the head'*. This was the most horrific time of my life. I experienced traumatic and delayed grief. However, I gained this insight only three years later, in psychotherapy. For the first time someone gave a name to my feelings and to all that I had been through.

As I wrote these last lines, I began to weep inconsolably, as if I had gone back to the very moment of birth. Now as a researcher, I recognize that this reaction of tears and the re-experiencing of pain and sadness, thirty years after the original trauma, means that such pain remains forever. It cannot be forgotten or completely healed. I will live with this painful scar for the rest of my life.

In retrospect, this trauma marked the start of a prolonged emotional, intellectual, and philosophical journey, a running motif for the rest of my life— concern with the process and issues of death and with women's traumas due to defective pregnancy, stillbirth, or the birth of a baby who is disabled and handicapped. I have had a very strong need to understand and heal my own grief reactions.

Third Way Station

I thought a change of profession would help me to cope better with my pain. Two years after my eldest son's birth I decided to leave regular teaching and become a special education teacher. But, after many years as a teacher of children and adolescents challenged by learning, behavioural and emotional difficulties, my hopes had been fulfilled only partially. I decided to study social work. In the course of these studies, I wrote three seminar papers on my personal experience of coping with the grief of giving birth to a handicapped child. The papers gave me some sense of relief and I gained new insights, mostly from the necessary academic study. The practice of social work was not enough for me. Having personally experienced both conventional verbal psychotherapy and the enlightening experience of dance therapy, I felt that treating people with words permitted only superficial communication with the internal world. I was looking for something deeper.

Fourth Way Station

In 1992, I made another switch — to dramatherapy. Suddenly I felt I had found what I had been searching for all these years. It was as if for the first time I was standing on that primordial ground where real transformations occur. I was totally captivated by dramatherapy and the way it affected me, as well as my clients, even while I was still studying. I realised that the use of 'dramatic language' referring to creative, metaphoric, symbolic and imaginative language based on actions, deeds and theatrical activities in therapy helps reduce suffering and start a healing process.

Fifth Way Station

My MA studies in dramatherapy constituted the next waypoint in my personal developmental journey towards understanding. . The research for my Master's dissertation was based on a single case study of dramatherapy with a client who had suffered a similar trauma to my own. Once again my personal and professional life was interlinked. I discovered illuminating insights about my profession, about myself, about my clients in general; especially about Iris (an

alias), the subject of my M.A. dissertation, who also became the subject of my doctorate. Iris' agreement to take part in this research and to contribute her own understanding and memories of what happened in our dramatherapy enabled this research to be undertaken. Additionally, my personal, professional and scholarly drive to continue to doctoral level research emerged from my feelings of unfinished business and dissatisfaction with the MA, since it only partially represented Iris' case study.

Iris's consent and partnership created an uncommon opportunity for a deeper and broader understanding of her case and the treatment of Post Traumatic Stress Disorder (PTSD) via dramatherapy In particular, it allowed me to focus the research on the role of three exceptional extra-therapeutic componential variables, which contributed to the successful outcome of recovery from chronic PTSD but were absent in dramatherapy knowledge. They include the concepts of: Client with Post-Traumatic Syndrome (C.PT), Imaginary Existence Zone (IEZ) and Time Adjusted Encounters (TAE).

This Prologue is an account of the background to my choice of a research topic. It presents insights on my professional perspective and sets the scene for the doctoral thesis.

PART 1: INTRODUCTION

Preface

This Part discusses the research topic and the core themes, and outlines the research questions and the study's characteristics. The thesis constitutes collaborative study with one client - Iris, the client in a private dramatherapy. The special relationship between the client and me, the therapist, and our mutual deliberations on her PTSD recovery, offered a unique opportunity for research, an on-going enlightenment for her therapeutic journey. In this thesis I adopt the first person mode to describe the research. It seems that this is the most appropriate – and natural – linguistic mode with which to authentically reflect my involvement in the entire process reported here.

The case study entitled *Stillborn to Reborn; A Dramatherapy Journey from Post-Trauma to Recovery* forms the foundation for this research; exploring three components that together formed the therapeutic and the conceptual model: within the dramatherapy framework, the Client with Post Traumatic Syndrome (C.PT), the Imaginary Existence Zone (IEZ) and Time-Adjusted Encounters (TAE) which together created the Curing Zone (CZ) and contributed to the client's recuperation.

Chapter 1 describes the therapeutic background and presents the client's post-traumatic state prior to the therapy and the initial development of the relationship between the therapist and the client based on similar experience. Additionally, it recalls some milestones in my own development as a practitioner, who was willing to learn from her clients and the contribution of this learning process to my professional growth.

Chapter 2 provides the academic background for the study and reviews my quest for original components which characterised, and might therefore explain, the successful outcomes of this case. This decision led to the creation of the original concepts C.PT, IEZ, TAE and CZ, which emerged from the contents and process of the therapy itself and the collaborative partnership with Iris; and from the

theoretical perspectives on which the research was established. These concepts were then the variables examined by the research.

Chapter 3 describes the process involved in developing the four specific research questions. The questions focus on the contribution of the variables to the successful outcomes of the treatment of the client with chronic PTSD.

Additionally to supplement the explanatory material of this Part, Appendix 1 explains the unique characteristics of the research and innovations used in the therapy and in the research. It discusses possible deficiencies of single-subject case studies in dramatherapy and psychotherapy.

Throughout my thesis I have deliberately included minor interpretations and professional experiences in the text. My choice of this writing style was to provide a direct link between the theory and practice as it was being considered. The chapters in Part VI consolidate these comments and observations within the evidence from my fieldwork. Therefore, I refer to 'my client', or 'Iris', and at other times to her so that our relationship in this research is appropriately framed. Thus, this format provides an 'at-the-time' series of additional insights on the story of the dramatherapy as it evolves.

Chapter 1: Therapeutic Background

Introduction

This chapter discusses two interrelated themes relating to the therapeutic background of the research that led to the authentic dramatherapy treatment for Iris between September 1997 and May 1998: the first theme reviews the client's history pre-dramatherapy, the reasons for coming to therapy, and the client's post-traumatic state. It also relates to the background for the special therapist-client relationship based on common experience. The second theme relates to my role as a dramatherapist, my beliefs and what I had learnt before the treatment of Iris from other clients who I consider to have been my teachers in my professional journey.

Because of its complicated circumstances, I viewed Iris's case as exceptional. I explain how this case evoked my curiosity about successful outcomes of dramatherapy for chronic complex PTSD. A long quest was initiated in order to understand the results of this case, engendering the study of new concepts grounded specifically in dramatherapy.

Iris and our Relationship

The research sprouted from the real-life experience of a shared dramatherapy journey. Iris aged 43, was an immigrant to Israel from North America, who converted to Judaism before immigrating and could barely communicate in Hebrew. As a result, for much of the time the therapy was conducted in English. Three years of unresolved grief after a stillbirth at age 40, combined with subsequent traumatic unsuccessful IVF (In vitro fertilization) treatments, were the causes of this childless client's distress. She was willing to try dramatherapy following disappointment with two previous psychological interventions. The dramatherapy comprised twenty long encounters of 3-4 hours, between September, 1997 and May, 1998.

At the outset Iris described her sense that she was in a 'living death' – depressed, helpless, disoriented, and apathetic – and she had trouble thinking and concentrating. The long affliction affected her personal, professional, and social life, gradually depleting her existing reservoir of physical and psychological resources. After eight months of therapeutic encounters of unorthodox length the PTSD symptoms had vanished and she felt she was regaining her life.

From the first encounter with Iris, on 18th September 1997, I experienced unexpected reactions. Intuitively and unconsciously, I knew Iris was the client that I wanted to study. During the second encounter, I asked Iris to be the subject of my MA research, and Iris agreed, despite her painful condition. Six months after therapy had been completed Iris decided to stop the fertility treatments. In September, 1999, she conceived spontaneously, with no medical intervention, and in May, 2000 gave birth to a magnificent, healthy baby boy when she was 46.6 years old. The gynaecologist's reaction to the delivery was: '*It's a miracle'*. Iris considered it an outcome of the dramatherapy. This unpredictable happy event in Iris's life led me to undertake this Ph.D. single-subject case study with her collaboration.

Outstanding therapist-client relations were formed in this therapeutic partnership, continued in collaboration through my Master's degree studies (relating to the first 6 encounters with Iris), and these relations developed into a professional friendship. Under these new circumstances a long-term enquiry and doctoral research project in the field of dramatherapy began. Iris's unusual open-mindedness and imagination enlarged my world-view, insights and comprehensions on dramatherapy and treatment for clients with PTSD. Iris and her case, with its successful outcomes, plus the rich and multidimensional data, constituted the inspiration and the foundation for this research topic, focus, questions and concepts.

In a way, my own personal tragedy, thirty years earlier, which involved a trauma accompanied by grief, loneliness, a sense of helplessness, and depression, was similar to Iris' experience. During Iris's intake, I became intensely interested in

her story, which reflected salient events in my own life. This coupled with my natural openness and self-awareness, gave me the courage to disclose my own experiences to the client - matters generally 'kept quiet' and shut away in the therapist's files – and this paved the way for the special therapist-client relationship that enabled the revelation of this story of complicated chronic PTSD recovery.

In my first encounter with Iris, listening to her painful story and witnessing her affliction, I underwent a metaphysical experience. My own emotional and bodily reactions were overwhelming. I was shaken; I felt that we had met in another world, a former incarnation. I surmise that this reaction was due to the arousal of my own very primary, unconscious old wounds recounted in the Prologue. Although at that time I had already started a Master's degree research on rehabilitated drug addicts, these feelings led me to change the topic.

Love Is Not a Knife, by Bergman and Sara (1998, Hebrew) presents an example of a psychotherapy collaboration between therapist and client, in this case a client who suffered from multiple personality disorder. Sparks (2000: 11) suggests that:

> *Deconstructing therapist magic creates the possibility of characterizing our clients as initiators and self-healers. Written accounts of therapists who include the clients' account in their voices and from their perspective allow these personae to emerge in the therapy processes … therapists can give voice to this new characterization in a number of ways.*

I chose to undertake my doctoral collaborative research with the client whom I view as the heroine of this drama.

Iris's reflections had ignored her central role, and given credit to the pivotal role of dramatherapy and my warm empathetic conduct, during the preliminary research that stretched over more than two years. However, I became convinced that it was the client, who constituted an extra-therapeutic factor, who was the main contributor to her own recovery and not known therapeutic factors such as the therapist-client relationship, modelling and the placebo effect (Duncan, Hubble and Miller, 1997). Nevertheless, supporting the importance of the therapeutic relationship factor, I had identified that my own feelings of equality,

reciprocity and humanistic behaviour were critically significant in this mutual journey.

Iris represented the fragility of ordinary human beings following severe traumas. The PTSD had developed despite psychological treatments that failed to assist her to achieve a full recovery. Professionally and personally I was impressed by her exceptional coping abilities and strategies, hidden within her frozen, devastated, helpless psyche and body-mind state. It was her determined will, free choice, unseen strengths and outstanding capabilities that allowed her to become a self-healer who led the therapy to its successful outcomes.

This strategy, trusting clients to lead the therapy, was based on my belief system, values and natural behaviour. It was rooted in humanism and existentialist philosophy. Since childhood my life-memories entwined kind, caring, compassionate and respectful conduct towards people and animals. I have always been aware of these vulnerable, sensitive character traits intuitively recognising and identifying with them in others. Years later, they were transformed into professional terminology and the already imprinted attributes were advantageous keys as I became a humanistic dramatherapist.

I consciously choose to remain vulnerable (Jennings, 1998) using this vulnerability to connect empathetically with the clients' suffering, trauma and pain, and to share their personal experience when appropriate. This approach combined with empathy, acceptance, trust and warmth, and a humane urge to help and lend strength proved successful. I am always genuine and unconditionally positive with my clients (Rogers, 1951), asking them to choose what they really want to do and accompanying them on their journey.

My Professional Journey before the Present Study: Learning from Clients

I remember that M, a young person diagnosed with schizophrenia, with whom I worked in my second year as a dramatherapy student, at a day-care centre for mentally challenged adults, gave me a precious gift. He said:

> *What you are doing with us reminds me of the things the dance therapist in the mental hospital does, but she does not follow a written programme; she goes with what emerges from us.*

His last words echo in my head and have become the motto of my professional practice.

Another early and significant source of development for me was a large group of mentally challenged people. These dear people taught me more than anyone about genuineness and non-verbal communication in therapeutic relationships. They showed me a different way to meet their true inner needs, how to make each therapeutic session a new experience, by seeking an original way to help each of them. I could undergo this unfamiliar non-verbal process only after I had decided to put aside all my knowledge and make a new beginning, like a baby starting to crawl.

I allowed myself to be with them in their reality and let them guide me in understanding their world. I began to 'listen' with all my senses to what these clients conveyed to me with their body language, voices, facial expressions, and easy emotionality. Equipped by this population's abilities, disabilities and emotional needs, with newly-sharpened senses and new insights, my therapeutic style now included simple physical contact and tender caressing, singing, dancing, telling stories, playing and enacting. The next teacher who opened new horizons in my professional journey was Iris.

Iris had been a successful career woman in her country of origin. She was a director and producer in a television network, a copywriter in advertising and marketing and also wrote stories, plays and scripts. From the very beginning I was impressed by her intelligence, imagination, gifted qualities and creativity. I

felt that Iris and her case challenged me professionally more than my former clients. I needed to find new ways to adapt myself and the therapeutic setting, in order to offer her the best treatment. Furthermore, unlike most clients with similar symptoms, Iris had not used any medications either during the three years of her long-suffering nor did she do so during the period of dramatherapy. This fact demanded extra skills on my part for quick adjustment, much flexibility, fine tuning and expanded sensitivity in each moment of the therapy, so that I was exhausted mentally, physically and emotionally after the encounters.

Witnessing Iris in the therapy and being highly emotionally involved due to my similar traumatic experience, taught me new notions about dramatherapy and how it affects a C.PT. Furthermore, it was a rare lesson to be able to observe Iris as she relived and re-experienced the PTSD symptoms, aroused intensely after repeated IVF treatments, almost every month. This complication caused severe regression in her situation and she felt horrified, miserable and helpless as at our first encounter. Therefore, I needed to restart the therapeutic processes from the beginning, instead of continuing its on-going natural sequence. Influenced by Iris' hopes for a cure I learnt not to become despondent during this frustrating process.

Additionally, sharpening all my senses, I became aware that all her 'Insightful Critical Incidents' were crucial moments, revealing new comprehension and turning points in therapy. These incidents occurred when she stopped talking and began enacting. While she was using 'dramatic language' either creative, metaphoric, symbolic or imaginative language based on actions and theatrical activities, she could remain in the Imaginary Existence Zone (IEZ) during the encounter as long as she wanted, since the time span was adapted to her needs in the Time Adjusted Encounters (TAE). Surprisingly rapid transformations happened after the fifth encounter and some severe symptoms disappeared. Then I understood that despite the complications and difficulties we were moving towards the right destination.

Summary

The therapeutic background focused on important milestones in Iris' life, plus my humanistic beliefs and conduct as a dramatherapist who was willing to learn from her clients. This chapter has reviewed Iris' situation before starting the treatment, the reasons for coming to dramatherapy and some of her traits. It explained how the special therapist-client relationship developed; why I was attached to her and how I, as the researcher-therapist and the research were affected by this relationship so that I was able to learn much from the client about PTSD and my own therapeutic profession (see also Appendix 2: Who am I?).

This chapter has prepared the scene for the academic background discussed in the next chapter, explaining how I, as the researcher, consolidated the definition of the research topic and developed innovative concepts based on relevant theoretical sources in dramatherapy and psychotherapy.

Chapter 2: Academic Background

Introduction

This chapter discusses the long scholarly quest in order to discover the crucial components which contributed to the successful outcomes of this case. In light of my professional experience, I had a prevailing sense that this was an exceptional case from its very beginning; so that the known factors contributing to successful outcomes were regarded as too obvious for this particular case. I felt it necessary to find more specific un-researched factors that led to the results; besides, as far as could be discovered, factors for the success of dramatherapy had not yet been identified. Consequently, I pursued an academic and creative process, stretching over several years, till it was possible to define new factors: the C.PT, TAE and IEZ which were specified as attributing to the success of this case.

My Quest for Answers

When I began the MA dissertation in 1997 I was convinced that dramatherapy was responsible for Iris's recovery. Under the enlightening supervision of Dr. Jack Glick, a clinical psychologist, I grasped my misunderstanding of the therapeutic process. I had ignored the important factor of the therapeutic relationship and alliance that participated in and contributed to the successful outcomes. Therefore I used my MA research to investigate the importance of the therapeutic relationship and the processes of dramatherapy, in assisting the client to achieve integration and conciliation with the experience of her stillborn baby, after three years during which she suffered from unresolved traumatic grief.

However, when I started my doctoral thesis in 2001, it was obvious to me that the main topic would be the client's recovery from the PTSD state and I felt this would encompass the entire treatment of this case. The reason for my decision was that the PTSD was the overall diagnosis of Iris's situation and the traumatic grief was only a part of this state. After identifying the client's central role in her recovery, I sought additional crucial components that contributed to the curing

process. As noted above, I was determined to find original components that characterised her case and not to depend on conventional and researched factors.

Then, after two and a half years, during a lecture delivered by Prof. Lahad to a professional conference in 2003, I suddenly 'saw the light'. It was a moment of enlightenment which gave me the strong feeling of having found what I had been looking for all the time. Prof. Lahad introduced an original abstract concept associated with the deep, hidden qualities of dramatherapy — 'Fantastic Reality' (FR), described as a healing space in impossible situations, such as post-trauma. In my professional experience, FR has been the basis of one of my deepest and most profound curative experiences. For seven years, (1995-2002) under Prof. Lahad's supervision, I accumulated theoretical and practical knowledge in this special method of assisting clients with PTSD. Subsequently, becoming a researcher, a new role for me, I aspired to create another term instead of automatically adopting Lahad's (2003) FR which I felt to be more appropriate for me, naming it as the 'Imaginary Existence Zone' (IEZ). This notion embraces the imagination's contribution to spiritual freedom (Frankel 1981), the concept of 'the zone' in sport psychology (Young and Pain, 1999; Cashmore, 2002), elements of the flow theory (Csikszentmihalyi, 1975; 1999), and theories relating to potential space (Winnicott, 1971).

I used the IEZ concept to describe a spiritual phenomenon, transcending and surmounting the psyche, above and beyond the body. It refers to a region of the imagination in the brain's right hemisphere that is located in the limbic system. This is a group of deep brain structures, common to all mammals and it is associated with olfaction, emotion, motivation, behaviour, and various autonomic functions, which more appropriately reflects my conception of this space. I then understood that another curative process had occurred beneath the IEZ. So, I decided to avoid the general description of a 'healing space' and to rename it as the 'Curative Zone' (CZ), a concept rooted in neuroscience research, focusing on the amygdala which is an almond-shaped neural structure in the anterior part of the temporal lobe of the cerebrum, a part of the limbic system where PTSD memories are engraved.

Rauch, Shin, and Phelps (2006), Sotres-Bayon, Cain, and LeDoux (2006), Sotres-Bayon, Bush and LeDoux (2007) and Likhtik et al. (2008) all indicate that this is the region where fear extinction occurs, while I argue that curing is enabled in the same area.

When I grasped Iris' situation I intuitively offered her double encounters of two hours each session in order to meet her needs. It was only after several encounters that I realised the full implication of my intuitive decision. Amazed by its influence on Iris I stretched the encounters to three hours. Although I knew that this was a deviation from the norm of professional dramatherapy treatment, I felt that accommodating the length of the encounter to the client's needs, especially in such acute circumstances, was more important than keeping rigidly to the traditional time boundaries. I called these sessions 'Time-Adjusted Encounters' (TAE). It became apparent that this component was appropriate for this case and distinguished it from my other treated cases. I was also interested in studying the effect of this extra-therapeutic variable that was regarded as unorthodox in the therapy field.

During my research I discovered very little literature relating to the three extra-therapeutic variables that explained the outcomes I witnessed in practice. The extant literature included various models: developmental paradigms (Johnson, 1982), story making models (Gersie and King, 1990), role models (Landy, 1993) and Embodiment, Projection and Role theory (EPR) (Jennings, 1998). Many aspects of dramatherapy relevant to the research, concepts that might parallel my suggested components of IEZ, C.PT, TAE and CZ, were insufficiently investigated. The literature did not provide a sufficiently specific basis of theory, to explain the extra-therapeutic variables I identified - which could not be attributed to the relationship, model, method, and affect placebo that were described as effective factors in successful outcomes (Duncan, Hubble and Miller, 1997). This fact reinforced my resolve to fill this apparent theoretical gap in existing knowledge.

I needed to search in wider theoretical fields for answers to the research questions and drew support from Schön (1983: 43) who criticises

> *… the preference of professionals to confine themselves to a narrowly*
> *technical practice, because of their hunger for technical rigor or fear of*
> *entering a world which they feel they do not know.*

On a more personal level of my academic curiosity, I wanted to complete the 'unfinished businesses' of my Master's dissertation; a study that had been based on the first six of the twenty sessions of therapy with Iris. I realised that this topic and the client's reflections on her therapy in two oral histories had no equivalent in dramatherapy literature. Clearly I needed to satisfy this interest by further study of the latent phenomena still unexplored in this case. It was then that I comprehended the significance of ethnomethodology in these words:

> *The earmark of practical sociological reasoning wherever it occurs, is that*
> *it seeks to remedy the indexical properties of members' talk and conduct*
> *… it is an investigation of the rational properties of indexical expression*
> *and other practical actions as contingent on-going accomplishments of*
> *organized artful practices of everyday life … seek*[ing] *to specify its*
> *problematic features, to recommend methods for its study, but above all*
> *to consider what might be learned definitely about it* (Garfinkel, 1968:
> 9,10)

Summary

This chapter argued that single case studies on my topic are lacking, representing a gap in knowledge in the dramatherapy and psychotherapy fields (McLeod 2002). This situation may indicate practitioners' absence of interest in such inquiry. The chapter explained the theoretical journey I underwent to define the core concepts that might explain the client's recovery. This process led to the formulation of the research questions relating to the interactions between these core concepts, considered here as focused variables. The questions are described in the next chapter.

Chapter 3: The Guiding Research Questions

Introduction

This chapter discusses the research paradigm and guiding questions and explains how I developed these four specific questions. The questions were formed to elicit data that would explain how the variables had contributed to the successful outcomes following chronic PTSD. I was intrigued to understand how, and against all likelihood, Iris had recovered from her severe trauma. This research maintains that the positive results reached in the treatment stem from the synergy of several adaptations made during her treatment.

Four Guiding Questions

The foundation for the conceptual framework and the guiding questions was constructed from seven main sources of data, which became interlinked in the research. The first source was the dramatherapy real-life experience that was conducted from September 1997 to May 1998 and supplied evidence from physical artefacts, stories and poems, transcribed therapeutic conversations direct and participant observation. The second source came from two oral histories prepared after therapy termination and continuing for several years. The third was my MA dissertation which enhanced my understanding of traumatic grief and a client, assisted by dramatherapy, experienced positive transformations. The fourth source emerged from long discussions with Iris. The fifth source stemmed from my own parallel academic growth which satisfied my professional and theoretical curiosity about the topic. The sixth source was derived from fourteen years of professional dramatherapeutic practice with hundreds of clients and under continuous supervision. The last source was the recollections of my personal traumas and therapeutic experiences through verbal channels.

Thus, employing a very long integrated process, I was able to discover and develop three crucial concepts or variables: (1) the C.PT, (2) IEZ, and (3) unorthodoxly long encounters, each of three to four hours (TAE), which together created a Curative Zone (CZ). It is argued that the unique structure of these

integrated components set the scene for the subsequent outcomes. In order to explore and explain how these three variables contributed to a successful recovery from PTSD within a dramatherapy context, the following four questions were asked:

1. How did the interaction between the C.PT personality structure, and actions in the IEZ contribute to the client's recovery?

2. How did the interaction between TAE and the C.PT contribute to the client's recovery?

3. How did the interaction between IEZ and TAE contribute to the client's recovery?

4. How did the interaction between the integrated components C.PT, IEZ and TAE contribute to creating a CZ and to the client's recovery from PTSD in this particular case?

The research questions emerged from several tangents and parallel processes. Being a dramatherapy practitioner and a social worker for many years enriched my professional knowledge and experience. My treatment of many cases of trauma and grief, beside my own personal traumas and my academic involvement in Iris's case study since 1997, initially in the MA and now in the doctorate, enlightened the process of asking questions. It was a process of trial and error. At first I was interested in 'what' had contributed to the recovery. Although I managed to identify the various components in the case it seemed too facile and obvious and unsatisfying to employ 'what' questions. However, when I began to ask 'how' it had happened in connection to these variables it became more challenging, interesting and satisfying. This implied that I was looking for a holistic, deep and genuine view of the case. I therefore defined the research boundaries by limiting the components to be studied to the three extra-therapeutic variables. This framework was based on my preliminary investigation of their existence in extant dramatherapy and psychotherapy literature. Since they were only briefly mentioned in this literature I chose to focus on the above four guiding questions to supplement my understanding. However, the long quest I undertook to answer these questions necessitated further investigation of broader

theoretical fields beyond dramatherapy. This in turn, evoked new queries about existing knowledge.

Additionally, new ideas emerge during the lengthy research collaboration with my client. I found our partnership helped me to define the questions, facilitating the gathering of information from the key actor (Shkedi, 2003) of this ethnographic case study. Simultaneously, a meaningful process engendered by the conflict between the different roles I performed in this study (Hargreaves, 1967) enhanced my scholarly and personal development. After several years of research, I was finally accepted the researcher role, putting aside the practitioner role. This role change enabled me to express doubts concerning other people's theories and practice by challenging existing axioms.

The Research Paradigm

The research questions were posed within the frame of the naturalistic-subjective paradigm. Burrell and Morgan (1979:7) assert that this paradigm *'stresses the essentially subjective nature of human affairs, denying the utility and relevance of the models and methods of natural science to studies in this realm*.' I was interested in looking into the subjective reality of the client's personal existence, the inside information of cognitions, perceptions, feelings, spiritual experiences, values and beliefs of the client during the therapy.

This paradigm was therefore my choice for the research. An additional reason for the paradigm's compatibility is its assumption that there are multiple interpretations of reality. On this basis very subjective and specific questions were asked, particular to this single case study and the specific client. This strategy is described by Burrell and Morgan (1979: 3) as follows:

> *… an emphasis in extreme cases tends to be placed upon the explanation and understanding of what is unique and particular to the individual, rather than of what is general and universal.*

Gerring (2006:101) explains that the *'extreme case'* method *'selects a case because'* of *'its extreme* value *'* on the *'independent'* or *'dependent ... variables'.* It also can be seen as a case that deviates in many ways from other cases, and can therefore be regarded as unique.

My choice stands as an alternative to the positivistic objectivist paradigm which is based on:

> *... Discovering the universal laws of society and human conduct within it; and acceptance of the natural science as the paradigm of human knowledge'* (Cohen, Manion and Morrison, 2007: 9-10).

Summary

The quest for the guiding questions was based on the process of integration of my roles and the collaborative nature of the study. The quest followed the processes I underwent since the beginning of the therapy in 1997, through the MA and doctoral studies which influenced the focus of the four questions that would examine the interaction of the components identified as crucial in contributing to PTSD recovery. The chapter also explained my choice of the naturalistic-subjective paradigm to examine this single case study.

The next Part introduces the theoretical perspectives that guided my research.

PART II: THEORETICAL PERSPECTIVES

Introduction

This part presents the theories and concepts that underpinned the research. It begins with Chapter 4, which defines PTSD, explaining how the syndrome can arise from stillbirth and infertility, and describing current conventional treatments for the syndrome.

Chapter 5 discusses the theory and practice of dramatherapy, distinguishing it from psychodrama. The 'nuts and bolts' of the therapy: the dramatherapist's roles, the processes the client went through and activities she implemented, are set out in some detail, including the means used to assess the client's state.

Additional sections assess the state of current dramatherapy research, showing how the present study is designed to fill a large gap in knowledge concerning factors contributing to successful outcomes. To the best of my knowledge, the role of the client as a contributor to and designer of the treatment has been almost completely ignored in the relevant literature. The chapter also indicates how dramatherapy can be pertinently applied to PTSD sufferers, in particular when PTSD stems from stillbirth and fertility difficulties.

Chapter 6 sets out four key concepts on which the conceptual framework was constructed developed by the author on the basis of her successful treatment of the client, Iris. These extra-therapeutic components, identified as effective contributors to a successful treatment of chronic PTSD are: the Client with Post-traumatic Syndrome (C.PT), Time-adjusted Encounters (TAE), the Imaginary Existence Zone (IEZ) and the Curative Zone (CZ), all of which are explained and traced to their theoretical roots.

Chapter 7 explains recent psychological theoretical perspectives which helped the researcher to construct the research arguments and its interpretation. Traditional theory was used to understand the pathology and distress of PTSD but modern positive psychology, with self-determination and personality trait theory, was used

to explain how the client could use her own inner resources to move towards successful recovery from extreme mental distress.

Lastly, Chapter 8 discusses the conceptual framework of this research, depicts its significance within the study; how it was devised and used as a guiding map, and why the specific key concepts were chosen.

Chapter 4: What is PTSD?

Introduction

This chapter will discuss general aspects of PTSD and show how they relate to the specific traumas of the studied case, including a realistic view of treatments offered for the syndrome. PTSD was revealed in this research as a most complicated syndrome especially when it stems from stillbirth and failed infertility treatments. The chapter explains the wide-ranging effects of PTSD that encompass all aspects of the client's life: emotional, cognitive, physical and behavioural; which shattered her life for so many years. It also presents current empirically valid methods customarily used in PTSD treatments. Despite application of these methods, and claims for success, recent recommendations based on neuroscience evidence call for more efficient pharmacological and psychotherapy treatments for the clients' benefit.

A General View of PTSD

Foa et al. (2006:11) claim that 8% of the populations of USA and Israel are subject to PTSD. For about 40% of them symptoms are still evident as long as ten years after the traumatic event. It is reasonable to assume that a similar situation exists in other countries. These severe findings indicate the complicated nature of the syndrome, especially in terms of the ability of treatment to produce successful outcomes. Therefore, the following quotation provides a realistic view of the disorder:

> *It should be remembered that the data gathered regarding PTSD indicate that the mental trauma caused by the syndrome is often irreversible …. however, many patients who suffer from this syndrome could benefit from a rehabilitative approach which takes into account the existing healing capability and tries to compensate for bio-psycho-social incapacitation by using extant skills* (Shalev, 1994:100).

PTSD is an anxiety disorder caused by exposure to a traumatic experience. It can occur when an individual has witnessed, or been confronted with an event or events involving actual or threatened death, serious injury, or threat to the physical integrity of self or others. Psychic trauma constitutes a response of intense fear, helplessness, or horror to an event or experience, overwhelming the individual's coping mechanisms. The traumatic response is characterised by a range of often paradoxical symptoms, some somatic in nature, others manifested as disruption to cognition and identity. Symptoms of PTSD can be divided into three main categories: re-experiencing, avoidance and hyper-arousal (DSM IV 1994:427-429). Often the symptoms include paradoxical alternations, for example, from a sense of total victimisation to one of total culpability, from emotional flooding (hyperarousal) to emotional constriction, from explosive anger to inhibition, from hyperamnesia to amnesia (Herman, 1997:121). The significant neurological foundation for PTSD and its links to the limbic system and amygdala; as well as a wider explanation for the researched phenomenon was made by Joseph (2001:111-112):

> *Spiritual, mystical, trancelike states, dreaming, astral projection, all these behaviours and belief are related to activation of the limbic system amygdala, hippocampus* [part of the human brain located in temporal lobes and a part of the limbic system] *and temporal lobe* [a region of the cerebral cortex that is located on both the left and right hemispheres of the brain involved in auditory processing and is home to the primary auditory cortex. It is also important for the processing of semantics in both speech and vision. The temporal lobe contains the hippocampus and plays a key role in the formation of long-term memory]. *In those states the limbic system display hyperactivity stimulated and excessively activated (105-106). The limbic system hippocampus and the right hemisphere in general are directly involved in the production of memory visual imagery expressed and perception of most aspects of emotions including love sadness depression fear aggression rage pleasure happiness and religious'*.

Recent findings (Verfaellie and Vasterling, 2009) enhance our understanding of memory changes in those brain regions associated with PTSD.

Moreover, PTSD is characterised by intrusive sensory recollections of traumatic life experiences and when people with PTSD relive their trauma they have great difficulty putting that experience into words. This is in contrast to ordinary events that are generally not relived as images, smells, physical sensations or sounds associated with the event. Ordinarily, the remembered aspect of experience coalesces into a story that captures the essence of what has happened. (van der Kolk, 2002:382, 387)

Neuroscience studies have proved that the limbic system and the amygdala are responsible for a person's emotions, motivation and behaviour; and the PTSD memories are engraved in these systems through sounds, olfactory sensation and pictures and not in words (LeDoux, 2003; van der Kolk, 2006; Bremner, 2007; Weiss, 2007). On the basis of neuro-imaging findings, Garfinkel and Liberzon, (2009) were able to confirm the hypersensitivity of people with PTSD to threat as a characteristic of PTSD, exhibited as hypervigiliance and hyperarousal.

The limbic system and the amygdala are involved in focused aspects of human functioning.

1. The acquisition, storage, and expression of fear memories.

2. Learning and storing information about emotional events; it is said to participate in emotional memory (an implicit or unconscious form of memory)

3. Processing of rewards and the use of rewards to motivate and reinforce behaviour

4. Implicated in different aspects of reward learning and motivation

5. Implicated in emotional states associated with aggressive, maternal, sexual, and ingestive (eating and drinking) behaviours.

6. Receiving inputs from visual, auditory, somatosensory (including pain) and olfactory systems (LeDoux, 2008).

A new broad perspective on the current stress process was presented by Ganzel, Morris and Wethington (2010). They developed an integrative model that highlights the brain as a dynamically adapting interface between the changing environment and the biological self. The model was established on: 1 the theory that identifies the brain as the central mediator of on-going system-wide physiological adjustment to environmental challenge, this process has been termed allostasis; 2 human neuroscience and 3 genetics combined with key elements of stress models. The authors emphasise the important contribution of the model to the design of interventions targeting individuals at risk.

PTSD and Stillbirth

Pregnancy is one of the happiest events in a woman's life. When it ends in stillbirth - the birth of a dead full-term baby, occurs in nearly 1 in 110 pregnancies (Cacciatore, Schnebly and Froen, 2009) or more than 3.2 million stillbirths occur globally each year (Lawn et al., 2009) - then stillbirth turns all hopes, dreams and joy into deep tragedy. Instead of a bond with a baby and the bliss of motherhood, the mother faces untimely and everlasting separation. She becomes the bereaved mother of a child she actually never knew.

This is a serious trauma to which grief, expressed as the process of the psychological, social and physical response to perceived loss, is a normal reaction (Rando, 1991). In the context of bereavement, Seyda and Fitzsimons (2010:102) have recently asserted that *'the impact on the family is life-changing because they are left with a "hollow or empty space" inside they will carry this grief with them through lifetime.'*

Shock, sobbing, numbness, yearning, crying, anger, sadness, anxiety, despair and guilt are all common grief reactions (Littlewood, 1996:151; Jacobs, 1999:8) This loss has also been associated with depression, anxiety, obsessive-compulsive disorder, suicide, marital conflict, and post-traumatic stress disorder (Engelhard et al., 2002; Hutti, 2005; Scheidt et al., 2007). In stillbirth, unresolved responses are mixed with psychological mechanisms similar to those found in PTSD which may be felt even 2-6 years after the loss (Turton et al., 2004; Buchi et al., 2007; Turton, Evans and Hughes 2009). Mothers who have undergone stillbirth

report that their trust in life is shattered, and, that a very real part of them has died. 20%-30% of women have appreciable psychiatric long-term morbidity and one in five suffers PTSD in a subsequent pregnancy (Walling, 2002).

Besides PTSD the most difficult reaction to stillbirth is complicated grief or 'traumatic grief' (Jacobs, 1999) which exhibits similar symptoms to PTSD. The death of a baby is associated with three key types of factors, relational, circumstantial and social. The uncertainty of the circumstances surrounding the death, the absence of a body, and the unanticipated nature of the death can all be associated with traumatic grief. Losses that are socially unspeakable or socially negated entailing the absence of a social support network have also been identified as contributory factors. Twenty years ago the norm in most western countries was to regard stillbirth as a non-event and to prevent parents from mourning their child by refusing them access to the dead baby. A typical procedure was for medical staff to remove the dead body as quickly as possible, discourage the parents from seeing and talking about the baby, and then to encourage them instead to think about conceiving another baby. The hospital often disposed of the baby's body in an unmarked mass grave. (Littlewood, 1996: 148-156)

According to Lewis (1979) the impact of such practices was severe: they led to a failure to mourn and to psychotic breakdowns or severe mental difficulties among the mothers. This conclusion is supported by the results of more recent research, which indicates that one-third of the women who lost a child at birth had serious psychic complications. Furthermore, if after one or two years the trauma has not been worked through the psychological complications become chronic (Rådestad et al., 1998).

During the past decade, practice has radically changed in most Western countries. The routine photographing of all stillborn babies and practices such as giving parents the baby's name-tag, lock of hair or other mementos have been introduced. Parents are encouraged to remember their baby and to talk openly about their loss. In many cases they are encouraged to see and hold the dead

child and conduct funeral services with ritual, in the belief that these actions promote recovery (Walling, 2002).

The notion that simply being given more information about the stillbirth will help resolve the grief has been widely accepted (Rådestad, 1998; WiSSP, 2009). However, a study by Hughes, et al. (2002) from the U.K. does not support the conclusions of Rådestad (1998) and other Swedish studies (Rådestad, et al., 1998); indicating instead that failure to see and hold the dead child can adversely affect the parents' mourning.

In this context of stillborn babies the Jewish tradition of burial, does not allow them to be buried in a separate grave but in a mass grave in a secluded place and without a headstone. Furthermore, the parents and the family are not allowed to 'sit' Shiv'ah – the traditional seven days of mourning after the death of a family member, when friends and family come to console the bereaved family. This is an important process which helps the bereaved to cope with their grief; but is unfortunately denied the stillborn parents who remain alone with their unbearable pain and sorrow as described in this study by Iris in the fieldwork findings. A contradictory approach from a completely different culture and religion (Islam) was recently established in a research conducted in Malaysia, with 62 mothers who suffered perinatal loss. The researchers found that there was a significant relationship between psychosocial impact after perinatal loss and support from friends; they therefore concluded that family and friends should continue to provide emotional support (Sutan et al., 2010).

PTSD and Infertility

As noted above, infertility, reproductive technologies and IVF treatment are also beset by psychological and psychiatric issues. Common reactions to these interrelated experiences are anxiety, depression, stress and grief (Harlow et al., 1996; Eugster and Vingerhoets, 1999; Schwerdtfeger and Shreffler, 2009; Lee et al., 2010) and PTSD symptoms have also been reported in patients during or after infertility treatment (Bartlik et al., 1997). Stotland (2002:13-26) indicates that infertility, reproductive technologies and abortion can be the most *emotionally weighty and philosophically contentious experiences in most patients' lives*.

Kendall-Tackett (2005) claims that all pre- and peri-natal events, including infertility, can cause trauma and leave a life-long imprint on women's lives that may later develop into PTSD. More recently, Cousineau and Domar (2007) added the societal repercussions of stigmatisation, a sense of loss of control and a disruption in the developmental trajectory of adulthood to this situation.

As each IVF cycle begins, hopes for a successful pregnancy are cultivated and these hopes probably enable couples to bear and overcome the physically painful procedures and the emotional burden. What then might be the effect of accumulated failures to conceive? Descriptions of increased anxiety, depression, stress, sadness, anger, helplessness and dissatisfaction are quoted by Schover (1997) and Verhaak et al. (2005). However, Thia et al. (2007) suggest that couples rate the experience of waiting for the outcome of the IVF treatment and an unsuccessful IVF treatment cycle as the most stressful. These failures may cause clients to withdraw from the fertility treatments; although the psychological burden was found to have the highest impact on the decision to stop treatments (Van den Broeck et al., 2009).

The multidimensional nature of the problem has been summarised by Gat and Alon (1994:136-143):

Emotionally:

> The IVF process is beset by anxiety. The failure to get pregnant awakens self-doubt, and can undermine the couple's emotional-sexual capacity, to the point of endangering their relationship and threatening their personal-sexual identity.

Cognitively:

> The couple's obsessive attempts to control what is uncontrollable can lead to hypochondria and attention disorders, such as derealisation and depersonalisation. They can come to feel that fate is against them, which then becomes a self-fulfilling prophecy.

<u>Physically:</u>

The massive hormonal therapy upsets the body's delicate hormonal balance, with side-effects such as weakness, tiredness, painful swelling and congestion. There is a risk of ovarian cysts forming and putting an end to the treatment ... the mother needs to be physically strong.

<u>Behaviourally</u>:

The process disrupts normal life, subordinating it to the treatment timetable.

For all these reasons experts recommend non-medical supportive treatments during IVF, social work support, psychotherapy and psychological support being the most common (Gerrity, 2001; Maillet, 2002; Haemmerli et al., 2008 Khodakarami, et al., 2010). Lately, based on research conducted in Switzerland Haemmerli, Znoj and Berge (2010) have presented a promising new approach for infertile patients - Internet-based interventions. In the present case Iris did receive professional support from two psychologists after the stillbirth and during the two years of her fertility treatments, but she terminated these treatments after a short time with no positive outcomes.

In many world states, debate is conducted and there is a continual search for effective research-based treatments. Spinazzola et al. (2005:434) maintained that:

(1) 'Treatments currently designated as efficacious for the treatment of PTSD should be evaluated for their capacity to ameliorate symptoms among more impaired trauma survivors; (2) Effectiveness studies of naturalistic clinical samples are needed to determine which identified interventions for PTSD work for individuals with more severe comorbid psychopathology, and to what extent; (3) Investigators should develop and evaluate innovative treatments designed to address more complex symptom presentations, as well as innovative or combination

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interventions that intentionally target subpopulations of traumatised individuals.

In this context, based on neurobiological recent evidences Weiss (2007) suggests certain practical implications, indicating that understanding what is happening in the brain following traumatic stress, can inform more targeted treatment for various symptoms that the individual may be experiencing.

The PTSD treatment methods empirically studied and found valid and effective are:

1. Eye-Movement Desensitisation and Re-processing (EMDR). This is a complex treatment that incorporates many different interventions, including imaginal exposure (under conditions of divided attention), free association, and other techniques; occasionally, 90-minute sessions are scheduled for EMDR treatment. The main intervention requires the patient to recall trauma-related memories while also attending to some form of external oscillating stimulation. Stimulation is typically induced by the therapist moving a finger from side to side across the patient's field of vision, which induces eye movements. Sets of eye movements are induced until distress is reduced (Shapiro 1999; 2001; 2002; Heber et al., 2002; Taylor, et al., 2003).

2. Exposure therapy involves systematic exposure to the traumatic memory in a safe environment that requires the patient to focus on and describe the details of the traumatic experience. Exposure methods include confrontation with frightening, yet realistically safe stimuli that continues until anxiety is reduced (Rothbaum and Schwartz, 2002). It typically involves the graded and repeated imaginal reliving of the traumatic event within the therapeutic setting and is believed to provide a low-threat context in which the patient can begin the therapeutic process as well as de-condition the learning cycle of the disorder via an extinction process (Rizzo et al., 2009; Gamito et al. 2010).

3. 'Prolonged Exposure' (Foa, Doron and Yadin, 2006; Freedman et al., 2010), includes repair of the pathological components in the fear structure and is based on: (a) learning the PTSD characteristics (b) learning relaxation (c) live

exposure (happens in the real space) (d) exposure in imagination (happens in the therapeutic space).

In exposure-based therapies traumatic memories are activated for the purpose of confronting feared situations and modifying pathological aspects of these memories through habituation, extinction and new learning.

4. Cognitive Behavioural Therapy (CBT), focuses on how the way you think affects the way you feel and act; it is a problem-solving approach, teaching skills to change thinking and manage reactions to stressful situations (Foa and Rothbaum, 1998; Butler et. al. 2006).

5. Guided imagery is a *'means of engaging the patient's imagination to direct change. Guided by verbal instructions, individuals are directed to create mental representations that are personally meaningful and often symbolic and to manipulate these representations toward a desired goal. This process is quite distinct from the use of imagery to recall or re-experiencing past traumatic events like in imaginal exposure a core component of exposure-based therapies'* (Strauss, Calhoun and Marx, 2009:364).

6. Pharmacologic treatment of PTSD includes psychotropic medication. Recently, results of a study with adults who were treated with EMDR and fluoxetine (anti-depressants) showed that psychotherapy intervention, was more successful than pharmacotherapy in achieving sustained reduction in PTSD and depression symptoms (van der Kolk et al., 2007). Similarly, experts have summarised efficacious treatments for pre-schoolers, children and adolescents with PTSD, asserting considerable support for CBT interventions; whereas research on psychopharmacological treatments lags behind that of psychotherapy and is currently inconclusive (Nikulina et al., 2008). Medication classes include: antidepressants, anxiolytics or sedative-hypnotics, and antipsychotics (Harpaz-Rotem et al., 2008). While more recently, Holbrook et al. (2010) found that the use of morphine during trauma care may reduce the risk of subsequent development of PTSD after serious injury.

The PTSD discussion is obviously complex; it is still one of the most difficult syndromes to be treated, especially when chronic. Contemporary approaches aim to restore self-confidence, stabilise the patient's life and support independent functioning. The key to success is the gradual exposure and re-exposure of the patient to their painful memories, using relaxation techniques as support, and trying to replace passivity with a sense of control (Yovel, 2001:47-50).

Summary

The chapter reviewed the nature of PTSD, its causes, symptoms, severity levels, and epidemiological distribution throughout many countries around the world. The syndrome was connected to two particular traumatic events – stillbirth and fertility treatments and their failures; the multiple complications of these feminine traumas encompass a wide range of symptoms and hurt and disrupt the life cycle. It is difficult to achieve full recovery in chronic PTSD, although special methods were found empirically valid and efficient. The realistic perspective of rehabilitation as a beneficial process for patients was suggested, since the syndrome is often irreversible; the chapter also indicates a need to encourage innovative treatments.

The conclusion drawn from this discussion is that despite intensive research in the field of PTSD, the optimum method for treatment has not yet been found, either in pharmacology or in psychotherapy. Hence, further research is needed especially in finding accurate medication and implementing neuroscience findings to create more effective psychotherapeutic treatment that will depend more on somatic levels and less on verbal channels (Joseph, 2001; Levine, 1999; LeDoux, 2003; van der Kolk, 2006; Weiss, 2007).

This chapter provides the background for Chapter 6 which explains the dramatherapy used to treat the studied case of chronic PTSD. Although dramatherapy was not mentioned above for the treatment of the syndrome; the successful outcomes and full recovery in the present case demonstrated its effectiveness. It is therefore discussed here widely from different theoretical and practice aspects, including its potential benefit for cases of PTSD following infertility or stillbirth.

Chapter 5: What is Dramatherapy? Theory and Practice

Introduction

This chapter discusses various aspects of dramatherapy theory and practice. The issue is examined through its special characteristics and healing elements, based on the paradox of dramatic distance and the unique 'role' feature of this form of therapy. The difference between dramatherapy and psychodrama is highlighted. Further attention is given to the profession's processes, activities and assessment and the dramatherapist's roles, due to the specific nature of dramatherapy and various forms of art-expressive therapies. The issue of dramatherapy effectiveness in treating infertility and PTSD is also reviewed.

Dramatherapy Characteristics

Dramatherapy is a synthesis of two significant processes: drama with therapy. The term is derived from Greek; 'drama' – a deed, to do, act or struggle and 'therapeia' meaning to cure, to heal, 'a service, an attendance' which, in turn, is related to the Greek verb 'therapeuo' meaning 'I wait upon'. Therapy was (and is) a service provided to the sick. The basic goal of therapy is the relief of suffering and to engender change. Dramatherapy needs only an individual or a group who use themselves - their body and their minds through action and often through speech to tell a story; in contrast to drama acted in a theatre which requires a composition in prose or verse, stage, props, costumes and scenery. Drama is an inherent activity of human beings and is a part of their essential development as people (Meldrum, 1994:114-132). We begin our dramas as babies by imitating sounds, facial expressions and movements before speaking and walking; while later on we can emulate 'as if' situations and take on diverse roles.

An official definition of dramatherapy has been adopted by the British Association of Dramatherapists, after many years of diverse suggested definitions by practitioners, all of which emphasised the explicit healing features that can be achieved through drama. It seems that they have adopted Winnicott's assertion in the early 1950s that *play itself is therapy* (1971:76); or the later concept of

Jones, (1996:4) that *'Drama itself is the therapy ….the drama process contains the therapy.'*

Thus, the accepted definition for dramatherapy in Britain is:

> *The intentional use of drama and theatre processes and related techniques in order to achieve the therapeutic goals of symptom relief, emotional and physical integration, and personal growth'* (Chesner, 1994: 115).

As an Israeli dramatherapist who has struggled for years to find a satisfactory explanation of this form of therapy, I adopted this definition which I think focuses on the central characteristics of the profession.

Jennings, one of the key dramatherapy pioneers in Britain, asserted (1992) that dramatherapy is an art form with a potential for healing and has a transformative power. In this way she attained a distinction between this profession and psychotherapy that uses artistic methods in addition to the centrality of the verbal therapeutic conversations. However throwing the spotlight on drama and theatre processes is important; since it accentuates the difference between dramatherapy and other psychotherapies, psychodrama and art-creative-expressive therapies. It illuminates the special dramatic-theatrical characteristic of the *'dramatic world of 'as if ', a different sphere of being which differs from the real world and is anchored in humanity's ancient history* (Grainger, 1995:35, 45).

Another perspective on dramatherapy's healing aspects was suggested by Landy (1993), an American pioneer in the field, who developed the concepts of the 'role model' and 'role taxonomy'. He explains:

> *The role is the primary component of healing through the art form of drama. The healing potential of role is found in that it positions the role taker or role player within the dramatic paradox of 'me' and 'not me'. The therapeutic actor, like the theatrical actor, is given permission to move in and out of two contiguous realities: that of the imagination, the source of unconscious imagery, and that of the everyday existence* (p. 50).

Landy's focus on the role as the central healing element in dramatherapy is a concept rooted in theatre, which in my opinion, is the most fundamental notion of this profession: more than other models, it emphasises the role as the core component of dramatherapy, a component which does not exist in other therapies. Hence, it can be agreed that the role is the 'jewel in the crown' of dramatherapy and constitutes its uniqueness.

Dramatherapy and Psychodrama

Dramatherapy and psychodrama are occasionally confused as both have drama at their core. In order to avoid this confusion a brief summation of the primary differences is offered. Dramatherapy was established in the U.K. in the early 1960s by a number of pioneers, whereas psychodrama was invented by Moreno (1889-1974) in the U.S.A. during the 1930s within a psychoanalytic context. Psychodrama is the realisation in dramatic form of the current interpersonal situation set in the present, it refers to what is actually going on in a particular person's life; the person, who is the protagonist of the drama and becomes the object of the focused empathic imagination of everyone taking part in the action. Whereas dramatherapy also uses drama, but in a less direct way, and less intentionally directed upon a particular individual who has been identified beforehand and it can focus on a whole group (Chesner, 1994).

If psychodrama is a powerful assault, then dramatherapy uses an oblique approach in which the purpose of the session emerges as the events unfold, and its subjective matter is fictional rather than autobiographical. Psychodrama uses techniques developed by Moreno to direct a precise therapeutic journey, the issue is identified within the first few minutes of a session and informs the choice of protagonist; while dramatherapy uses any element of the full range of dramatic activity as a therapeutic tool, and issues are explored in a free-floating way (Grainger, 1995). In this sense, we can see that dramatherapy approach is softer, non–confrontational, indirect and flexible. Thus, it is far less threatening in comparison to psychodrama.

The Dramatherapist's Roles

The dramatherapist plays many roles, some passive, others active, and a well-trained dramatherapist is comfortable with a complete range. Landy (1992) and Johnson (1992) distinguish between working 'out-of-role' and 'in-role'. In-role, the dramatherapist takes an active participating role within the client's drama and acts as suits the client's needs, situation, image, problems and conflict. Some in-roles are: faithful rendering, act completion, defining, repetition, intensification, pre-empting, joining. They are used to extend the depth and breadth of the client's experience and help the client achieve a greater tolerance of their inner world (Johnson, 1992:120-124). Out-of-role, the therapist takes a distance, encouraging the client to work on their own. Such roles are: follower, witness, director, provocateur, invoker (Landy, 1992:106-108) and coach, leader, guide (Johnson, 1992: 114-115).

The therapist roles applied in the present case were out-of–role, performed according to the client's needs and will. The dominant roles along the therapy were defined as permissive director, reflective listener (McMahon, 1996) reflective follower and supporter. My roles were adapted to Iris's implicit wish not to hear any advice, after she had two bad experiences from her former psychologists. Hence, I took a very gentle, careful and non-intrusive approach. I believed that it enabled her to play the heroine role each moment; changing the scenery, props and roles according to her true will in her transitory emotional situation and with free choice. In the context of the PTSD, it assisted her to transform her helplessness and passivity into a sense of control and power, a central theme in the syndrome's treatment.

Dramatherapeutic Processes and Activities

The theoretical background of dramatherapy has been established on varied sources: theatre, anthropology, developmental psychology, psychiatry, psychology and psychotherapy. Some of its processes and activities are unique to dramatherapy such as dramatic/theatrical distance, dramatic reality, role play, role paradox and ambivalence. Some are shared with other creative-expressive therapies, such as: symbols, metaphors, rituals, movement, drawing and

storytelling. From the theatre, dramatherapy adopted the core concepts, the foundation and the source of its distinction from other therapies; which also constitute the exceptional strength of this profession. In this chapter the emphasis is given to the implemented activities employed during the therapy and the important processes the client underwent, both of which formed the basis for the analysis and interpretation.

'Theatrical or dramatic distance' refers to the distance that exists between the actors and the audience, the stage and the theatre hall; in dramatherapy too, it enables different realities – everyday reality and dramatic reality - to co-exist (Jennings, 1998) or the creation of an 'as if space' (Lahad, 2007). While moving from everyday reality to dramatic reality we have the ability to pretend we are somebody else, or to imagine we are in a completely different place, or we can enact many human and nonhuman roles, whenever we want to. For children, this is a natural act included in their developmental activities.

In dramatherapy when the client starts any dramatic activity, they enter and remain in the dramatic reality; as, for example, in object-sculpting (spectrogram) - a variety of small objects which express metaphorically how the client sees the world through deeds and not through words. These assorted symbolic objects create a representation of past, present or future (Jennings, 1986; 1993). While remaining in the dramatic reality the client is able to become detached from everyday reality and imaginative power is activated silently and nonverbally. Simultaneously the curative process begins to affect the client, firstly unconsciously and gradually transforming into a conscious process when verbal communication is added.

In this sense, the symbolism in dramatherapy, as Jones (1996: 242) observed; 'is a way of encountering unconscious material and a way of negotiating between inner conflict, outer expression, and potential resolution. The symbol needs two things, a physical form and particular kind of relationship'

Linked to the use of symbols and dramatic distancing is the use and meaning of metaphor, which is:

A statement that brings together two objects and says that they are one. A metaphor also permits expression and provides a means for exploring the presenting problem and can help clients get in touch with highly problematic material. The dramatic metaphor creates distance from the real-life, identity of the problem and thus a new perspective are emerged' (Jones, 1996: 222-223).

I often encountered the powerful effect of the spectogram's oblique unthreatening activity with children and adults, who expressed their surprise when new revelations emerged from their sculpting. However Iris's reflections (Appendices 4 and 5) threw new light on this point:

Spectogram is letting your inner self tell you what you think about things, especially your life. And I think it is quite amazing how it works, but… your subconscious is smarter than you are and the first one I did in the dramatherapy session really shocked me to the core – shocked me [by showing me] *that my world was so small and I was insignificant and it wasn't until I put all these things on the page THEN I saw what I put on the page – I didn't think…*

The same process, demonstrating dramatic distancing and entering into dramatic reality occurs in Sandplay. It has the additional advantage of the sand itself as a gentle, pleasant and primary material; whereas it is a *'Buddhist element* [that] *represents the deepest parts of the unconscious'* (Markell, 2002:30). Usually the therapist and client sit beside a tray filled half-way with sand. Nearby there are shelves bearing hundreds of miniature figures - animals, both real and imaginary, stones and feathers, marbles, beads, shells, all kinds of people, houses, bridges, trees and plants, cars, boats, planes, and so on. The client is invited to put any item(s) that they wish to choose into the tray, moving sand and objects until the scene feels right. The therapist photographs the sand world and, if the client wishes to do so, the client talks about the scene just created. The therapist may comment on the symbolism or perhaps respond at the sandplay level by suggesting another image, or asking how it would feel if an object were moved to another spot in the tray (Collins and Molchanov, 2007).

Sandplay is a method used for psychotherapy and personal development, mostly known because of, and based on, the analytic psychology of C.G Jung (1875-1961) and also influenced by Oriental thought and philosophy. The *'ultimate goal of sandplay is wholeness of ego and self, of body and soul or psyche and matter, which finds its expression through the transformation of energies'* (Markell, 2002:24). Sandplay creates a bridge between the conscious and the unconscious. During the sandplay process the conscious mind relaxes its control, enabling the unconscious material lying beneath the surface to emerge (Kalff, 2004: v, xi). It is a way of getting beneath the level of the conscious personality, of encouraging the unconscious mind, what Jungians call the 'Self', to work creatively with the psychological conflicts and unresolved needs of the person. Kalff (2004:6) asserts that:

> *The self may manifest as a dream symbol or as a depiction in the sand box. Such a manifestation of the self seems to guarantee the development of the personality'*

On the one hand I agree that sandplay is a deep-reaching powerful method, especially based on my experience with Iris, whose PTSD symptoms obviously disappeared after she had played in the sand box six encounters out of twenty. On the other hand, I would argue that each dramatic nonverbal activity like drawing, clay work, movement and enacting a role, has the quality to act as a bridge to the IEZ where curative processes are taking place. Although sandplay is regarded as a therapeutic method in its own right, in this research the attitude was to view it as a dramatherapeutic activity; relying on the understanding that dramatherapy is larger than sandplay and the first encompasses the last. Additionally the way in which the sandplay was implemented in the course of the encounters via the use of symbols, metaphors, enacting different roles and storytelling following the sandplay presented pure drama.

Nonetheless, the sandplay constituted a highly important activity for this case of PTSD, and the description of sandplay by Markell (2002:239-240) reflects Iris's reactions.

The internal geography that emerges in sandplay, whose somatic aspect often features the revelation of stored memories of pain, grief loss or rage, reveals landscapes that frequently are unspeakable. The meaning is dramatised by the body, often in a repetitive manner, until new meanings can develop. Somatic eruptions are therefore very likely to occur during the sand process. Acknowledgment, expression and containment of these often dramatic and negative effects, which are released by accessing the archaic body storehouse through symbolic images, often result in a decreased severity of bodily symptoms.

Indeed, Iris' continuous yawning and sense of coldness - the conspicuous somatic responses - existed only in the sandplay activity. In this sense I assumed that sandplay had the additional value of being a small container with clear boundaries, which helped her to concentrate and focus within the given frame; while the other activities were operated on the larger 'stage' limited by the therapy room's walls. Iris's case emphasises the curative quality of sandplay and at the same time supports the views of Kalff and Markel; as well as highlighting the use of the role, dramatic distancing and dramatic reality as curative characteristics.

This specific distancing technique is matched by a paradox of closeness to what is happening on the theatre stage. In dramatherapy, distancing actually draws the clients nearer to their difficulties; no matter how oblique or distant the play, story, myth may be from the client's problematic themes, this paradox will exist and enable the therapeutic process to take place (Jennings 1992; 1998). Another crucial paradox exists at the centre of the client's dramatic role termed by Landy (1993:11-12) as 'dramatic paradox':

The individual as actor or group or chorus lives simultaneously in two realities … present and past, rehearsal and performance, the studied moment and the spontaneous moment … The paradox of drama is 'to be and not to be', simultaneously.

An additional core notion related to the client's dramatic role is its ambivalence.

> *Role ambivalence occurs in three ways – within the role itself, between two conflicting roles, and as an existential state of being and not being…..By recognising the ambivalence of being and trying to discover a way to live within and among one's often conflicting roles one moves closer to a balanced, integrated life* (Landy, 1993:13-14).

Both the above-mentioned notions appear in the actor's performance in theatre and in dramatherapy. Besides being an experienced dramatherapist, I have also been an actress for many years hence I can testify that the paradox of 'be and not to be' that occurs with the ambivalence while performing the role are unconscious processes. I never consciously thought about them when I was on stage, no matter which role I played although I am aware of their existence within me. In therapy, observing hundreds of clients, it was obvious that when they played roles they were unaware of these processes; only after a while did they gradually become conscious, as depicted by Iris in her reflections *'what an incredible force my subconscious mind had to choose that character'.*

The general aspect of role and role playing was explained by Jennings (1998: 56), who alleged that this behaviour emerges around ages 4-5. Rather than telling or listening to known stories, children start making up their own stories, dramatising them, taking on roles and playing various characters. Jennings sees the child's earlier developmental stages as 'embodiment' - the first stage in the normal human development pattern. Throughout its first year, a baby experiences the world through physical exploration of its immediate surroundings. Clay work, sand play, water and fingers paints activities, belong to the embodiment stage; a media for sensory play, which creates a bridge between the senses and feelings (Jennings, 1993:25-27). The next stage is projection: when the infant starts to play with toys and objects outside itself; drawing, clay, stories and fairy tales belong to this stage.

According to this developmental model (EPR), Jennings (1998) asserts that embodiment, projection and role are all crucial to the development of imagination and understanding of everyday reality, as well as the child's notion of 'self' and

'other'. The model can be applied to adults with great success (Bar-Yitzhak, 1999). In this context, Jones (1996) expanded and deepened the projection process and linked it directly with dramatherapy, seeing dramatic projection as one of the core concepts in dramatherapy. My experience, based on my dramatherapeutic work with Iris and many others, supports this conceptualisation and I argue that dramatic projection is one of the strongest, most insightful and transformational processes within dramatherapy.

In many treatments there are children and adults who find it difficult to move on to the role stage and to enact different roles, often this indicates that they have become fixated in the initial developmental stages. Hence they remain in the projective stage and the curative processes occur through dramatic projection. The emphasis put on 'dramatic' projection indicates the clear distinction between this process and projection in psychology.

Jones (1996:101-102) describes the projection process in both dramatherapy and psychotherapy:

> *Firstly, the client experiences unmanageable feelings; secondly, there is an unconscious fantasy of putting this unmanageable feeling/state into another person in order to dispose of it or to make it manageable. Thirdly, there is an interact pressure, with the unconscious aim of making another person have these feelings instead of the client.*

While he describes dramatic projection as:

> *The process, by which a client projects aspects of themselves, or their experience into theatrical, or dramatic materials, or into enactment, thereby externalizing inner conflicts.*

In this sense in psychotherapy the therapist is the only object available onto which the client can project their thoughts, but in dramatherapy there can be many objects, human and material. This intrinsic difference highlights the wider curative opportunities existent in dramatherapy, since it is based on nonverbal creative activities which do not all depend on the therapist. The many activities enable clients to choose their preferred modes and feel comfortable. Although the

client does not focus on the conversation with the therapist while enacting a role or playing with the objects, I argue that the unconscious curing processes are nevertheless occurring during the play.

The activities in dramatherapy serve as a vehicle or a bridge to help the client to traverse from everyday reality and to hover in dramatic reality; while the duration in the IEZ is enhanced and encouraged by the sense of enjoyment. Besides the activities mentioned above, there are other basic customary nonverbal deeds like body movement. As Jones (1996: 148-166) explains, in dramatherapy:

> *The body is the main tool of communication and expression. It is essential to exploring emotions, identity, relationship to self and others, to constructing social persona and to increasing awareness of the body's range and potential.*

Whereas, Thornton (1996:78-80) argues that:

> *Through movement we can learn about the world and actualize or change our place in the world. It can enable us to allow our inner, creative/expressive voice to speak.*

Moreover, movement is connected to the first human developmental stage of embodiment. Often we meet clients whose natural body movement was damaged at this stage and they have difficulty moving their bodies spontaneously and uninhibitedly; this may also occur in cases of PTSD where the somatic system is in a situation of increased arousal, hyper-vigilance and/ or frozen as exhibited in Iris's appearance. Therefore, it is highly important in therapy, to work through the body to help the client to get rid of bodily rigidity, motionless and traumatic somatic experience. While doing so, the therapist assists the client to move on further to the role stage where body movement is an integral part of the enacting any role.

In the context of movement to music, the combination of relaxation and music enables the individual to relax and be calm and so release bodily and emotional tension. Additionally, guided imagery can help to repair clients' stressful and anxious experiences. It supplies them with a significant source of strength,

support and courage; while using their own inner imaginational power which affects both the physical and emotional systems. It is a powerful process which leads to internal relief, creativity and insights. It helps to bypass logical left-hemispheric thinking and free the right hemisphere, the imaginative and creative realm so that new revelations can emerge (Lahad, 2000; Tusek and Cwynar, 2000; Strauss, Calhoun and Marx, 2009).

The PTSD treatments that use these techniques with the C.PT aim to assist habituation to a new more positive experience and to reduce anxiety connected to the traumatic memory. In Iris's case the immediate effect on her soma was clearly visible, it transformed her body's status from frozen tight and rigid to loose-jointed and relaxed; her mind was completely calmed, becoming serene till she fell asleep while I continued the guided imagery.

Although the nonverbal activities were highlighted as a consequence of my argument that they constitute a crucial bridge to the IEZ, where the curing processes took place and contributed to the chronic PTSD recovery; it is impossible to ignore the therapeutic value of the verbal channels within dramatherapy which also assisted the development of a positive transformation in the syndrome symptoms. Among them was the use of stories and metaphors, a strategy based on the assumption that *'they can represent the objective or subjective perception of internal or external reality. Relating to the representative image can change internal reality or bring about a change in the perception of external reality'* (Lahad, 2000:15).

Stories can be told or invented by either the therapist or client or both; in our case Iris was the only one who told the stories, mostly after she engaged in dramatic action. The most prominent evidence supporting Lahad's explanation, appeared in Iris's stories followed her enactment in the sand tray, including the integration of symbols, metaphors and stories that represented her inner world; a reflection of her post-traumatic frozen, isolated, dependent and helpless real life. It is reasonable to assume that the combination of these dramatic elements gathered three-fold power so that the successful outcomes were achieved in a

relatively short period. Another story sprouted from the use of therapeutic cards; helping Iris to express feelings of detachment and alienation (Chapter 14, Encounter 10). PERSONA cards consist of 77 colour portraits depicting a wide range of people from young to old and from different cultures. The cards are regarded as a projective technique both for diagnosis, probing and as a good way to stimulate storytelling (Lahad, 2000:80). Additionally, to tell a story is a conscious process, although the contents may arise from the unconscious mind; but the fact that the client hears their own story is meaningful and strengthens self-confidence, self-esteem and the ability to grasp existence differently. Specifically, telling and retelling the traumatic story, enabling exposure with the help of imagination is one of the basic techniques in PTSD treatment by Prolonged Exposure. This strategy is advocated by Foa, Doron and Yadin (2006), who claim that in order for recovery to occur there is a need for intensive working through of the traumatic event.

A basic feature of every dramatherapy session is combination of ritual and risk, and the balance between them varies with the client's development. The ritual component represents safety, the predictable, and the known. In the wider context, examples of ritual may include a group of people who gathered and shared a special event such as circumcision, a wedding or in ancient times, participated in ceremonies of dancing and praying for rain. Drama constitutes the means by which ritual is performed and rituals, like drama and theatre involve the transition into dramatic reality from everyday experience and back again (Jennings, 1998).

In therapy, ritual can be enacted by the individual client; however, there are many clients who prefer to be active, by performing the same deed for months. They are stuck in a ritualistic circle, feeling too afraid and unsafe to take risk. This status is characteristic of the C.PT; some are probably fixated in early development stages such as embodiment or projection. In other words, they are not able to rework their experience, and *'keep repeating the event in many variations, or repeat their coping mechanism for dealing with the event. Therefore*

reworking is an important activity which enables us to move on in our lives' (Jennings, 1998:123).

Connected to this is the process of 'retelling' which is similar to ritualistic behaviour; when people are not listened to or their experience is not affirmed they may find themselves always telling the same story (Jennings, 1992:17). On the other hand, the risk component represents the unexpected, the unknown journey, uncharted territory. Hence, when a client dares to try a new activity or technique they are taking a risk and advance towards cure. In our encounters, Iris went through these processes but exhibited contrary behavioural stands. She kept on retelling the same afflicted stories again and again which is typical in a state of mourning, especially after traumatic grief. At the same time she was able to summon her virtues and strength; determined to be well again, she took risks and reworked her experience.

Assessment in Dramatherapy

In dramatherapy, there are alternative ways to diagnose and assess the client's state. Among them are Jennings' Ritual-Risk and Embodiment-Projection-Role method (1993) and Jones' method, based on an expressive inventory, a dramatic involvement scale, projective techniques and diagnostic role play (Jones, 1996). The best known method was suggested by Lahad (1992), who developed a tool in Israel to assess individuals' coping strategies in situations of stress, known as the Six-Piece Story-Making (6PSM) and BASIC Ph method.

In the 6PSM the client follows a set of instructions to create, tell and discuss a fictional story. The assumption is that 'in telling a story based on elements of fairy-tale and myth, we will see the way the self projects itself in organised reality in order to meet the world' (Lahad 1992:157) According to this method, the six dimensions underlying the client's coping styles are:

B   Belief - life span, beliefs, meaning, values, clarification and attitudes.

A   Affect - emotions, ventilation, listening skills, acceptance, verbal and non-verbal expression.

S Social - social role, social structure, social skills, assertiveness, groups, role play simulation.

I   Imagination- creativity, play, 'as if', symbols, guided fantasy

C Cognition - information, order of preference, problem solving, self navigation, self-talk.

Ph Physical - activities, games, exercise, relaxation.

The number of times each dimension appears is counted, the most frequent being the predominant one. This method can also be used to identify underlying themes and conflicts in the client's narrative, which they may not be fully aware of (Lahad, 1992:161).

Research regarding effectiveness in treatment: Dramatherapy versus psychotherapy

The existing literature on dramatherapy consists mainly of models, methods and techniques, whereas the issues of treatment effectiveness and the components contributing to successful outcomes have received minimal attention. Recently two Ph.D. theses in dramatherapy were submitted in Britain; the first in 2002 by Casson who published the thesis as a book in 2004; and the second by Dent-Brown in 2004. Neither of these theses was single case studies nor did they research which therapeutic factors assist in therapy outcomes. In psychotherapy, on the other hand, the effective factors of therapeutic alliance, the therapist-client relationship, different methods and techniques, have been widely studied. Particular variables associated with the client, remain almost unexplored (Miller, Duncan and Hubble, 2005) with the exception of recent qualitative studies which have investigated this factor (Greaves, 2006; Duncan, Miller and Sparks 2004; Manthei, 2007; Mackrill, 2008; Faris et al., 2009).

Quantitative research into successful outcomes factors in psychotherapy has given the following numeric values to the contribution made by four factors: the therapist-client relationship—30%, the technique/ model applied— 15%, placebo—15%, and extratherapeutic variables (the client) — 40% (Lambert,

1992). More than that, Duncan, Miller and Sparks (2004;51) note *'that forty years of outcome data show that clients and their strengths, resources, relational support - all that is available to them inside and outside of therapy account for 40 percent or 87 percent (depending on the analysis used) of change'* . Their assertion supports my argument regarding the client's crucial role in her successful outcomes.

It nevertheless seems puzzling, why the client has not been more widely researched (Macran et al., 1999). Kazdin (2005) claims, that although four factors have been found to influence successful outcomes, researchers are still far from solving the mechanism of therapeutic change and of treatment effectiveness. Hence it can be argued that to continue doing more of same by conducting quantitative researches is not the solution to this problematic situation. Instead, it is suggested that more qualitative studies especially case studies may enhance our understanding concerning specific factors and the processes of change (McLeod, 2003:99).

Focusing on 'how' questions, such as how the client contributed to the successful outcomes, can perhaps draw us nearer to greater understanding of the therapeutic process and outcomes. This approach is reinforced in light of Pfaffenberger's (2006) general criticism of current positivistic research; he concludes that it is too narrow to present the field of psychotherapy adequately. Further support is given by Gordon (2000) and McLeod (2001; 2003) who call for qualitative, ethnographic and case study research regarding the therapeutic process. It seems that researchers focus on the overall framework and external themes, more than the intrinsic and internal core of the profession. Innovations in the field need to meet open-minded courageous researchers who dare to swim against the stream of the accepted scientific paradigm.

The Client as a Factor in Treatment Outcomes

It is as if the significance of the client is absent on the dramatherapy research stage. Yet as early as the 1950s Rogers (1951: 65-130), the founder of the client-centred approach within Humanistic Psychology tried *'to qualitatively hear the client's voice.'* He dedicated a whole chapter to how clients experienced their therapeutic relationship, and his clients' words are almost the same as those that Iris used with me fifty years later. I have also replicated Rogers' use of open-ended naturalistic interviews to collect his clients' perceptions of their therapy. Rogers wanted *'to achieve the client's internal frame of reference, to gain the centre of his own perceptual field'* (Rogers, 1951:32).

More than fifty years have passed and Rogers' words are still relevant. Professionals must develop awareness, *'that psychotherapy research focusing on the perspectives of the consumer will provide relevant data, which will increase our understanding of psychotherapy and its effects'* (Gordon, 2000:15). In this sense, one preferred way of gathering relevant data from our clients is through participant observations, in-depth interviews, projective methods and artefacts used in therapy. If each psychotherapist would conduct single case studies then we would be enriched by many new researches which might change the contemporary picture of the client's perspectives, and the changes due to therapy and its effectiveness.

In the past two decades psychotherapy research has consistently found that the quality of the therapeutic alliance is related to therapeutic outcome. Binder and Strupp (1997:121) assert that *'a good therapeutic alliance has proven to be an important contributor to positive outcome in the individual psychotherapies of adults.'* While the alliance factor alone, as the essential element in the therapeutic process was addressed by Martin, et al., (2000), I do not doubt the importance of this factor. On the contrary, I am well aware of the ability of a warm and empathic relationship to open sealed doors and without them I believe no therapy can be established. However, it is still a riddle [for me] that there are so few studies on the role of the client as a contributing factor in the therapy

successful outcomes; in comparison to the ample studies on the therapeutic relationship and models' factors refer to this issue.

It is clear that the one critical outcome-influencing factor agreed on by researchers using quantitative approaches is the therapeutic relationship and alliance. Half of this alliance is, of course, the client, yet the literature has reviewed this extra-therapeutic component in general terms only and has not made it a fundamental research question (Maione and Chenail, 1999). Clients have been asked, during and after therapy, to recall thoughts, images, emotions and feelings they were experiencing (Rennie, 1994), to report on effectiveness of therapy episodes (McKenna and Todd, 1997); their experience of therapy (Dale, Allen and Measor, 1998); their 'ideal types' of client experience (Kühnlein, 1999); and to report symptom relief during the course of psychotherapy (Gallegos, 2005). A number of qualitative studies have attempted to provide a richer insight into the client's perspective of the efficacy of therapy compared to more traditional quantitative outcome studies. On the whole, they support the idea of an active client capable of making therapy work for their own purposes (Rodgers, 2003), and as a self- healer and the driver of change (Bohart and Tallman, 1999). Yet none of these studies has related to the way in which the client contributed to recovery, nor assessed the post-traumatic client's role, strength and virtues in recovering from chronic PTSD.

An indirect link to the discussed issue can be found in the qualitative study of 'client agency' conducted by Rennie (2007) in which the client's experience of psychotherapy, the concepts of client reflexivity and the client's relationship with the therapist were used to develop a rationale for rating the appropriateness of the therapist's direction of the therapeutic process. Rennie (2007) concludes that, the unconscious determinants of experience and action underlying the clients' self-awareness play a significant role in their engagement in therapy. This is the nearest finding that resembles the conclusions of the present research regarding the contribution of the client's unconscious processes and IEZ to recovery.

Dramatherapy and PTSD

PTSD research around the world has focused mainly on the victims of war and natural disasters. In Israel, the focus has been on the casualties of terrorism, war, road accidents and Holocaust survivors. However, in many countries there has been a recent increase in research on the issues of PTSD, infertility and stillbirth (Verhaak et al., 2005; Cousineau and Domar, 2007; Thia et al, 2007). As far as I was able to discover, this dramatherapy case study is the only investigation in this field encompassing these three issues.

The few studies that have related to dramatherapy and chronic PTSD, asserted that dramatherapy is an effective treatment for the syndrome (Winn, 1994). However doubts have been expressed regarding the extent of recovery for Vietnam veterans, James and Johnson (1997:394) refer specifically to their experience in group work:

> *Drama-therapy is no cure to Vietnam; it cannot eradicate the memory of their dead buddies. The aim of the treatment for veterans with chronic PTSD is to minimise the extent to which the illness permeates and interferes with their entire existence.*

Dramatherapy methods have mainly applied 'aesthetic distance' defined by Glass (2006:58) as *'the point at which the client can have access to his feelings and also maintain an observer stance'*. This strategy is combined with exposure therapy, to treat clients experiencing PTSD. Glass claims that exposure work using drama therapy techniques can enable the client to alleviate the severity of intrusive memories and move forward. Johnson, Lahad and Gray (2008) view the creative art therapies including dramatherapy as effective treatments for adults with PTSD. Although it is known that full recovery from chronic PTSD is difficult to achieve (Shalev, 1994:100), rehabilitative processes such as those offered by James and Johnson are alternative ways to treat syndrome survivors.

Despite all that is mentioned above, my experience has taught me that cure and successful outcomes are possible. A wide approach to dramatherapy's artistic form links its processes to the right brain hemisphere, the origin of imagination,

emotions and creative thinking (Joseph, 2001). Therefore, it helps to bypass verbal communication, which has been found less effective in treating PTSD (van der Kolk, 2006). Additionally, in the present case the dramatic distancing paradox, the oblique nature of dramatherapy, and periods spent within IEZ enabled the client to come closer to the very genuine, remembered physical senses. Employing symbol, metaphor and role, she was exposed to traumatic memories without being overwhelmed, frightened, threatened or losing control. Thus, it seems reasonable to assert that in this case, dramatherapy presented a cure for the symptoms engendered by stillbirth and fertility treatments failures and proved efficient in treating chronic PTSD.

Dramatherapy and Infertility

I have found three researches dealing with the issue of infertility and creative therapies –the first one examining the role of art therapy in the fertility clinic (Campbell, 1995) and two dramatherapists who have engaged with this topic. Jennings worked as a dramatherapist in a gynaecology ward in a fertility treatment centre in England, and Heller, an Israeli dramatherapist, wrote her M.A. dissertation on *'The use of dramatherapy in supporting women suffering infertility'* (1999). Jennings (1995:133-150) notes the specific importance of dramatherapy for fertility treatment patients: it enables clients to give shape to feelings about infertility and creates structures within whose limits painful questions can be dealt with by means of creative work, ritual, metaphor and symbol. She viewed the fertility counselling process as a rite of passage incorporating three stages, fertile desire, barrenness and reconciliation.

Heller (1999) showed that all three subjects of her study had, through dramatherapy, experienced significant change in their attitudes to their bodies and their connection to their inner strength, which led to a new understanding of their condition and an ability to make changes in their lives. She points out fundamental distinctions between verbal therapy and dramatherapy which underscore the superiority of dramatherapy in treating clients experiencing infertility:

a. Through dramatherapeutic processes (such as impersonation, dramatic projection, embody a role), new lives and worlds can be born and developed and old ones can be shed;

b. Dramatherapy enables clients to demonstrate their feelings about their infertility using mainly physical language: sounds, movement, colour, text and the like. In these ways feelings tend to be subjected to less cognitive and critical processing. This is important for clients with fertility problems because the experience of the medical treatment is physical and sometimes difficult to express.

c. Dramatherapeutic embodiment works with and by means of the body. Fertility problems are based in the body; this is where the treatments are conducted; the woman's body bears the wished-for pregnancy. It is possible to relieve stress and pain directly or through guided imagery.

d. Dramatic work offers an opportunity to develop the projective aspect and give the internal organs colours, shape and sound;

e. In dramatherapy, it is possible to work on the most painful problems (barrenness, for instance) from the optimal distance that the client requires. Landy (1992:97-111) defines this as 'aesthetic distance' (Heller, 1999: 16-17).

These findings highlight the effectiveness and the benefit of implementing dramatherapy with the special population that suffers from fertility difficulties. In order to enable positive transformations among these women either by conciliation and acceptance of their barrenness; or by easing their coping with negative effects of the fertility treatment, therapists should consider dramatherapy as a preferable method instead of conventional psychotherapy. Moreover, it is probably correct to assume that at least some of these women have post-traumatic symptoms (Verhaak, et al., 2005); in which case dramatherapy offers an opportunity to bypass the verbal channel in order to deal with deeper causes of these symptoms.

Summary

This chapter reviewed significant issues in dramatherapy that form the wide framework encompassing the crucial variables that contributed to the PTSD recovery in the present case. The unique characteristics of dramatherapy, its healing aspects of dramatic distancing and role, the core processes and activities were detailed and its fundamental distinction from other expressive therapies were highlighted. The chapter also depicted how the dramatherapist's roles differ from other therapists' roles, and the special ways by which the client is assessed in dramatherapy.

A survey of current research into dramatherapy, in comparison to psychotherapy shows that little research has been conducted regarding the factors contributing to successful outcomes in dramatherapy, which constitutes the focus of the present research. Specifically, the contribution of the client to his own recovery has been almost completely ignored in both fields.

The chapter ended by, showing how dramatherapy can be applied to PTSD, in particular when it is caused by stillbirth and fertility difficulties. It indicated that dramatherapy covers common ground with PTSD, mostly because of the common link to the right hemisphere and to nonverbal expression; hence, the conclusion is that dramatherapy constitutes an effective method to treat PTSD, although this has not yet been empirically studied.

This chapter serves as the foundation for an overview and explanation in the next chapter of the theoretical perspectives, on which the new concepts developed in this research were established. These concepts C.PT, TAE, IEZ and CZ were developed by me on the basis of the successful treatment with the client, Iris and the scholarly case study inquiry.

Chapter 6: New Concepts

Introduction

This chapter will discuss the four new concepts of: C.PT TAE IEZ and CZ. They were derived from several sources: the therapy itself, the collaborative relationship and the discussions with Iris, her reflections on the therapy and the academic quest through the research processes. These concepts represent extra-therapeutic components, which, except for the client factor (C.PT), appear not to have been investigated in psychotherapy outcomes research (Lambert, 1992).

The theoretical roots for the C.PT and TAE were scanty whereas the concepts of IEZ and CZ grew from Lahad's theoretical concepts of 'fantastic reality' and 'healing space' (2000; 2003; 2007), which have not yet been the subject of further research. The widened concepts of IEZ and CZ also drew on the theoretical perspectives of Winnicott (1971), Frankel (1981), Csikszentmihalyi, (1999) and Csikszentmihalyi, Abuhamdeh and Nakamura, (2005), and also from sport psychology and neuroscience. These innovative concepts within the encompassing frame of dramatherapy formed the focused core of the research's conceptual framework.

The Client with Post-Traumatic Syndrome (C.PT)

The term 'client' is preferred to 'patient' in this research, as it is in humanistic client-centred therapy (Rogers, 1951) and also in dramatherapy. 'Patient' has connotations more appropriate for illness-based psychotherapies.

The notion of the C.PT emerged from my attempt to conceptualise the client variable instead of relating only to the specific client - Iris. Using this concept, I slightly revised the conceptual framework of the research constructed several years ago. Without any prior intention to do so, conceptualising this term C.PT helped me to be less emotionally involved with the subject of the research. Consequently I was able to adapt a new wider conceptual perspective and avoid the personal involvement

Although, the research was based directly on the treatment of Iris, the population who suffers from PTSD share the same symptoms no matter the cause of the traumatic event. Therefore it is reasonable to assume that other C.PT will have similar characteristics as a result of the afflicted symptoms. On the one hand, Iris was an individual with unique creative talents; traits and virtues which were muted due to her severe situation. On the other hand, at the same time she was a C.PT who was afflicted by the chronic prolonged PTSD.

My understanding of the C.PT's contribution to a client's own recovery is derived in part from Jung's (1989: 61) perspective on the unconscious:

> *What is the nature of unconscious events? What they are made up of? Of course, as long as they are unconscious, it is impossible to say very much about them. But they are occasionally revealed by symptoms or actions, manipulative opinions, hallucinations and dreams.*

Additionally Jung (1989: 67-68) indicates:

> *The unconscious mentality is instinctive: it has no defined functions: it does not think in the way we think of 'thinking'. It can only produce a picture conforming to the state of the person's consciousness, a picture that contains both ideas and emotions and is everything but a rational product of intellectual judgment. Perhaps it would be best defined as 'an artistic vision'*

In this context it was evident that drawing important knowledge from the C.PT's unconscious world, with the assistance of dramatic non-verbal language, provided a wider, richer and more holistic comprehension of the client. Furthermore, due to the difficulty that the C.PT has in expressing the traumatic event in words, the unconscious content is often exhibited in symbols, actions, metaphors or dreams, constituting the main dependable source. For example Iris's action in the second encounter (Part IV) when she sculpted her 'world now' with small objects; the picture that was constructed reflected her close, empty, shallow, isolated, small almost invisible life. As she described the process in her two oral histories, she had picked up the objects unconsciously. This simple dramatic action

demonstrated her real post-traumatic unbearable situation more than any words might have done.

Despite the copious literature relating to PTSD, it contains minimal consideration of the question: how is the cure achieved through the clients' resources, behaviours and actions. It also does not appear to offer, as this study does, the client's longitudinal reflections on the therapeutic process gathered by in-depth interviews over an extended period. The fact that there is so little evidence of the C.PT's contribution to successful outcomes and so few works *'hearing her/his voice'* as the hero of the therapy (Duncan, Miller, and Sparks, 2004) which could produce an account of recovery from the most frozen, helpless chronic state is almost incomprehensible to me. In this sense there is definitely room for the new concept C.PT that can help to fill this gap in knowledge.

Time-Adjusted Encounters (TAE)

Psychoanalysis and psychotherapy are both traditionally provided in 'doled out' 45-50-minute sessions. This has been axiomatic since Sigmund Freud first found that 50 minutes was a practicable length of time for a session (Elmhirst, 1978; Shapiro, 2000). The accepted length of therapeutic sessions has hardly been questioned since, either in psychotherapy or dramatherapy (Shapiro, 2000). The three-to-four-hour encounters that Iris and I held stand in sharp contrast to the traditional therapeutic hour, even to the few examples of 90-minute sessions in PTSD treatments (Foa, Doron and Yadin, 2006).

Shapiro (2000) criticises the stagnation of maintaining the traditional session time in comparison to the profound evolution of thinking about theory and technique since Sigmund Freud. She claims that case conferences discuss many variables such as frequency of sessions, technical considerations regarding timing of interpretations, or counter-transference dilemmas, but that session length is almost never questioned. She suggests that clinicians lock into a time scheme that may be uncreative and not optimally responsive to a patient's problems. The case examples that she analysed support the notion that double sessions can often revitalise and shed new light on the therapeutic endeavour.

Jennings (1998:144) found *'it curious that dramatherapists generally have adopted the psychotherapeutic time structures of the 50-minute hour for individuals and one-and-a-half hours for groups, usually once a week.'* She has not found, she says, any research to suggest that these are ideal lengths of time. Shapiro (2000), similarly, searching the literature for discussion of double sessions, found only one article (Cohen, 1980) relating to the use of extended sessions in psychodynamic or psychoanalytic treatment.

Cohen proposes *'double sessions as a planned strategy and part of the basic contract between patient and analyst.'* He describes five goals for the idea of double sessions:

1. to accelerate the removal of defences, such as blocking, denial, obsessive trends, phobias, intellectualisation, and isolation;

2. to break down ritualistic behaviour patterns;

3. to provide an opportunity to work-through conflicts in the dependence-separation dimension;

4. to provide a positive holistic experience in an interpersonal situation; and

5. to provide adequate time within one session to make periodic assessments of the status of the analysis (Cohen, 1980: 67:69–81).

Dahlberg's (1967) psychoanalytic work stands out in his use of extended sessions of many hours, and outdoor adventure. While there is evidence that the office setting and the standard therapy 'hour' of 45-50 minutes is helpful to many clients, others may find them constraining. For example, it is not unusual for clients to 'drop a bombshell' on their way out of the door, leaving no immediate opportunity for response or follow-up. The uniqueness of wilderness and other adventure therapies is that they are not limited to 50 minutes and it is possible to intensify the therapy by capitalising on the therapeutic aspects of the wilderness environment, by working on the edge of the comfort zone, and by employing other components of experiential education (Berman and Davis-Berman, 1994; O'Shea, 2008).

Most important is Winnicott's (1971) unique psychoanalytical work in long sessions:

> The patient had found she needed a session that was not time limited. Soon we entered a routine of three-hour appointments, afterwards shortened to two (82); … in fifty minutes no effective work could be done. (88)

Winnicott maintained that it was the therapist's duty to provide the conditions within which the patient could function, like a 'good mother' who adjusts to her baby's special needs.

The French psychoanalyst, Lacan, (1901-1981) also took a radical but different approach. He considered that, as a talking cure, psychoanalysis should depend on the patient's talk, not on the clock. From 1947 onwards, he would end a session, either before or after the 50-minute point, according to what the patient had to say (Jones, 2004). In this sense I argue that my concept of TAE differs from double sessions and depends on the client's actions at least in dramatherapy. It is the time the client needs to enter, continue and end any dramatherapeutic process without being disturbed by the limited time. In the present case the long TAE was especially necessary due to the chronic PTSD complexity and Iris's horrific unbearable state.

These perspectives suggest that three guiding indicators can be deduced regarding the length of therapeutic sessions. Firstly, therapy can benefit from more creative and flexible thinking about session length. Secondly, when transference is intensifying and the patient is able to handle this intensification of feeling, double sessions can move the work along faster. Thirdly, under the right circumstances, extended sessions can help resolve impasses, reduce counter-transference resistance, and lessen performance anxiety and self-consciousness on the part of both the therapist and the patient, while furthering a sense of connection between them (Shapiro, 2000:24).

The session length has not been studied as an outcome-influencing factor, therefore it is considered in this study as an extra-therapeutic variable. I prefer the term 'encounter' to 'session' in this study because it fits the research's

humanistic-existentialist foundation. 'Encounter' as Schmid (2001) argues signifies a real meeting between people, where each treats the other as a full human being.

Imaginary Existence Zone (IEZ)

The Imaginary Existence Zone (IEZ) is a key contributor to PTSD recovery in this research. The term has its roots in Lahad's theoretical concept of 'fantastic reality' (2000; 2003; 2007) which has yet to be adequately or extensively researched. The term describes a spiritual and transcendent phenomenon wherever the physical body may be, even in extreme, terrifying and horrific situations, the imagination's capacity for mental choice and free will remains intact. Its unique and powerful qualities release new life-saving strengths, and protect sanity, creativity and the ability to cope (Frankel, 1981; 1996; Bar-Yitzhak 2004; Lahad, 2007).

Lahad uses the term 'fantastic reality' to indicate a space or place of healing. He talks of *'transcending into the fantastic reality where time and space are suspended and where the impossible is made possible'* (2000:16). He refers to *'the survival of people in extreme situations, who use their fantasy space as an escape'* and to *'the vital role of the imagination in the saving of lives'* (20-21).

Lahad (2001; 2003:15) recalled Winnicott and Frankel as a sources for his conceptions, although he preferred the term 'fantastic reality' while they refer specifically to the imagination. In an unpublished article *Fantastic Reality – Where healing can take place in impossible situations* (2001:1) Lahad describes *'the phenomena of fantasy, dissociation and day-dreaming in the process of survival in traumatic incidents and its healing potential.'* In another paper (2007:47-52) he describes the Fantastic Reality concept as the *''as if' space in which everything is possible and may be.'*

While agreeing that 'Fantastic Reality' is a good term, it became important for me to coin a term which expressed my conception of this region more widely and conveyed its connection to PTSD and dramatherapy and was appropriate for Iris' case; arguing that the bridge by which clients reach and stay in the IEZ is

dramatic activity and nonverbal artistic language. However, I depart from Lahad's concept, in that for me the healing processes only *start* in the IEZ which I posit is located in the limbic system, critical for emotional processing and behaviour (Carr et al., 2003). I argue that the IEZ serves as a 'passageway' to the deeper layers of the amygdala, the neural mechanism of emotion and memory, where especially traumatic memories are engraved (Adamec, 2000; LeDoux, 2003; Verfaellie and Vasterling 2009 and is also correlated with fear extinction: Amano, Unal and Paré, 2010). Assuming that this is so, it is reasonable to claim that the Curative Zone (CZ) is located in the amygdala, and that this is the region specific to cure and recovery.

I also prefer 'IEZ' to 'Fantastic Reality' because even Lahad (1992) referred to the imagination, not to fantasy, as one of the coping resources which human beings possess. He can be understood as regarding the imagination as the whole and fantasy as one of its products. Additionally, recent neurobiological researches on the cerebral hemispheres' functions only relate to imagination not to fantasy (Henkin and Levy, 2001; Nichols, 2006; Ogino et al., 2007). Moreover, I sense the word 'reality' as something concrete, material and physical whereas 'existence' concerns metaphysical aspects, emotional, cognitive and spiritual qualities and freedom of choice.

The concept IEZ was derived from three theories regarding 'imagination':

> *The unique capacity of the human organism to evoke a mental representation of an absent object, affect, function, or instinctual drive, enters into all aspects of psychic activity whether adaptation to reality, normal mentality, pathological mental processes, or artistic creativity* (Beres, 1960:252).

The first theory is that of Winnicott (1971), relating to play, reality and 'potential space' and his differentiation between fantasy and imagination. He argues that fantasy remains isolated, absorbing energy and not contributing either to life or to dreaming. In this sense, it is connected to dissociation and illness, whereas the imagination is connected to health, active life in the real world and to the internal mental reality that is the live core of the personality.

Thus:

Fantasy is imagination manqué; it refers to the kind of day-dreaming that walls the person up in his/her internal world and leads to no form of doing, of efficacy. On the other hand - imagination is the means by which we reach out and connect with others; and play is the operation of imagination, not of fantasy (Levine, 1997:27-42).

Levine (1997: 27-42) further explains: that

For Winnicott ...to be alive is to be able to live in the imaginative and playful space of experience and to be capable of being creative; when we lose the capacity for imaginative life, for play, then we 'die' to ourselves, we experience a living death which is often masked by compliant outer shell' .

The second theoretical base for the IEZ is Frankel's (1981) theory that emphasises the centrality of the imagination in horrible, horrific and abnormal predicaments and the ability for self-transcending as a human phenomenon (Frankel 1996). Frankel was a Holocaust survivor who established the theory of Logotherapy as an existential psychotherapy, mostly based on his personal experience and observing the behaviour of others in the concentration camps. He argues that when a man or woman is able to transcend into their imagination they discover a rich internal life and spiritual freedom, which helps keep them sane and helps them to survive. He defined the process in these words:

Permission was given to the imagination' to withdraw from the awful whereabouts, whereas the ability to intensify the internal life allowed the prisoner to escape to the past. This assisted him to find shelter from the emptiness, inanition, dejection and spiritual destitution of his existence (Frankel 1981:55).

It can be seen that Frankel and Winnicott, held a similar conceptions about the imagination and its significance for healthy mental life. In both theories, there is a direct link between imagination, cure, illness and abnormal situations. In my understanding of dramatherapy, too, the IEZ enables us to restore imaginative

capacity, while simultaneously it forms a bridge to the Curative Zone (CZ) where healing and recovery occur.

Flow theory is the third basis for the IEZ concept. The holistic sensation that people feel when they act with total involvement has been called the flow state. Csikszentmihalyi, (1975) the theory's developer, describes the flow concept as follows:

> *In the flow state, action follows upon action according to an internal logic that seems to need no conscious intervention by the actor. He experiences it as a unified flowing from one moment to the next, in which he is in control of his actions, and in which there is little distinction between self and environment, between stimulus and response, or between past, present, and future'* (Csikszentmihalyi, 1975:36).

On another occasion he explained that flow was:

> *A particular kind of experience that is so engrossing and enjoyable that it becomes autotelic,* (internalised self- rewording) *that is, worth doing for its own sake even though it may have no consequence outside itself. Creative activities, music, sports, games, and religious rituals are typical sources for this kind of experience* (Csikszentmihalyi, 1999:8).

Later, following many years of detailed research, Csikszentmihalyi, Abuhamdeh, and Nakamura, (2005:600) described flow as

> *Subjective experience that the respondents of their research enjoyed so much, that they were willing to go to great lengths to experience it again, and they used the metaphor of current that carried them along effortlessly. People are completely involved in something to the point of forgetting time, fatigue and everything else but the activity itself. The defining feature of flow is intense experiential involvement in moment-to-moment activity. Attention is fully invested in the task at hand and the person functions at his or her fullest capacity.*

In this context, in relation to the present research, and in line with the concepts of Frankel (1981), it is paradoxically in situations that seem farthest removed from the enjoyable, namely, solitary prolonged survival ordeals, that people also describe having flow experiences (Logan 1988:172-173). Such post-traumatic situations characterised the client however, she experienced flow when performing dramatic activities and when she remained within the IEZ.

Based on advanced researches in neuroscience (LeDoux, 2003: 2008; Van der Kolk, 2006; Shin, Rauch and Pitman 2006; Bremner, 2007 Verfaellie et al., 2009; Garfinkel and Liberzon, 2009) and the three above-mentioned theories, I offer IEZ as an inclusive term and concept containing the diverse terms currently used by practitioners to describe this zone. Hopefully this will make a modest contribution to the creation of a shared professional language based on a wide theoretical perspective.

The Curative Zone

The Curative Zone (CZ) refers to Lahad's (2000; 2003) concept of 'a healing space', which, like Fantastic Reality, has been under-researched. I propose that the CZ is located in the amygdala, where cure and recovery take place. Although 'cure' and 'healing' have the same meaning, I prefer 'cure' because 'healing' has been taken over by the complementary therapies, where a 'healing touch' refers to treating people by means of various energies (Cook et al., 2004; Ventegodt et al., 2004; Weze et al., 2006). Unfortunately in Israel anyone can take course of a few months and set up as a physical and mental 'healer'. Dramatherapy is a registered licensed profession and so 'cure' is the preferable word.

As for the term 'zone', the concept was introduced by sports psychology as that mythical place where one can do no wrong. Flow experiences are similar to athletes' experiences of 'being in the zone.'

> *This is the state achieved by athletes in a peak experience, in which total engrossment, effortlessness, and transcendence of self, can be achieved independent performance* (Dillon and Tait, 2000:1).

More specifically, the zone is a distinct and unusual psychological state. Six characteristics allow the individual to enter into this state: confidence, focus, pleasure, non-verbal thinking, calmness, and the ability to tolerate excitement. These six processes are considered necessary and sufficient to enter this psychological state (Ferraro, 1999). The 'zone', denoting an optimal or heightened state of consciousness, can be linked to a diverse range of phenomena covered by the umbrella terms of ecstasy, transcendence or altered states of consciousness. Descriptions of the zone also include the concepts of 'peaks', 'perfect moments', 'mindfulness', 'peak experience' and 'flow' (Young and Pain, 1999; Cashmore, 2002).

The nature of the zone as 'a rare and dynamic state' is illuminated by flow theory, while the primary theories of Winnicott and Frankel are also echoed in it. There is a strong likeness between the zone's characteristics and IE — non-verbal thinking, altered states of consciousness and time, metaphor-generation and loss of self-consciousness (Hanin, 2003). I have therefore combined 'zone' and IE into one concept, the Imaginary Existence Zone (IEZ). The IEZ is dominated by right-hemisphere functions (Joseph, 1988), the right hemisphere also being responsible for the creative activity of dramatherapy (Weinstein and Graves, 2002).

I have thus built three concepts into a broad foundation underpinning the claim that the CZ constitutes a region of curing. The IEZ itself (located in the limbic system) is a product of the structure and activities of dramatherapy and is where the cure processes begin to operate. In my conceptualisation and understanding, it is served by the flow phenomenon, although Nakamura and Csikszentmihalyi (2001) did not apply the flow concept to any specific brain region; neither Winnicott (1971) nor Frankel (1981) considered the link between the power of imagination and processes of creativity to the limbic system, amygdala and right hemisphere.

IEZ serves as a passageway to the CZ, which I posit, lies in the deepest layers of the mammalian brain system, within the amygdala where traumatic experience is engraved. This is part of the limbic system where traumatic blockages can be released and chronic PTSD can be cured. Joseph (2001), Morgane, Galler and

Mokler (2005) and LeDoux (2008) support this postulation. This process relates to how and where fears are acquired and how learned fears are diminished. It was found that the amygdala is important for both the acquisition and extinction of conditioned fear (Phelps, et al., 2004; Sotres-Bayon et. al, 2009; Shin and Liberzon, 2010; Tye et al., 2010).

Summary

The four concepts C.PT, TAE IEZ and CZ that I developed as a result of my research were explained by theoretical perspectives to support the argument that they were crucial extra-therapeutic contributors to recovery from chronic PTSD. These theoretical roots clarified the constitution of the integrated variables, which together led the client to reach the CZ within the encompassing framework of dramatherapy's non-verbal language. Moreover, the construction of a direct connection between dramatherapy, recent neuroscience researches on the limbic system and the amygdala linked to PTSD was established enabling me to provide further support for the research postulation.

The conclusion originating from this chapter is that the innovative extra-therapeutic variables appear to provide a firm foundation in explaining successful outcomes of the treatment of PTSD, at least in the case of Iris. However, in order to enhance the research argument, additional theoretical perspectives, are examined in the next chapter, to further illuminate and explain the C.PT variable.

Chapter 7: Psychology - Recent Theories

Introduction

This chapter will discuss recent theoretical perspectives in psychology, which were found significant in understanding the researched phenomenon of PTSD recovery. Modern Positive Psychology (PP) together with self-determination and personality trait theory are used to construct further interpretations of how the client was able to use her own inner resources to build a successful recovery. The new movement in psychology focuses on people's well-being and positive qualities. It presents an opposite approach to traditional theories that deal with human distress and pathology.

One of its bases is Self-determination Theory that focuses on people's intrinsic motivation, volitional, self-determined behaviours and their sense of ability to choose. The other basis of positive psychology is Personality Trait Theory dominated by the Five Factor Model (FFM) of personality traits, divided according to five basic dimensions, each associated with six facets, which all highlight positive features. These psychological approaches are dealt with in the last section. Thus, the chapter contains four interlinked sections, demonstrating the positive characteristics identified in the client's personality and behaviour and enabling further understanding of her contribution to successful outcomes.

Positive Psychology (PP)

The humanist-existentialist beliefs and ideas which motivated this research are directly linked with the questions 'what is positive' or 'what is valuable'. These questions can be answered on the basis of three indicators; first, the choices people make are one indication of value. That is, if something is chosen regularly, the chooser probably believes in its value or goodness. Second, people can judge whether or not something is satisfying: whether an object, event, process, or outcome is pleasant. Third, judgments of what is positive or good can be made with reference to some value system or set of cultural norms (Diener et al., 1997). The issue of what is positive was not researched or extensively discussed

in the early days of psychology; however recent trends in psychology have aroused interest in this topic.

Since World War 2, psychology has become a science relating primarily to healing. It concentrates on repairing damage within a disease model of human functioning. This almost exclusive attention to pathology, deficits and the management of disabilities neglects consideration of the fulfilled individual. PP, in contrast, emphasises the individual's strengths, aiming to begin to catalyse a change in the focus of psychology from preoccupation with repairing the worst things in life to building positive qualities. At the subjective level, it is about the value of the individual experience: well-being, contentment, and satisfaction (past), flow and happiness (present) and hope and optimism (future). I employed this subjective perspective in my research since it studied the subjective experiences, perspectives and reflections of the client and the researcher (Peterson, 2006).

At the individual level PP relates to positive individual traits – *'the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future-mindedness, spirituality, high talent, creativity and wisdom'* (Seligman and Csikszentmihalyi, 2000:5). In a wider perspective PP *'is the study of the conditions and processes that contribute to the flourishing or optimal functioning of people, groups, and institutions'* (Gable and Haidt, 2005:104).

Additionally, PP focuses on enhancement, understanding and facilitating happiness and well-being; and explaining these states by means of scientific enterprise (Carr, 2004:1). It seems that these contrasting approaches to the human beings' psychological life present contradictory philosophical attitudes.

The illness-oriented approach was first established in psychoanalysis while Humanistic-Existentialistic psychologists broke fresh ground with the wellness - oriented approach. In practice, PP draws on the methods used to advance the science of mental disorders in order to study mental health and well-being. It is constructed on pioneering work by Rogers (1902–1987), Maslow (1908-1970), Jahoda (1907-2001), Erikson (1902-1994) and Deci and Ryan (1985).

A revolutionary step in the field was taken by Peterson and Seligman, (2004) who developed a typology of Character Strengths and Virtues (CSV), asserting that the CSV represents the most ambitious project self-consciously undertaken from the perspective of positive psychology. They intended to create a categorised handbook for psychological well-being, to parallel the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (1994) that defines the psychological disorders that disable human beings. The CSV describes and classifies strengths and virtues that enable human thriving. The general scheme of the CSV relies on six virtues that almost every culture across the world endorses: wisdom and knowledge, courage, humanity, justice, temperance, and transcendence; overall including 24 particular Character Strengths.

This new development is highly significant, especially for therapists and researchers who are interested in human well-being and less interested in pathology and it matches my resolve to focus on the client's strengths during the therapy. In the research, I continually searched for theories that would help me to interpret the findings according to my beliefs and be based on the positive perspective; this would support my argument, that Iris owned and employed many virtues and positive traits and was therefore the crucial contributor to her recovery.

An important assertion relating to this context is that the research findings from positive psychology are intended to supplement, not to replace, what is known about human suffering, weakness, and disorder, to form a more complete and balanced scientific understanding of the human experience. The authors believe that a complete science and a complete practice of psychology should include an understanding of both suffering and happiness, as well as their interaction, and validated interventions that both relieve suffering and increase happiness (Seligman, Steen and Peterson, 2005). The stance proposed by those authors seems reasonable due to the complementary nature of the two approaches. The human world needs them both, in order to fulfil the best conditions for all people - those in distress and those who are happy, those who are ill and those who are

healthy. Our lives are fragile and unpredictable. They even occur as they did for Iris, plunging from a happy content and optimistic existence during her pregnancy, when she suddenly experienced tragedy and afflicted feelings when her baby was stillborn. Hence, effective assistance in such a case needed to employ knowledge from both orientations; how to produce a cure and how to reconstruct and restore Iris's strengths and virtues.

Positive psychology and its sister theories match both the humanistic spirit of this research and the optimism of dramatherapy, depending as they do on the client's strength and personal resources (Jennings, 1998: 41, 76). The evidence provided by this study's fieldwork, which demonstrates the practical value of directing the therapy to the client's healthy aspects, instead of relating primarily to her distress and the symptoms of PTSD is also in line PP. The client's free choice of preferred activity, the judgments she made of what was good and helpful for her and the overall strategy of focussing on her strength and virtues were all anchored in positive psychology.

Self-determination Theory

Self-determination Theory (SDT) is one of the central pillars of positive psychology. Humanistic-Existentialistic ideas which are so fundamental to this case study stand at the core of this theory (Nieghbor et al., 2007).

SDT is a macro-theory of human motivation concerned with the development and functioning of personality within social contexts. The theory focuses on the degree to which human behaviours are volitional or self-determined, that is, the degree to which people endorse their actions at the highest level of reflection and engage in actions with a full sense of choice (Ryan and Deci, 2000).

With regard to my client's PTSD, it seems that it was only in the narrow 'social context' of the therapy that the client was able to fulfil her motivation and self-determination and to actively perform according to her own free will. While in the wider social context, she was actually stuck and frozen and could not employ these features. Moreover, the strategy that I applied by adjusting my roles, the activities and the encounters to Iris's needs was crucial to the successful

outcomes as echoed in the client's reflections (See Appendix 4 and 5) and in the explanation below.

Within SDT, the nutriments for healthy development and functioning are specified, using the concept of basic psychological needs, which are innate, universal, and essential for health and well-being. To the extent that the needs are fulfilled, satisfied people will function effectively and develop in a healthy way, but to the extent that they are thwarted, people will show evidence of ill-being and non-optimal functioning (Deci and Ryan, 1985; 2000).

In this context, there can be little doubt that Iris had suffered from lack of psychological nutriment caused by her PTSD. This condition had deprived her of need-fulfilment and she was stuck in a state of disorder for three years. As soon as her psychological needs began to be fulfilled, a rapid transformation occurred within the first encounters.

Brown and Ryan (2003) suggest a conceptualisation of intrinsic motivation as the inclination we have for spontaneous interest, exploration and mastery of new information, skills and experiences. Their theory predicts that when our needs for competence, relatedness and autonomy are satisfied, intrinsic motivation is likely to occur, while personal well-being and social development are optimised. This view is significant for any form of therapy, especially for PTSD treatment, in the light of the helplessness, loneliness and vulnerability of the C.PT's experience and due to their difficulty to achieve full recovery. Hence, constructing the therapy on these needs will enhance the client's intrinsic motivation and sense of control which are especially important to a C.PT. In the thesis I used SDT together with dramatherapy assessments and personality trait theory to illuminate the contribution of the client's personality, character and roles to her recovery.

Personality Trait Theory

Trait theory has come to be dominated by the Five Factor Model (FFM) of personality developed by Costa and McCrae (1995). They asserted that in interaction between external influences, notably shared meaning systems, and personal traits contribute causally to the development of habits, attitudes, skills,

and other characteristic adaptations. According to McCrae (2002) the FFM is a comprehensive taxonomy of personality traits, defined as tendencies to show consistent patterns of thoughts, feelings, actions and behaviours. The FFM has been shown to be a reliable and valid measure for the assessment of normal personality traits. Although originally developed in the USA, it appears to describe personality structure well in a wide variety of cultures, suggesting that personality trait structure is universal.

This model is an important addition to the above theories, which all highlight the individual's positive features, opening new channels for psychotherapy professionals to exploit for the benefit of their clients. The shift in observations from the clients' weaknesses and pathology towards accepting their strengths, positive traits and virtues should increase therapy's successful outcomes.

The FFM provides a hierarchical organisation of personality traits according to five basic dimensions, each associated with several facets:

1. 'Neuroticism which is characterised by anxiety, angry, hostility, depression, self-consciousness, impulsiveness, vulnerability. The positive opposite refers to stability, which is characterised by courage, calmness, happiness, self-esteem, impulse control, and resilience.

2. Extraversion which is characterised by warmth, gregariousness, assertiveness, activity, excitement seeking and positive emotions.

3. Openness which is characterised by openness to fantasy, to aesthetics, to novel feelings, to novel actions, to new ideas and openness to different values.

4. Agreeableness which is characterised by trust, straightforwardness, altruism compliance, modesty and tender-mindedness.

5. Conscientiousness which is characterised by competence, orderliness, dutifulness, achievement, striving self-discipline and deliberation' (Carr, 2004:184; Costa and McCrae 2008).

Advantages of the FFM include the provision of a precise, yet comprehensive, description of both normal and abnormal personality functioning. It enables the avoidance of the many limitations and problems inherent in the categorical diagnostic system of the DSM-IV which can be understood as a system of maladaptive variants of the personality traits included within the five-factor model (FFM) (Widiger and Lowe, 2007; Samuel and Widiger, 2008). Believing in the client's healthy personality, I used the FFM in conjunction with Self-Determination Theory to help define her personality traits, as they appeared during the therapy period, and to explain how they contributed to the successful outcomes.

Two Conflicting Psychological Approaches

Paradoxically, my thesis depended on contemporary PP and its related theories, which focus on flourishing and well-being, even though the research subject was recovery from chronic PTSD, a condition necessitating treatment of disorder. The reason for this is that my research focuses on the elements contributing to recovery, neither on the pathological factors nor on the disorder itself. Thus, it was appropriate to deploy positive theories to analyse and explain the elements of the cure.

My professional attitude during the therapy is completely in line with the approach of PP, since I accepted the client as a healthy woman who suffered from a long but temporary unhealthy situation. This does not mean that I ignored the chronic disorder. On the contrary, it was actually in light of her afflictions that I encouraged the reawakening of her positive virtues and traits, which had remained shattered for three years. In this way Iris was able to recall her strengths and modes of coping, enabling her to reconnect with her real self and entity that she had almost forgotten. Additionally the approach of PP tallied with the research argument that the human being variable, the C.PT, plays a crucial part in contributing to successful treatment outcomes through the employment of optimal coping resources and roles.

The traditional approach can efficiently explain disease course, causes and symptoms but does poorly at explaining recovery. The extra-therapeutic components which contributed to the creation of the CZ and recovery - the C.PT, the IEZ and TAE, can only be comprehended by understanding and adopting the new theories dealing with positive traits and the strengths conducive to well-being. PP and its sister theories also match both the spirit of this research and the optimism built in dramatherapy, although dramatherapy also relies upon traditional theories. This is why it made sense for me to base my theoretical perspectives on the above-mentioned modern psychological theories: they encompass and explain both the study's concepts and its fieldwork, providing the research with an integrated holistic philosophical and theoretical framework.

In this sense I needed dual vision to accept the traditional theories on dysfunction and pathology in order to understand the client's distress, while adopting the new theories in order to explain her recovery. This study thus creates a body of complementary and recent knowledge and thus hopefully makes a meaningful contribution to current knowledge on dramatherapy.

Summary

This chapter reviewed three recent psychological theories - PP, SDT and personality trait theory: FFM, as they relate to this research. These theories were identified as significant conceptual tools to understand the studied phenomenon of chronic PTSD recovery from the positive world-view. This viewpoint fitted the Humanistic-Existentialist spirit of the research and supported the reliance on healthy features that characterised the case study. These theories are therefore employed to explain how the client could exploit her own inner resources, strengths, virtues and traits to build a successful outcome from an extremely disabling mental distress.

These theoretical perspectives enhance and deepen comprehension concerning other sides of human beings; emerging from the darkness of illness and pathology, into the light – a position of hope, well-being, fulfilment and growth.

The conclusion arising from this chapter is that the above-mentioned theoreticians identified gaps in knowledge in the psychology field; they filled the gap with new knowledge providing a highly important contribution to humanity.

Chapter 8: The Conceptual Framework

Introduction

This chapter discusses the significance of the conceptual framework within the research, its importance in helping me to reach the conceptual levels of the study, and how it helped me to draw conceptual conclusions at different stages.

Conceptual Framework Features

According to Miles and Huberman (1994) *'A conceptual framework explains, either graphically or in narrative form, the main things to be studied - the key factors, constructs or variables - and the presumed relationships among them.'* (p. 18). More widely Maxwell (1996:25) views it as *'the system of concepts, assumptions, expectations, beliefs and theories that supports and informs (your) research.'*

Additionally, Leshem and Trafford (2007:7) summarised the issue of the conceptual framework from two points of view. The first one is *'a set of relationships within the research process; which locates the conceptual framework as fulfilling an integrating function between theories that offer explanations of the issues to be investigated.'* The second view sees the conceptual framework as *'a map, providing a picture of the theories and issues relating to the research topic. This map gives meaning to the relationship between theoretical variables, by showing that theories have the potential to provide understanding of, and insight upon, the research topic.'*

Nevertheless, in both views, the authors emphasized the centrality of the theories. The conceptual framework underlying this research emerged first and foremost from the fieldwork, which took place prior to the research, three years before I embarked on the Ph.D. (09/1997-05/1998). The initial source contained the dramatherapy treatment and its successful outcomes in a case of chronic PTSD.

In 2001, after starting the research, I could establish the other sources of the conceptual framework based on my observations and experience as well as

reflections on my reading of a wide range of theoretical perspectives (Trafford and Leshem, 2003:6).

As Trafford and Leshem assert, in naturalistic research the conceptual framework can be constructed on the basis of an examination of the topic in fieldwork or by reading, thinking and model building. In the years between the therapy termination and the beginning of the research, I had many understandings and insights that might explain the recovery phenomenon. But I sensed that they provided only partial explanations, mostly intuitive. I needed to find theories that would reinforce my feelings, observations and intuition. The theoretical foundation that I gradually compounded from multidimensional disciplines included understandings from: psychotherapy, neuroscience, Frankel's 'Logotherapy', the theories of Winnicott and Lahad, flow theory, sport psychology, dramatherapy, positive psychology, self-determination and personality trait theory.

Conceptual Framework Components

Within the fieldwork, the client, the long encounters and the dramatherapeutic activities were observed and recognised as curing contributors to the client's recovery from the syndrome. During the research these components were reformulated and conceptualised to become: C.PT, TAE, IEZ and the CZ. These four components formed the underpinning foundation for the research's conceptual framework that facilitates deeper comprehension of the researched phenomenon of PTSD recovery. In this way I was able to elevate my level of thinking from purely descriptive to analytical/interpretative and subsequently to reach a conceptual level (Leshem and Trafford, 2007; 103).

Figure 8.1 below presents the structure of the research's conceptual framework. It depicts the wide frame of dramatherapy that encompasses the interaction between C.PT IEZ and TAE and the effect of these components on the CZ and eventual recovery.

Figure 8.1: The Conceptual Framework for the Research

A Dramatherapy Model of PTSD Recovery
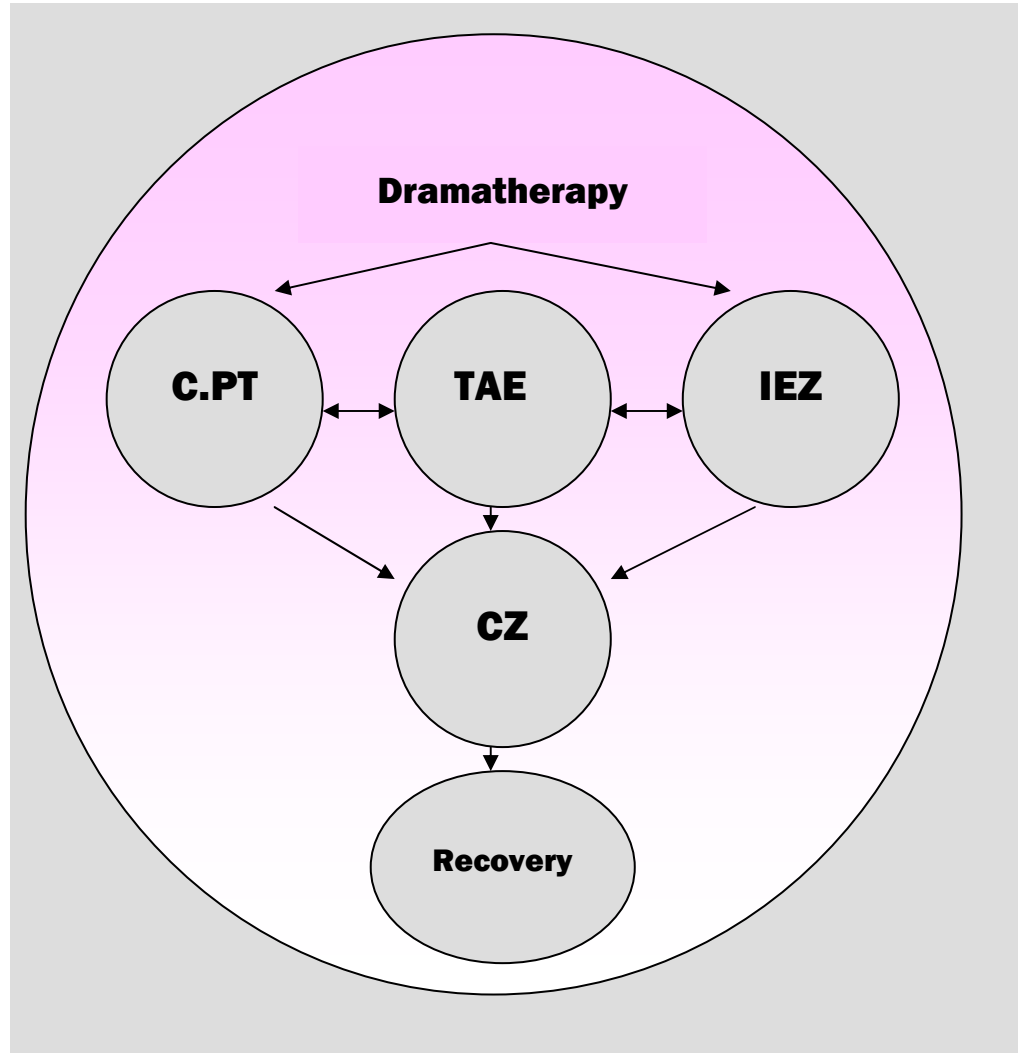
The conceptual framework served as a wide umbrella encompassing the multidimensional theoretical perspectives that underpinned the different components of the framework as well as *'offering a model that shows the relationship between theories'* (Trafford and Leshem, 2003:4) that is further elucidated in the next chapters.

The process I went through as I created these innovative concepts: C.PT, TAE, IEZ and the CZ and eventually the graphical conceptual framework extended over seven years. Intentionally, since the beginning of the research, in my quest to

understand the recovery phenomenon I had looked for unique explanations; and did not want to explore obvious common therapeutic factors like models, techniques or relationships which were widely studied (Lambert, 1992). The trial and error involved to discover these explanations featured my hectic efforts to define minimally examined areas. Mostly it was an imaginative and creative process, although I was frustrated, disappointed and angry when I failed to find the accurate notions that would satisfy me.

However, when I finally found the correct components (regarded as extratherapeutic factors in psychotherapy) that sprouted from the dramatherapy case of Iris, it was an exciting, euphoric and flow experience. I then began a new intellectual and scholarly quest to transform these components into academically established concepts. I used to talk to myself and try different words in varied combinations in order to describe the identified components, to see if these words could explain them exactly. Simultaneously, I examined many theoretical perspectives, looking for similar ideas. I made up my mind that I would only choose the specific concept after I had revealed that there was no equivalent or parallel term mentioned in the literature.

The last phase was to create a graphical scheme of the conceptual framework, a comprehensive picture of the separate concepts that would explain the interaction between the variables. My assumption was that the dramatherapy frame encompassed the conceptual components and each component had a reciprocal relationship with the others. Moreover, together they formed an integrated whole that influenced the creation of the CZ and consequently the recovery.

The first component, relating to the client and her contribution to the recovery was quite obvious during the therapy period (fieldwork). It was seen in her willingness to be active, to initiate, to experiment with new modes of therapy and to rapidly lend herself to dramatherapy nonverbal activities. The transformations that occurred in the client's symptoms pointed up her crucial role in the successful outcomes. At that time I depended on my professional practice and my observations; the idea to focus on the client component as one of the concepts that would construct the conceptual framework, emerged in 2003, after reading

an article on the contributing factors in successful outcomes (Maione and Chenail, 1999) and the fact that little qualitative research had been conducted on the extratherapeutic factor: the client.

It was only in 2007, following a suggestion by two expert colleagues and many years of reading psychotherapy and neurology literature, that I was able to conceptualise this variable and defined it as the Client with Post-trauma (C.PT).

The long dramatherapeutic encounters lasting between 3-4 hours were characteristic for this specific treatment. Within the therapy period I was convinced that this second component had a strong influence on Iris's mood and feelings, especially on the rapid diminishment of the PTSD symptoms. Therefore I also decided to focus on this variable, viewing it as a crucial contributor to the successful outcomes of recovery, despite the minimal theoretical background in the extant literature. The conceptualisation of this component includes time, adjustment and encounters – TAE, elements which explain exactly what happened in the therapy, when I was tuned to the client's needs by stretching the traditional time of the encounters, in order to eradicate the afflicting symptoms as soon as possible.

The third component was derived from the dramatherapy itself. I was looking for an original feature that could explain the recovery beyond the obvious curing features that this profession provides. I had found that the concept of 'fantastic reality' as a healing space proposed by Lahad (2003; 2007) was valid in the context of this research, since it so accurately described the dramatherapy experiences that Iris embraced.

However, I wanted to develop it to a wider and more authentic concept that would describe exactly the characteristics of this case in consideration of wide-scale neuroscience theories. I therefore chose to reframe it so that it became the concept of an Imaginary Existence Zone – IEZ focusing on and emphasising the powerful impact of imagination in recovery (Winnicott 1971; Frankel 1981). Additionally, the flow theory, the rich meaning of the word existence and the concept of the Zone as it appears in sport psychology added new dimensions to my concept.

The Significance of the Conceptual Framework within the Research

I argue that in this inductive case study the conceptual framework has been used both as guiding map and as a set of relationships (Leshem and Trafford, 2007:7). However, I must admit that for about five years of the research, this was not the situation at all. Throughout that period of time, I felt confused and sensed that I was drowning in the enormous amount of the evidence and the data and probably seriously misunderstood the meaning of the conceptual framework. I had many ideas about the topic but I could not see the whole picture. During that period I even wrote-up the analysis part of the thesis but later on, I understood that I had completely lost the correct direction and since I had taken the wrong path, the research would never end. I therefore decided to start again from the beginning.

Slowly, in the last 4 years things became clearer and understandable, it is reasonable to assume that it happened partly after I wrote-up the theoretical perspective part, and that this engendered the long process of changing my way of thinking - I stopped think as a dramatherapist and was able to accept the fact that I am a researcher. Overcoming this obstacle enabled me to organise my ideas and use the concepts that were already established in my mind in a wide picture. Since then I continually visualised the conceptual framework diagram and the graphical structure of the relationship between the components; it helped me at each step to remain focused and maintain the boundaries of the research.

I needed this guiding map, enabling me to stride forwards in the right direction. It guided me in the further stages of the research, especially in designing the fieldwork part and to decide what this part should include; seeking for the correct theories that would underpin the concepts and completing the writing of the theoretical perspective part; and mostly in the analysis and interpretation stage which was re-written. Eventually, the deep understanding I gained from the conceptual framework scheme, helped me to use it accurately in the discussion and conclusion parts of the research.

Adopting the scheme of Trafford and Leshem (2003:6) for analysis and interpretation (part 3 chapter 15 section 15.2) I also used it as a guiding tool. The clear structure of the scheme assisted my construction of the conceptual

framework components in a logic order; to perceive the relationships and the overlaps between them, and to understand that the implicit overlapping areas should be analysed and interpreted. To turn the scheme into a verbal explanation was an illuminating process; at last I felt that all the puzzle's parts were organised in the correct order. I sensed confidence in the way that the analysis and the interpretation of the evidence encompassed all my latent ideas and thoughts about the researched phenomenon and was able to express them accurately. It was a very creative process due to the many new ideas that had been revealed during the writing of the analysis, enriching the explanations; while simultaneously I could trace the conclusions as they emerged from each step of the interpretation and the analysis of the conceptual framework components. I was especially helped at this stage by relying on Leshem and Trafford's (2007:103) enlightening figure that explains the technical, practical and conceptual aspects of doctoral research and the different levels of thinking involved.

The set of the gathered conclusions enabled me to distinguish the factual from the interpretational conclusions. Then, I distanced myself from these conclusions and the individual case. Using general, comprehensive points of view on the researched phenomenon and depending on the well-established and explained innovative concepts; I was able to transcend to the highest level of thinking and to create the conceptual conclusions.

Summary

This chapter explained the features of the conceptual framework and its importance in understanding the relationships between its constituent components and how it was used as a necessary map.

In sum, Part II reviewed and discussed the underlying theoretical perspectives of the research, explaining the new concepts and the positive theoretical basis that facilitate deeper comprehension of the PTSD recovery. These components formed the underpinning foundation of the research's conceptual framework, whose significance as a guiding map was explained. Part III below presents the research design and methodology.

PART III: RESEARCH DESIGN AND METHODOLOGY

Introduction

This part reviews the research methods that were employed. It provides the underlying rationale for the choice of the qualitative naturalistic-subjectivist paradigm and the interpretative inductive case study method and design. In addition to my reliance on and belief in my particular humanist, involved and voluntary manner, the research was founded on the humanistic-existentialistic world-view as the research philosophy.

Chapter 9 describes the considerations involved in the choice of the qualitative research as opposed to the quantitative approach, while Chapter 10 discusses the specific case study method with a sample of N=1 and explains the reasons that phenomenology was not employed in this research.

Chapter 11 sets out the rationale and practice of inductive design; while Chapter 12 shows how different tools were used for data-collection.

Finally Chapter 13 deals with the issues of the reliability and validity of research in general and the ways in which I coped with these issues including the ethical considerations that arose during the research and the specific difficulties involved in the present study. Chapter 14 summarises the entire research process and provides the research time-line.

Chapter 9: The Choice of Paradigm - Naturalism

Introduction

This chapter discusses the reasons for my decision to adopt the naturalistic-subjectivist paradigm in preference to the positivistic-objectivist paradigm. The nature of this case study suits the characteristics of this paradigm and its philosophical perspective since it originated in real life subjective experience and encompasses unconscious and latent processes which were ascribed specifically to the single client. Considering that dramatherapy is a relatively new profession, the scarcity of a substantial body of doctoral research is perhaps understandable. So, this chapter reviews the different research approaches to the more general issue of psychotherapy.

Humanistic- Subjectivist Approach

The limited body of qualitative research in psychotherapy is particularly puzzling. After more than fifty years of quantitative research relating to the effectiveness of this treatment, and despite the growing legitimisation of the naturalistic or socio-cultural paradigm, the objectivist approach to research still appears to predominate. In an overview of psychology research, Rettig (2006) says that since it was defined as a study of behaviour, the positivist approach became the dominant orientation in academic psychology, making little difference between the methods employed in studying man and animals in laboratories. In psychotherapy this tendency to stick within the scientific, objectivist boundaries seems to be rooted in the early criticism of the profession as non-scientific. Most researchers have relied on prescribed theoretical orientations as the safe way to win scholarly recognition. This may explain why few researchers use qualitative methods to study clients' contribution to their therapy (Maione and Chenail, 1999). Furthermore, there has been almost no consideration of the complexity of researching the 'human factor' in psychotherapy.

My research relates to the therapeutic process applied in a case of PTSD. Although PTSD symptoms have been widely studied and explained within neuroscience research (Ledoux, 1997; 2008; Verfaellie and Vasterling, 2009), the issues of therapeutic interaction, inter-subjective matters, imaginary existence zone, time adjusted encounters and the client's contribution to cure have not been studied. In psychotherapy in general and more specifically in psychotherapy in cases of PTSD, they can neither be statistically measured nor studied in artificial laboratory conditions.

The alternative approach which I adopted for this research is interpretive sociology, since it envisages the ability to understand beyond what is obvious as Weber, (1981:151) explains:

> Unique to human behaviour however (at least in the fullest sense), are relationships and regularities whose course can be intelligibly interpreted. An 'understanding' of human behaviour achieved through interpretation contains in varying degrees, above all, a specific qualitative 'self evidence'… We understand the typical course of the emotions and their typical consequences for behaviour … Ecstasy and mystical experience, just as above all, certain kinds of psychopathic context …. are not as accessible to our understanding and our interpretive explanation as are other processes. Yet the 'abnormal' as such is not inaccessible to interpretive explanation … On the contrary: the act of an exceptional person can … be absolutely understandable and directly accessible to comprehension.

Offering a similar perspective, Burrell and Morgan, (1979:2) suggest:

> To objectively treat the social world like the natural world as being hard, real and external to the individual is unacceptable if one is interested in the internal implicit world.

The humanistic alternative for the study of human behaviour is hermeneutic and discursive psychology. These alternatives offer a deeper understanding of human actions in a situated field. They attempt to take into account the motives and aims of people's conduct (Rettig, 2006) since they employy the *philosophical*

assumption of social reality, which stresses the importance of the subjective experience of individuals in the creation of the social world ' (Burrell and Morgan, 1979:3). This was, therefore, my preferred research approach. It allows room for the consideration of free will, the client's choice of creating a new reality of rebirth and a personal belief system.

Referring to reflective practitioners, who base their research on a positivist epistemology, Schön (1983: 42) criticises *'their definition of rigorous professional knowledge [which] excludes phenomena they have learned to see as central to their practice. Artistic ways of coping with these phenomena do not qualify for them as rigorous professional knowledge'.* In psychotherapy, reliable objective measures of variables derived from theories and models have been used to create controlled experimental conditions within which to test a hypothesis. From this perspective, the subjective feelings, states of minds or belief of clients are not considered to be legitimate topics of interest (McLeod, 2001; 2003).

The neurologist Sacks (1986: ix-x) reminds us that:

> *The natural history of* [a] *disease tells us nothing about the individual and his history; it conveys nothing of the person, and the experience of the person, as he faces and struggles to survive his disease. There is no 'subject' in a narrow case history … to restore the human subject at the centre - the suffering, afflicted, fighting human subject - we must deepen a case history to a narrative or tale.*

If this is obvious in medicine, it can be argued that it should be all the more so in psychotherapy and dramatherapy since human beings are the pivotal actors in any enquiry.

In line with McLeod's view (2001; 2003), Gordon (2000) also criticises psychotherapy's quantitative researches, and suggests that instead of conducting quantitative experiments, psychotherapy practitioners, should be involved in talking with people and exploring how they make sense of their experience.

Each of these opposite traditions, the subjective versus the positivistic/objectivist, has advantages and limitations in inquiring into human nature. The essence of the subjectivist approach is:

> *The premise that the ultimate reality of the universe lies in 'spirits' or 'idea' rather than in the data of sense perception. In its approach to social reality it stresses the essentially subjective nature of human affairs, denying the utility and relevance of the models and methods of natural science to studies in this realm (Burrell and Morgan, 1979:7).*

The study reported here is rooted in interpersonal, intra-psychic and interrelated subjective qualities that developed over a period of years. Its initial source was the therapy of a single client. The therapeutic relationship then developed into a collaborative research relationship between client and therapist. These characteristics fit the choice of the naturalistic/subjectivist paradigm as the methodological umbrella for this research.

The qualitative approach is also most compatible with my professional humanist-existentialist philosophy that human beings are both biological creatures and self-aware beings. They are autonomous creatures who are free to act, make choices, and develop expectations. This freedom enables them to accept responsibility and to define their identity based on their subjective experience of life (Elizur, Tyano, Munitz and Neumann, 1989: 52-53). I was and still am interested in looking into the subjective reality of personal existence, the inside information of cognition, perceptions, feelings, spirituality, values and beliefs. Therefore for this research the naturalistic paradigm was my preferred choice, as it assumes that there are multiple interpretations of reality.

The choice of the naturalistic paradigm and my reliance on the humanistic-existentialistic world-view also rely on Hammersley and Atkinson's (1995:7) wider perspective:

> *The first requirement of social research according to naturalism then, is fidelity to the phenomena under study, not to any particular set of methodological principles, however strongly supported by philosophical arguments.*

It was highly important to remain loyal not only to the phenomenon, but to the participant's integrity and authenticity, as well as to the principles of dramatherapy.

Sometimes, in psychotherapy, if researchers impose a theoretical structure on the events they are studying in order to exclude phenomena that can be neither measured nor controlled, they set limits on what can be investigated and artificially narrow the field of inquiry (Gordon, 2000). My research runs contrary to the major trend in psychotherapy research. The considerations that guided my choice of paradigm and methodology purposely widen the field of inquiry. They are both the result of dramatherapy's minimal theoretical substrate and seek to amend that lack. The dramatherapy case constituted the research field, yet it was also a real therapy. It related to the relationship between two human beings, who together created multiple subjective realities within the objective reality. The reality of that therapy and relationship encompassed the subjective atmosphere, unconscious processes, emotions, relationship, experience, shared humanist-existentialist beliefs, behaviours, ways of thinking and values.

Also relevant to the choice of research paradigm is the participation and collaboration of the client at the core of this study. Psychotherapy literature indicates the lack of qualitative research into the client component of therapy. This is a gap in professional knowledge that I am certain needs to be filled.

Macran et al. (1999) support the view that psychotherapy research should consider the client's perspectives, which should be viewed as an integral part of research, equally valid to a researcher's perspective. Therapy's extra-therapeutic components in general, implicit processes and the therapy participants' subjective experience are all under-researched.

Development of Dramatherapy Theory through Research

Theory testing was not the aim of this present research. However, the lack of theory in dramatherapy troubles Lahad (1994:182). He claims that *we are moving towards an era where we have brilliant ideas, vast experience, and there is a need now to conceptualise it into more theoretical approach … to move from experience and models to theory*. I drew heavily on a number of current theories

to explain the success of this therapy and hope that the resulting synergy will make a modest contribution to dramatherapy's theoretical base. Thus, my choice of an inductive approach to research corresponded with the need to develop theory in this particular field of professional activity.

Summary

This chapter discussed my choice of the naturalistic paradigm for my research. I purposely maintained my fidelity to the researched phenomenon, the subjective attitude and to the humanistic-existentialistic philosophy that underpin the treatment and the research as well.

Chapter 10: Case Study Method

Introduction

This chapter outlines the case study methodology. It explains the methodological issues involved in the choice of a single respondent for the case study. The chapter also discusses the phenomenological approach and explains the reason why it was rejected as a possible research approach for this study.

Case Study Definitions and Characteristics

One way to view case study is when

> *We have all been entranced from time to time when someone has described an interesting and important experience ... it has held our attention ... the personal experience, a few hard facts, a little dialogue ... and some description of the context ... as the events unfolded ... . What we are hearing is the presentation of a case study* (Trafford, 2001:22).

My research is presented through a single case study. It involves Iris's personal experiences and my own. It describes, with analysis and interpretation, a series of dramatherapy encounters and a lengthy collaborative and reflexive inquiry into their content and outcome. We were so affected by this mutual journey and its outcomes that we found it sufficiently significant to share with others, so that both the analytic process itself and the resultant understanding might contribute to knowledge.

However, case study methodologies have been criticised:

> *The case study has long been stereotyped as a weak sibling among social science research techniques. Investigators who did case studies were regarded as having deviated from their academic discipline* (Yin, 1994: xiii).

The most frequent criticism of case study methodology is that it cannot be generalised, and this deprives it of scientific value (Tellis, 1997). Other limitations include the uniqueness of the case situation which is almost impossible to replicate. A case may not be representative, and therefore causal inferences cannot be drawn from its conclusions since it would lack statistical reliability. Thus, generalisations cannot be advanced. However, these criticisms originate from a deductive methodological perspective while case study research seeks to develop theory within an inductive perspective. Thus, these limitations can be noted but they do not invalidate the epistemological foundations on which case study methodology is founded. Furthermore, experimenter reactivity or experimenter bias may lead to fallacious *ex post facto* reasoning.

Lincoln and Guba (1985:42:216:247) highlight the value of the case study method:

> *[Researchers] depend so heavily for their validity on local particulars, including the particular investigator-respondent interaction, the contextual factors involved ... It implies understanding in a very holistic way and the case study story will provide 'thick description'.*

In support of this view, Yin (1994:3) suggests that:

> *The case study allows an investigation to retain the holistic and meaningful characteristics of real life events - such as individual life cycles ...A case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and contexts are not clearly evident.*

McLeod (2000; 2001; 2002; 2003) argues that case study is the ideal method in qualitative psychotherapy research. In medicine and related fields, when a rare phenomenon has come to light or the purpose is to study the extreme and not the common or the regular, it is sometimes presented as a case study.

> *[The term] 'case' has dual reference to person and situation, thus it can be a person presented as an example of a situation, or as a unique entity existing in his or her own right (Higgins 1993:15).*

and

> *It is a complex description, holistic and involving a myriad variables, not highly isolated variables (Stake, 2000:24).*

However the question still lingers— what is the core of a case study? Is it the phenomenon, the disease, or the diagnosis? Or is it the subject - the human being behind the 'case'? Can they indeed be separated? Where does pathology begin? What is are its course, and its end, without the human actor?

Gable (1994:113) highlights three strengths of the case study method:

1 The researcher can study information systems in a natural setting, learn about the state-of-the-art, and generate theories from practice;

2 The method allows the researcher to understand the nature and complexity of the process taking place;

3 Valuable insights can be gained into new topics emerging in the rapidly changing information systems field.

More recently, Khairul (2008) views case study as being concerned with how and why things happen. This allows the investigation of contextual realities, using multiple sources of evidence and intending to focus on a particular issue, feature or unit of analysis. Thus, case studies become particularly relevant where a particular situation needs to be understood in depth, and where rich information is accessible.

Moreover, cases are a way to capture real-life contemporary human situations, and establish public accessibility in reports. Iris's request to have her unbearable PTSD symptoms treated via dramatherapy happened in real life and not in a laboratory or an artificial context.

While Yin (1994:8) highlighted the exploitation of multiple sources of evidence:

> *The case study's unique strength is its ability to deal with a full variety of evidence - documents, artefacts, interviews and observation, direct and participant and archival records.*

He also asserted that the requirements and inflexibility of experimental or quasi-experimental forms of research may mean that case studies are the only viable alternative in some instances (Yin, 1994).

Donmoyer (2000: 45- 66) supported this view by suggesting three further advantages contained within the case study approach:

1   Case studies can take us to places where most of us would not have an opportunity to go;

2   Case studies allow us to look at the world through the researcher's eyes and, in the process, to see things we otherwise might not have seen;

3   The vicarious experience provided by case studies might be preferable to direct experience: vicarious experience is less likely to   produce defensiveness and resistance to learning.

The Single-subject Clinical Case Study

The key to understanding my choice of this method is my Particular Humanist approach. As explained by Mitroff and Kilmann (1978: 95), Particular Humanism, argues that:

to study people in general, even from a humanistic perspective, such as the Conceptual Humanist's, is inevitably to lose sight of the unique humanity of an individual — to fail to capture precisely this person.

Since my research encompasses the points of view, explanations, interpretations, and reflections of the client and the therapist, the single-subject clinical case study is an appropriate vehicle for this purpose. This is because

… it focuses on the primary object of the Particular Humanist – the in-depth, detailed rendering of the life space of a single individual … capturing the total sense of an individual's world … no amount of quantitative sophisticated or theoretical generalization can substitute for the physical presence of a concerned, caring, human observer and the

interaction that takes place between observer and observed (Mitroff and Kilmann, 1978: 96-97).

Particular Humanism

This approach to human uniqueness is one of the concepts which fix the form and content of this research study.

> *All birds, even those of the same species, are not alike, and it is the same with animals and with human beings. The reason Wakantaka the 'great spirit' of the Dakota Indian tribe does not make two birds, or animals, or human beings exactly alike is because each is placed here by Wakantaka to be an independent individuality and to rely upon itself* (Shooter, 1993:52).

This wisdom was current among our ancestors thousands of years before humanism and existentialism sprouted in recent generations. It has now passed into psychotherapy:

> *Each person is an individual. Hence, psychotherapy should be formulated to meet the uniqueness of the individual's needs, rather than tailoring the person to fit the procrustean bed of a hypothetical theory of human behaviour'* (Zeig and Gilligan, 1990:xix, quoted Milton Erickson).

These ideas convey not only the way this dramatherapy case was treated in practice but also the research's holistic regard of the client as a whole universe. Such a perspective on human uniqueness can define the internal and external boundaries of a research study.

In qualitative research a 'clinical case study' refers to

> *… an inquiry conducted from a qualitative perspective on the nature of the therapy process. Such studies are performed to learn more about what happens during therapy sessions…..the choice of participants decides how extensive the study will be, you may be looking at only a single session of one family* (Maione, 1997:1, 3).

and

> *... case study may begin and end with the individual and his or her small group. Most sociologists list important case studies based on intensive focus on a single individual ... the representativeness of the 'sample' of one is determined informally. One must gain deep knowledge of the setting to judge whether or not the individual 'informant' can be taken, in any of several ways to represent a group (Harper, 1992:147-148).*

Does Iris, as my client, represent a population group? Can this particular case study be considered as representative of PTSD recovery via dramatherapy? These questions are not the primary objective of this research. On the contrary, I claim that it is a clear single induction-oriented and non-generalisable case study. But after being involved practically and theoretically with the topic for many years, it is clear from other women's stories, that Iris' story (not the dramatherapy case) is an extreme one but one that may represent a large but 'silent' group of women. Recently, more and more women have dared to publish their afflictions following stillbirth, e.g. *When a Meeting Is Also Farewell* (Rådestad, 1999), Theoretical perspectives on the women's body, psychological reactions to stillbirth and the trauma of fertility treatments have also appeared (Rådestad, 1998; Littlewood, 1996; Rando, 1991). In this context Yin (1994:39) endorses a choice of research method:

> *One rationale for choosing a single-case design is when the case represents an extreme or unique case, thus providing a rationale for a simple holistic case study.*

Stake (1978: 5) holds that this method is suitable for the in-depth research of one person and their story, focusing on process, progress and treatment within a defined period. He claims that case studies are preferred methods of research because they lend themselves to studying human affairs, are potentially down-to-earth and attention holding for readers. Higgins (1993:98) argues that *'the advantage of the single-case study research is its closeness to clinical practice'.* This is illustrated by Cox (2001:862) who demonstrates the importance of the actor and storytelling in medicine:

> *Every case contains a human story of illness and a medical story of disease ... A story begins with a real world situation with some predicament and a sequence of events ... patients tell their illness story; their clinicians translates that into disease story .... Clinical stories recount pointed examples of 'what happened' that expanded our expertise in handling a case.*

Furthermore, the single-subject design

> *provides the most powerful technology to detect treatment effects and provide the greatest generality to other situations. In single subject designs, the same individual serves as both the treatment 'group' and the control 'group'* (Palya, 2000:1).

How the individual behaves under the treatment is compared to how that same individual behaved both before and after the treatment. The 'before' and 'after' conditions and their resulting behaviours are used to cancel out the effects of the unwanted confounds as potential causes of the resulting behaviours during the treatment condition. Only the difference in the conditions is the likely cause for the difference in the behaviour.

A key quality of the individual case study design is that it *'tends to focus on antecedent, contextual factors, perceptions, processes, experiences and attitudes preceding a known outcome'* (Robson, 2002:147). Above and beyond this specificity to the individual client, the understanding of the client's entire intrinsic world which this design makes possible is highly preferred in the field of psychotherapy and counselling highly recommended by McLeod (2000) despite its limitations.

In the published literature on dramatherapy I have found short excerpts from case studies and one relatively long case study based on a role model by Landy (1993: 56-110). The others were an M.A dissertation *Analysis of a journey:* An *exploration of one child's and one therapist's experience of individual drama therapy* by Benathen Wiesz, (1999); and Heller, (1999) *The use of dramatherapy in supporting women suffering infertility multiple case study.*

However, there was an obvious lack of attention to clients' perspectives on their therapy experience, longitudinal reflected memories and the dramatherapist's vulnerable involvement and reflexivity during the therapy. Therefore my understanding remained partial and my wish to study the experiences of colleagues in my profession, at a deeper level, frustrated. This pointed to another gap in dramatherapy research which I felt it important to begin to fill.

The goal and scope of my research were fixed to provide a shared platform for Iris and me as we investigated how the client's recovery was produced. The single-subject design was chosen as a credible, authentic way to determine in an honest way, the holistic 'wall-to-wall' perspectives of this story. In psychotherapy such a perspective is equally rare: *'only one published study of the reasons for termination has examined directly the reasons given by therapist-client pairs'* (Todd et al., 2003: 13).

Researchers may well hesitate to face the challenges of a ~~an ethnographic~~ single-subject case study. It demands deep personal involvement, closeness, cooperation, and self-exposure to client and self over and above the standard therapeutic relationship. It also requires professional interest in how clients may play a central role in achieving successful outcomes and acknowledgement of the client's ability to choose and lead the healing process (Bar-Yitzhak, 2000; 2003). This may well undermine the therapists' sense of omnipotence and their belief in current theories.

In public psychotherapy services, such studies may be avoided due to economic, time management, ethical, and bureaucratic considerations. Researchers in this setting probably prefer to investigate a larger sample. In private practice, the difficulty of obtaining support, both academic and financial, is a crucial and regularly-appearing obstacle. For researchers with a similar professional profile to my own this is a simple yet insurmountable practical problem. Furthermore, in both sectors finding the appropriate informants and obtaining the client's consent to participate in research after the end of therapy is almost impossible. Similar reasons may explain the absence of research into Lahad's (2000; 2003) theoretical concept of Fantastic Reality as a healing space in impossible situations.

Perhaps too, his far-reaching notion is too complex and abstract to be researched, and it clearly deviates from the dominant conventional psychotherapy for treating PTSD by verbal means. Furthermore, studying his concept in a traumatised population requires an adequate sample consenting to be treated by dramatherapy, which seems almost impossible to organise.

My choice of a single-subject case study design reflected my judgment that there were far more advantages to this method than limitations. I believed that this case study would be sufficiently rigorous to counterbalance the weaknesses. I was a privileged researcher who received a rare opportunity due to the client's willingness to voluntarily expose the *Stillbirth to Rebirth* case study, in which client and therapist committed themselves to a longitudinal collaboration. To me it seems much more than a holistic case study, it expresses our mutual will to share with others our most intimate painful experiences in order that others will benefit. It was not 'limited' by the absence of other cases and it is an example of an extreme and unique (Yin, 1994) but highly meaningful case.

A sample of N=1

The subject of this research is my client who constitutes a sample of n = 1. Iris is therefore the universe for this study. The unusual nature of this case offers both advantage and limitation. The advantage of dealing with a 'universe of one' (Schön, 1983:108) is obvious in the therapy period, but it becomes a weakness and a bone of contention in the research mode. As Knight (2002:122) asserts *'One sampling strategy is only better than the other in terms of a particular inquiry and in relation to the sort of claims that the researcher wishes to make'*. His observation is germane to my investigation and methodology.

Iris was at the same time both sample and population. The research arguments and conceptual framework had to be defined through her single case. She was both an opportunity and a purposeful sample. As Harper (1992:150, 154) says: *'With luck we find an individual...willing to act as a subject and informant'*. I can neither claim generalisability for this case nor can I say that it is representative of a defined population. But Yin (1994:38-40) lists three possible circumstances in which it is appropriate to conduct a single case study:

1   *The case is a critical one in that it brings together a set of propositions or circumstances that make it particularly appropriate for exploring or formulating a theory;*

2   *The case is extreme or unique and its exploration will extend our knowledge of the particular features it exemplifies;*

3   *The case is revelatory and has previously been inaccessible or difficult to access.*

Iris' case satisfies all these three criteria. The case represents a rare, once-in-a-lifetime chance to research and demonstrate the successful therapy of far-from-uncommon suffering and affliction.

As Higgins (1993) puts it:

The unique person is more than a collection of an infinite variety of scores on an infinite number of nomothetic measurements, which place a person on a particular scale by comparing his or her performance with that of other members of a defined population … The unique may also furnish appearances of elements not yet broken down into any scales (63) … *Single–case research is the most direct development from a single person case study'* (89) *[and] … the advantage of single–case research is its closeness to clinical practice* (98).

In line with the view of Higgins (1993), the concepts of Richards, Taylor, Ramasamy and Richards (1999) provided reinforcement for single subject research. They indicated how it could be planned, designed, conducted and analysed in educational and clinical settings with single subjects. They described the basic concepts and certain conventions used in single subject research as including: *'the concept of independent - the intervention, treatment - and the dependent - changes in behaviour variables'* (6-7).

However, it should be remembered that my research was conducted three years after the treatment's termination; it was the result of my insight, stemming from experience, that Iris' case study could be appropriate as a subject of further

research at a higher level than the M.A. These circumstances meant that the planning and design differed from that suggested by Richards et al. (1999).

My choice accorded with the concept of Knight (2002:119) that:

> *Sampling is about choosing who or what is to be studied. A population can consist of one person …. in any one of us a multitude of collections (populations) are available for testing.*

Knight also emphasised tendencies in research thinking and practice according to anti-realism and post–structuralism which provide additional argument to support this single case study.

> *These methods are more sensitive to the individual and personal - meaning, beliefs, feelings etc. Small samples, even N=1* [are] *often acceptable. Full participation in research situations and absorption of informants' perspectives and beliefs … is acceptable, even desirable … emphasis on in-depth naturalistic inquiries of specific cases persons etc. … anything that can be imagined as a method is a method. Anything that can be imagined as data is data. Anything that can be inferred is an interpretation* (Knight, 2002:205-209).

Hilliard (1993) adds another dimension to the potential contribution of single-case methodology in psychotherapy. He discusses the problems of researchers in the field dealing with the threat to the internal validity of single-case studies, problems which led to this design being abandoned. But then he quotes Kiesler (1983:6):

> *Our available theories in psychotherapy are in a form too global or general to provide much guidance for identifying the significant change-process events occurring within the therapy session … Studies seriously pursuing change-process goals cannot attain them by use of traditional, rigorous experimental or nomothetic designs. Instead, what seems to be most appropriate and necessary are small N or single-case studies.*

Kiesler's view is representative of a widespread resurgence of interest in single-case designs in psychotherapy research, as Hilliard (1993:377) concludes:

Single-case study research needs theories that address the psychotherapy change process at the level of specificity. Such theories can then serve to generate specific research to be tested empirically. Unfortunately, much of single-case psychotherapy research appears to tap around in the dark without clearly formulated questions.

Such research studies are nevertheless still uncommon in dramatherapy, with its limited stock of original theory and its need to establish itself professionally and scientifically. But, facing the method's limitations squarely, the study reported in this thesis formulates clear questions, furnishes copious evidence made as objective and as checkable as possible, and addresses those questions in terms of relevant current theory all framed in a serious attempt to understand a specific and significant psychological phenomenon. I hope that dramatherapy will benefit and be enriched by this basic understanding of the client's role in recovery, and by the meaning and role of the Imaginary Existence Zone as a healing space in impossible situations, even if this understanding comes from a case study of a sample of N=1.

The researchers of another clinical single-case study of a 32-year-old depressed male patient Van de Vliet et al. (2004) also explain the methodological rationale for single-case design. They make four main claims:

1. *It is extremely difficult to find enough patients with the same deficiencies, and possibly the same background, to compose more or less homogeneous groups for making comparisons or to draw meaningful conclusions for this population…it is not always possible to employ true experimental designs that take these methodological aspects into consideration. This is particularly the case for patients being treated in a hospital setting'.*

2. *The statistical handling of group data can obscure relevant changes. In group research, emphasis is placed on statistical significance, sample size, etc. Unfortunately, there is often little relationship between what is statistically and clinically significant. Small, but consistent, changes which in a group design would not emerge as statistically significant can be of major importance for the individual. In the intra-individual research, on the contrary, clinical significance*

or relevant is stressed. Single subject designs have been recommended as a useful method to examine clinical accountability. They can provide a systematic approach to documenting clinical change and also provide objective evidence regarding the effect of treatment. Another clear advantage is the ability to suit to routine clinical practice without significant disruption of the usual therapeutic routine'.

3. 'It is possible that the enhanced experience of well-being reported by an individual reflects changes in psychological constructs other than those intended and assessed in a given study. This goes along with the variety of additional person-specific complaints and symptoms that are presented in the diagnosis of clinical depression'.

4. 'Questionnaires are not appropriate for detecting intra-individual variability. During the construction of questionnaires, items that fail to discriminate between groups of individuals are eliminated. The remaining items tend to represent the extremes of a trait dimension so that they are not sensitive enough to detect individual changes, which are small, but can be relevant for a particular patient. Questionnaire results show the patient's average degree of, for example, depression in his or her functioning across situations. However, nothing can be inferred about the potential influence on the patients' behaviour, the relationship with other emotions or behaviours, nor can different reactions to a treatment or intervention be distinguished (153–167).

These claims clarify the main justification for conducting clinical single case study research.

In the similar professional therapeutic area of clinical psychology Ragan's (2000) research used a single-case study in Ph.D. research to study traumatic grief. Despite its limitations, which include the absence of a conceptual framework and unsatisfactory methodology, it cannot be ignored due to its similarities to this study:

1. A single-case study based on therapy that occurred several years before turning it into an issue for Ph.D. research.

2. Two participants, the client and the psychologist. Both women shared a long therapeutic relationship.

3. Multiple traumas and traumatic grief subsequent to a child's death.

As a fellow-practitioner I expected to learn more from Ragan's work: unfortunately it provides a general description of the clinical interventions with only few quotations from their therapeutic conversations. Minimal information about the client made it difficult to capture her essence and her story, plus adequate information concerning the psychologist's personal involvement was limited. As a result, it was a case study without thick description. Nevertheless it is a precedent of single case studies in clinical research emerging from real life events. Further examples of doctoral theses in which single case respondents have formed the research universe are provided in Appendix 3.

Unfortunately the researchers referred to above and also in Appendix 3 did not offer rationales for their single-subject research design. We have seen in the former cases that single-subject research usually involves only one researcher and one respondent. Thus, this medical case seems exceptional among the others but enhances the justification for single-case studies. It can be assumed that in such complex cases under severe physical and psychological stress the obstacle is to find more than one respondent: *'with luck we find an individual'* (Harper 1992:150, 154)

An example of a single-case study in dramatherapy was conducted by Benathen Wiesz (1999). This retrospective study reviews the process of a therapist and a nine-year-old child undergoing individual dramatherapy, suffering from the

traumatic experience of abuse and abandonment. When the therapy began, the therapist had no plans to pursue this type of research. However, she found *'the work to be so rich that she wanted to create a framework through which she could review and understand the case more deeply'* (3).

The researcher concluded that *'individual dramatherapy provided a medium in which the child could safely work through traumatic material; found it to be an effective treatment modality for children who have difficulty distinguishing between fantasy and reality'* (71). In some ways this study reminds me of my research that began as dramatherapy to treat Iris's chronic PTSD.

Phenomenology

An alternative research strategy for this study was phenomenology since it also belongs to the qualitative-constructivist paradigm. Moustakas (1994:26) asserts that:

> *What appears in consciousness is the phenomenon. It comes from Greek to flare up, to show itself to appear. In a broad sense that which appears provides the impetus for experience and for generating new knowledge.*

Similarly, Shkedi (2003:63) observed:

> *Phenomenology offers a transcendent search after the essence of the human experience, focusing on understanding the meaning events have on people. The term phenomenon as a general term, describes the real understanding someone has about things and real events existing in the world, it is the event as experienced by those who 'lived' it.*

This was very much my goal - capturing the client's understanding of the essence of her traumatic experience. However, in phenomenology, data are collected mainly through formal interviews and personal diaries rather than through naturalistic inquiry, where the information is gathered directly via participant observation and from artefacts collected in the field (Shkedi, 2003:65). Since the primary data for this thesis had been gathered during the therapy phase through naturalistic techniques, this beginning dictated that the non-formal close relationship would be maintained throughout the course of the research.

An additional view on phenomenological research was described by Magee (1987:257):

A systematic analysis of the contents of conscious awareness including material objects, immaterial 'systems' such as music and maths, and our experiences of thoughts, pains, emotions and memories. An analysis of what something is and not what causes it. In phenomenology we let things show themselves as they are in themselves.

Although this perspective had some attraction my research did not lend itself to the formality of data-collection associated with interviews or research diaries. A more personal reason for rejecting phenomenology was my professional interest not in what appears in consciousness but in the deep aspects of unconscious processes and tacit knowledge. In dramatherapy these are mostly detected via non-verbal dramatic actions, symbols and metaphors. Although the client's recovery from chronic PTSD can be viewed as the phenomenon under study, the key search was for an understanding of how it happened, how the extra-therapeutic components had contributed to the cure processes and the meaning of this process for the client, data collected through in-depth open and unstructured interviews. I decided that a single case study could achieve these outcomes more readily than phenomenology.

Summary

This chapter has presented the rationale for my choice of a case study methodology, and the reasons for not choosing the phenomenological approach. It has also justified my sample size of one and presented evidence of how such a methodology has been used successfully in doctoral research. Thus, it has explained why my research design was based on a single respondent.

Chapter 11: Inductive Design

Introduction

This chapter explains my choice of inductive design and how it influenced the design of my research

Inductive Approach

According to Hayes (2000) inductive research, begins with the collection of data, so that the research has a set of observations to interpret. It uses the information derived from the data to formulate a theory. While Palya, (2000) indicated that inductive research starts with a behaviour of interest and searches for an integrated context for that behaviour. In general, if you observe some behaviour and wonder why it exists, then you are engaged with inductive research (Palya, 2000).

A similar view provided by Barragan (2008:1) indicates that research design within the inductive paradigm is:

> *A process of using observations to develop general principles about a specific subject. A group of similar specimens, events, or subjects are first observed and studied; findings from the observations are then used to make broad statements about the subjects that were examined.*

I was interested in my topic from several angles. However, most importantly I wanted to know how the clients' conduct contributed to the therapy outcomes. But I never thought at the start that I would be able to find a sufficiently satisfactory answer to this 'how' question on which to erect a research study.

Black (1958) sees inductive thinking as an argument guided by rules:

The use of inductive rules has often led to true conclusion about matters of fact. Common sense regards this as a good reason for trusting inductive rules in the future' (p.718). Lincoln and Guba (1985:40) highlighted further contributions of induction to the naturalistic paradigm:

Inductive process is more likely to identify multiple realities, is more likely to make the investigator-respondent interaction explicit, recognizable and accountable; and this process is more likely to describe fully the setting and to identify the mutually shaping influences interacting in it'. Inductive method *'is an extremely effective process for obtaining general, observation-based information about the world.*

In fact, the inductive method is one of the most common and natural forms of making logical assumptions about what we observe.

This inductive logic underpinned my qualitative-naturalistic approach. I moved from the evidence gathered in fieldwork and the processing of the data to propositions, to developing a theory, and lastly to conclusions (Shkedi, 2003). My research argument was established on the basis of the therapy of one individual whose therapy was observed, documented and recorded. Trafford and Leshem (2003) confirm that, in inductive naturalistic research, the conceptual framework is built after exploring the issue through fieldwork. This is exactly what happened in this study — the conceptual framework changed over the years and was only finalised after six years of research.

Morse and Mitcham (2002:233) explored the pitfalls in inductiveness and presented methodological strategies to maintain both the integrity of the concept and the integrity of the research. They assert that it enhances, rather than threatens, validity. However, unlike deductive research ~~that those tests~~, inductive research seeks to develop theory. It makes sense of open-ended data and provides explanations that can extend theory. Alternatively, in the absence of existing theory it can generate and so develop theory based upon the evidence that is collected (Trafford and Leshem, 2008:97). My research design combined methods that collected experiential data, opinions and values from my single respondent. This sample of one did not allow me to test for reliability, but instead provided highly valid data. Thus, my findings are not generalisable due to the epistemological position that was adopted towards the nature of knowledge creation (Burrell and Morgan, 1979).

This decision determined my choice of methodology and the associated methods which were employed in data-collection. Knowing that my findings would not be generalisable enabled me to adopt fieldwork techniques which captured the values, senses, feelings and aspirations of my respondent. In turn, this design process created a strategy of enquiry that had coherence between its components. Furthermore, it was consistent with my professional role and practice. In this way, an inductive methodology complemented the professional relationship between me and my respondent.

Thus, an inductive approach facilitated the humanistic existentialistic spirit of this study. The direction of the process from the therapy in the field to the development of the research assumptions and conclusions was also in line with inductive reasoning

Summary

This chapter provides my explanation for adopting an inductive approach to my research. It informs the way in which my research approach was designed and conducted as is explained in the following chapters.

Chapter 12: Data-Collection

Introduction

This chapter discusses the issues of data-collection within two periods. In the therapy period it was gathered through audio-recording of the encounters, direct and participant observation, physical artefacts and documents. In the after-therapy period the data was collected via oral history.

The Modes of Data-Collection

The research material was collected from six sources: the data from the therapy encounters – audio-recorded on tapes, direct and participant observation, and the documented artwork created by the client – plus two extended oral histories recorded in interviews with the client. I wrote detailed notes after each encounter but was aware that relying exclusively on these notes would not be precise enough to comprehend the holistic picture and grasp what had really happened during the encounters. No doubt the best way to collect the encounter data would have been to video-film them but this would have violated the therapy's ethical requirements.

Audio-recording the Encounters

Iris agreed that audio-recording our therapeutic conversations would not disturb her therapy and so, from the third encounter on, all our therapeutic conversations and interactions were recorded.

These 'conversations' might be considered as unstructured interviews as Harper (1992: 153) describes it, *'the talk that was our interviewing had a natural beginning and ending'.* Certainly in our case 'talk' would be a much more accurate term than 'interview' during the therapy period. Fontana and Frey (2005: 698) support this definition:

> The most common type of interviewing is individual, face-to-face verbal interchange … it can be unstructured … and be used for therapeutic reasons … it can take place over multiple, lengthy sessions.

They also emphasise the importance of empathic interviewing:

… in which two people are involved and their exchanges lead to the creation of a collaborative effort. Whereas the barriers between the interviewer and the interviewee were removed in the process of the interviewing (696).

These recordings furnished the bedrock data of the research. They were later transcribed into a written story of the dramatherapy journey and appear in Part IV. These recordings enabled me to reconstruct the emotional reactions, voices, silences, weeping, shock and laughter that appeared as Iris' state fluctuated (Bryman, 2001: 291). Listening to the tapes was more trustworthy than relying on the written notes to reconstruct the encounters.

The therapeutic conversations were held in Hebrew and English, according to the client's convenience and preference. I adapted myself to her choices. All her written products – poems, prose, private diary, and letters from the therapy period – were in English, her native language.

Oral Histories collected by In-depth Interviews

The data from the second phase of the research, after the therapy, were derived from two oral histories. Oral-history interviewing was originally developed by historians as a technique for collecting information about the past. It has developed into a qualitative research process and uses personal interviewing adapted to understand meaning, interpretations, relationships and subjective experience as Ritchie outlines:

Memory is the core of oral history, from which meaning can be extract and preserved. It collects memories and personal commentaries of historical significance through recorded interviews (Ritchie, 2003:19)

Additionally, Sommer and Quinlan (2009:2) assert that *'oral history increases understanding of the importance of memory as 'people's history'; also a clarification of an understanding of the 'subjectivity' of memory'.* Furthermore, '*it*

can become a vehicle for documenting not only facts about the past but also more subjective insights into how people organize their views of their history '. (ibid: 4)

The first interview (May, 1998) consisted of a four-hour in-depth interview following Plummer's (1983:97) suggestion of the format for such interviews:

> *The researcher initially opens up a wide area with a broad statement or question allowing the subject to respond in as open and as general a way as possible.*

The second oral history (July, 2002) consisted of a one-hour interview to elicit the client's free reflections and recollections of her therapy after a lapse of four years. Both interviews were conducted at her home in English and audio-recorded and transcribed. This was the format we found most suited to our earlier close relationship, as well as preserving the free conversational flow of the therapy period.

The connotations of 'interview' are of formality, distance and hierarchy. I felt that we were both in a completely other sort of relationship. 'Talk' is a more accurate term, not 'small talk' but talk 'to a purpose' between two partners to a joint project. This point is echoed by Plummer (1983:138) *'Here is almost a methodology of friendship, of building a quite special relationship founded partly on research goals but equally on friendship'.*

The interviewing was more like 'talk to a purpose' between two partners. The purpose was recording the past in order to understand how the past shapes present-day values and actions: oral-history

Physical Artefacts and Documents

> *The richness of the case study evidence base derives largely from this multi-facetted perspective yielded by using different sources of evidence. Each of these different sources requires different approaches to their interrogation, and likely to yield different kinds of insights (Rowley 2002).*

The physical artefacts that Iris produced during the dramatherapy encounters and her written documents were the third source of evidence. They included sculptures, paintings, pottery, sandbox images and chosen objects, and artefacts that clearly illuminate a recovery process based on nonverbal activities, differing completely from verbal psychotherapy.

 I photographed all her works of art, which is a common procedure in dramatherapy, and in sandbox work and used in case study. Good quality photographs constitute a way to include physical artefacts in research. The use of visual records of the artefacts is supported by Gillham (2000), who asserts that *physical artefacts* [refer] *to anything that is made and in variants of case studies this kind of evidence may be the most important of all. Some kinds of evidence cannot be described or measured only shown ... Physical evidence has a direct quality; it is first hand. ... the visual dimension is uniquely powerful. In research it can bring your report to life - enable people to 'see' in the cognitive as well as the visual.*

From the beginning of the research, I viewed these physical artefacts as one of the most enlightening pieces of evidence in this case study.

Perhaps the most vivid and rare evidence in this case is the collection of Iris's written documents and physical artefacts. They enable the entire dramatherapeutic process to be clearly observed, tracing the changes she underwent at every point. Together with knowledge from the interdisciplinary perspectives they formed the conceptual bridge to her shattered right hemisphere. One of Iris's greatest complaints before therapy began was her loss of energy and creativity. The manual work enabled her to move into a zone of imaginary existence, into the curing zone and to recover.

Direct and Participant Observation

Although watching is a natural behaviour, for the purpose of research it is necessary to watch, listen, ask about and record a whole social and personal setting. Direct, participant observation is a case study technique which typically relies on multiple sources of information (Neale, Thapa and Boyce, 2006). The

fieldwork stage of the case study involves first-hand observations of what is occurring. Soy (1997) explains that in this sort of observation, researchers carefully observe the object of the case study and identify causal factors associated with the observed phenomenon. Renegotiation of arrangements with the objects of the study or addition of questions to interviews may be necessary as the study progresses. Case study research is flexible, but when changes are made, they are documented systematically.

Cohen, Manion and Morrison (2000), draw a distinction between structured participant observation as a very systematic mode, and naturalistic observation in which researchers are part of the ongoing social life, gathering 'live' data from 'live' situations (305-316). They claim that '*this technique is a powerful tool for gaining insight into situations*' (315); they also assert that observation studies are superior to experiments and surveys when data are being collected from non-verbal behaviour, because:

- Investigators can discern on-going behaviour as it occurs and are able to make appropriate notes about its salient features.

- Researchers can develop more intimate and informal relationships with those they are observing, and in natural environments.

- Case study observations are less reactive than other types of data-gathering methods. Direct observation is faithful to the real-life, *in situ* and the holistic nature of a case study. (Cohen, Manion and Morrison 2007:260)

Harper (1992) provides an additional view of the relationship between observers and observed, emphasising what he calls 'buddying-up' with his subjects and forming social bonds with them, both sides being influenced by each other. At the time of the therapy reported here, I acted as a dramatherapist, an integral persona of the therapeutic process. That the client would be influenced by my presence, personality, behaviours and relationship was a fact, and I also comprehended that I would be influenced by her. I observed both the client and myself and thus simultaneously acted as a direct and participant observer (Bryman, 2001).

Summary

The different modes of data-collection were explained in detail how it was performed and its logic. The audio-recording, direct and participant observation, physical artefacts and documents and oral history are typical and fundamental techniques and instruments used regularly in case studies. Data gathered through these tools enhance our understanding of the researched phenomenon providing a precise and authentic picture of the particular individual.

Chapter 13: Validity and Ethics

Introduction

This chapter explains how I handled those measures that provide rigour to research and consequently justify its findings. It uses an inductive framework to illustrate how my research approach was undertaken, to ensure that it displayed the findings with clarity. Since my methodology implied ethical considerations, the chapter also explains how I accommodated the ethical considerations relating to my study.

The key to understanding the issues of reliability and validity as they relate to my research is provided by Lincoln and Guba's discussion of these issues in the context of the naturalistic research paradigm (1985:189, 219). They suggest redefining the *'conventional [that is, derived from the quantitative paradigm] criteria for trustworthiness. Thus, instead of internal validity - credibility; transferability replaces external validity; dependability replaces reliability; and confirmability replaces objectivity'.* How those issues were handled and their ethical implications are shown below.

Confirmability

'Confirmability, replacing the quantitative 'objectivity', is defined as the ability of others to satisfy themselves that the research was carried out in the way described by the researcher (Lincoln and Guba, 1985).

The basic technique for ensuring confirmability is maintaining a record of the data collected through such means as recording tapes, transcriptions, interview notes, secondary sources, so that other researchers can review the chain of evidence (Christie, et al, 2000). This study lays right to confirmability by dint of its auditable chain of evidence and its authenticity in disclosing intimate personal data both of client and researcher. Though the client remains anonymous, my involvement and reflections are totally exposed, without any masks, revealing her most private world. Presenting the data in this way enables others to assess its objectivity and trustworthiness.

All my fieldwork data were recorded, transcribed, reduced and edited for the purpose of including them with my doctoral thesis. The photographs of the client's artefacts which accompany the verbal transcription provide additional evidence.

Credibility

'Credibility' (replacing the quantitative 'internal validity') seeks to demonstrate that the explanation of a particular event, issue or set of data which a piece of research provides can actually be sustained by the collected data.

'The findings must accurately describe the phenomena being researched'. (Cohen, Manion, and Morrison, 2000:107). In naturalistic inquiry credibility *'can be addressed by prolonged engagement in the field, persistent observation, triangulation, peer debriefing, and participant validation'* (Lincoln and Guba, 1985:219, 301). To establish a phenomenon in a credible manner within qualitative case-study research, a study will locate the generative mechanisms that assist in determining inferences about real-life experiences. Its case analysis will ensure the internal coherence of findings, precisely distinguish the unit of analysis, link analysis to theory identified in a literature review, and triangulate its data. Shkedi (2003:233) claims that '*thick description'* is an additional way to establish credibility and that it should include information about the data-gathering context, pertinent quotations from informant(s) and a discussion of the concepts the informant uses. Further, the research arguments and conclusions will be the more convincing if the data interpretation is more cogent and reasonable.

Maione and Chenail (1999:59) highlight the significance of reflexivity in order to establish the credibility of qualitative research:

> *It is important for qualitative researchers to take great care to delineate who they are … how they participate in their on-going research endeavours. Through these self-reflective narratives and by an accurate and honest accounting of their actions qualitative researchers establish their credibility. These narratives give research consumers an over-the-shoulder perspective and a contextual vantage point from which to evaluate and critique the study.*

Dependability

'Dependability' replaces the quantitative 'reliability'. In quantitative research the test of dependability is that other researchers can replicate the study and achieve similar results (Christie, et al, 2000). But, naturalistic studies reflect the uniqueness and idiosyncrasy of situations, such that the study cannot be replicated. However, this quality should be considered as their strength and not their weakness ...

> *In qualitative methodologies reliability includes fidelity to real life, context-and-situation-specificity, authenticity, comprehensiveness of detail, honesty, depth of response and meaningfulness to the respondents* (Cohen, Manion and Morrison, 2000:120).

Lincoln and Guba (1985) suggest, in addition to reflexive journals and independent audit, that the researcher should identify acceptable processes according to which the inquiry was conducted so that the results are consistent with the data. To achieve dependability in case study research demands identifying documentation trail (Christie, et al, 2000).

Remaining loyal to my naturalistic paradigm, I argue that this study, based as it is on a single therapy case cannot be replicated by others. The reason for this assertion is that the client has recovered. However, since the conditions and processes of the dramatherapy are provided in detail it might be possible to employ the same conditions and support for another client in a similar predicament. It can be evaluated, however, in addition to all the other corroboration means, as mentioned already, through the reflexive writing of both client and researcher.

Transferability

'Transferability' replaces 'external validity' in quantitative research, where the test of 'external validity' is the degree to which the study's results can be generalised to a wider population, or to other cases or situations (Cohen, Manion and Morrison, 2000:109). Validity in qualitative research

… might be addressed through the honesty, depth, richness and scope of the data achieved, by the participants approached, by the extent of triangulation and the disinterestedness or objectivity of the researcher… through careful sampling, appropriate instrumentation and appropriate statistical treatment of the data

(105).

According to Lincoln and Guba (1985), in qualitative research generalisation can be made to other cases to the extent that the similarity of their contexts can be established through 'thick description'. Donmoyer (2000) is most convincing in his approach to the single case study when he builds on Stake's (1978) naturalistic generalisation and asserts that difference rather than similarity is to be valued in the study of cases.

Donmoyer draws on Piaget's concepts of assimilation and accommodation to explain how generalisation from a single case takes place: the formation of meaning progresses through a succession of different experiences such that the progression assumes great heuristic value, rather than being eliminated as a weak link. One of the most interesting suggestions he makes is that in providing an opportunity for the reader *'to see through the researcher's eyes,'* the reader's range of possible interpretations and cognitive structures or 'repertoire of schemata' is expanded (Donmoyer, 2000: 63-66).

Even with the illumination Donmoyer provides, the issue of generalisation is still a critical limitation in single case-study design. In this regard, Stake (1995:8, cited in Shkedi, 2003) asserts that *'the real occupation of case study is uniqueness and not generalization'* and suggests studying uniqueness as a way of achieving naturalistic generalisation. Although it contains an internal contradiction, this is the paradox of qualitative research - that by studying the single case's uniqueness we learn to understand the universal (Simons, 1996 cited in Shkedi 2003:237)

The issue of transferability in this example of naturalistic research can be answered in a few ways. One way is to simply declare that the research cannot be generalised and that it was never intended to be. On the contrary, all its features point to its uniqueness, rarity and exceptional circumstances. After all, how can a

very private, personal, intimate and subjective research be generalised to other cases, even given the thickness of its description?

Stake (1978:6-7 cited in Shkedi 2003:237) confirms that naturalistic generalisation *'derives from latent knowledge about the essence of things'*. This kind of generalisation is *'intuitive, empirical, based on personal direct and vicarious experience'* (Stake, 1978, cited in Lincoln and Guba, 2000). This leads to the conclusion that the research consumer, the reader, and not the researcher, is the one who must determine a study's generalisability (Shkedi, 2003:238).

Similarly Lincoln and Guba (1985:316) argue that:

> *It is not the researcher's task to provide an index of transferability; rather he should provide sufficiently rich data, fit for a case-study database, so that readers and users of the research can determine whether transferability is possible.*

While Sanger (1996:15) claims as well that:

> *The strength of a naturalistic perspective lies in the acceptance of the singularity of the moment and the reliance upon third party audiences to make of the research what they will.*

Therefore, within these dimensions my investigation cannot claim generalisability for its conclusions. However, the propositions that emerge from my conclusions provide material for others to test in their respective contexts and circumstance.

Triangulation

This study combines multiple sources of evidence and applies multiple dramatherapeutic methods to the client's therapy. The thick description and the verifiable reporting of the events of the research process also serve the demands of triangulation (Yin, 1994; Mason, 1996; Fetterman, 1998).

In the social sciences, the use of triangulation can be traced back to Campbell and Fiske (1959) who developed the idea of 'multiple operationism'. They argued that more than one method should be used in the validation process to ensure that the variance reflected was the variance of the trait and not of the method. Thus, the

convergence or agreement between the two methods '. . . enhances our belief that the results are valid and not a methodological artefact' (Bouchard, 1976: 268). It is largely a vehicle for cross validation when two or more distinct methods are found to be congruent and yield comparable data.

Additionally, Jick (1979) asserts that triangulation can also capture a more complete, holistic, and contextual portrayal of the unit(s) under study. That is, beyond the analysis of overlapping variance, the use of multiple measures may also uncover some unique variance which otherwise may have been neglected by single methods. Qualitative methods, in particular, can play an especially prominent role by eliciting data and suggesting conclusions to which other methods would be blind. Triangulation may be used not only to examine the same phenomenon from multiple perspectives but also to enrich our understanding by allowing for new or deeper dimensions to emerge. The effectiveness of triangulation rests on the premise that the weaknesses in each single method will be compensated by the counter-balancing strengths of another (pp. 602-611).

Yin (1994:91-92) asserts that:

> Triangulation is the rationale for using multiple sources of evidence, it is a major strength of case study data-collection … and the most important advantage of using it is the development of converging lines of inquiry. Thus any finding or conclusion in a case study is likely to be much more convincing and accurate if it is based on several different sources of information.

According to Cohen, Manion and Morrison (2000:112), triangulation may be defined as 'the use of two or more methods of data collecting in the study of some aspects of human behaviour' with the aim that one method will corroborate the other(s). They also suggest that 'Triangulation has special relevance where a complex phenomenon requires elucidation' (115), which is certainly so in this dramatherapy case.

In spite of the difficulties this entailed I took a deliberate decision to include as much of the evidence as a whole and to preserve the almost endless data gathered (Shkedi, 2003:233). I felt this was demanded in this particular case

where both the therapeutic and research method involving a client-therapist collaborative inquiry, were so unusual.

Cohen, Manion and Morrison (2000:115) also claim that *'triangular techniques are suitable when a more holistic view of outcomes is sought'* which again is an essential element of this study. Thus, the two linked aims – to increase the study's credibility and to contribute to knowledge — are fully compatible and guided the conduct of my investigation.

Ethical Considerations

Many ethical issues were considered in this doctoral research study. The client agreed to permit the use of all the collected material pertaining to her therapy for her therapist's MA and Ph.D. research on the condition that her anonymity was preserved. This assurance was provided by me and honoured throughout our relationship and beyond**.**

She also agreed to contribute in other ways to the research, in particular by reading and commenting on the finished work. When she agreed, the client was well-informed of the issues and risks entailed in dissemination and publication of data relating to her therapy and the research findings. She agreed to proceed so that useful information could reach those who could use it to help other in similar circumstances though, again, her condition was that her identity and that of her family should remain confidential. Cohen, Manion and Morison (2000:51) explain the ethical rules in this situation:

> [The researcher] *needs informed consent and by that ensures the free choice of the participant to take part in the research and guarantee that the exposure to the risks is undertaken knowingly and voluntarily.*

This was especially pertinent since the mutual intention of therapist and client was eventually to publish the completed research as a book for both professional practitioners and a wider general audience.

In addition to issues of privacy for both client and therapist, ethical considerations included the provision of professional confidentiality by the therapist vis-à-vis the client. This acknowledged the possibility of reopening closed wounds for both

client and therapist, and issues concerning the families of both parties in which their confidentiality and/or participation might be needed or excluded, either of which could be problematic.

A further consideration was to ensure the right of either party to withdraw from the research partnership in the event that some painful subject or life event caused one or the other participant to want to reduce their exposure. Iris sent me a partial withdrawal notice in June, 2003, as a result of which a valuable component of the planned research design had to be cancelled. The client's motivation for participation in the research was a desire to help others in similar situations. The issue of payment to the client for this service never arose. However, the professional treatment that she received attracted a professional fee for my services. This sum was paid.

The client was not hospitalised nor under any medical care at the time of the research that might have affected her judgment, or that would require special dispensation or approval from any other official body. Thus, it was not necessary for me to seek approval from professional or public bodies to undertake this research. Throughout this study, I was guided by the publications and ethical standard obligations of Ethics Guidelines for Research, Anglia Polytechnic University/Anglia Ruskin University, (2001; 2008), and the Israeli Association of Creative and Expressive Therapies Guide to Ethics (2007).

Summary

This chapter has explained how issues of research dependability, reliability, validity and triangulation were established in line with the naturalistic research paradigm and case study method. The way in which ethical considerations were handled was also explained and these features are reflected in the next chapter.

Chapter 14: The Research Time-Line and the Plan of the Research Process

Introduction

This chapter outlines the research time-line, its diverse periods and the research plan. Figure 14.1 below summarises the overall research time sequence indicating the different phases that occurred during the four year period.

Figure 14.1: The Research Time Sequence

Phase 1

Therapy period	8 months, 9/97-5/98	Data	350 transcribed pages;
Duration	70 hours		
Client behaviour	Endless need to talk, much repetition, unfocused, associative, hesitant, without energy, frozen, helpless, difficulty making decisions.		

Phase 2

Therapy style	First oral history 21.5.98	Data	80 transcribed pages.
Duration	4 hours, one week after end of therapy;		
Client behaviour	Still had strong need to talk, less associative, more focused feeling and looking good.		

Phase 3

Therapy style	Second oral history 4.7.2002	Data	12 transcribed pages.
Duration	One hour, 4 years after end of therapy;		
Client behaviour	Concrete, focused, clear, brief and fluent, happy, self confident, joyful, in a good mood, free, serene, high energy, assertive.		

Significance of the Timing in Research

Lincoln and Guba (1985: 225) argue that *'timing cannot be predicted for the naturalist inquiry'.* Nor can the end of dramatherapy treatment be predicted unless it is initially defined as short-term therapy for a given period. I planned time boundaries for data-collection, as well as particular research design, but in practice they had to be altered.

The research spanned two separate periods. The first phase was the dramatherapy that included 20 encounters over eight months. The duration of the encounters was flexible, unorthodox depending on the client's needs. Each encounter lasted from three to four hours. The boundaries of this phase were natural and clear: it had a clear start and end. However, both the client and I sought to further our understanding of the subject by gathering additional data beyond what was perhaps needed for my original study proposal. So we embarked on the second phase of the research, focusing on an oral history, in the form of two open-ended interviews, conducted one week and four years after finishing the therapy and without pre-determining the duration of each interview.

Our first meeting after the therapy ended was at Iris' home on 21st May 1998. I conducted a long oral history interview to record her reflections on the eight months of therapy before she went abroad to visit her family.

Phase 2 began in March, 2001, when I decided to continue on to study Iris' whole therapy as the single core case study of a Ph.D. thesis. Again Iris was glad to collaborate with me. She knew that my intention was to give her voice a platform and make her views, memory, opinions and reflection on the therapy a key component of the thesis. Iris became a full participant co-researcher in the research, willingly contributing her share to the project. During the Ph.D. phase I realised to what extent the research totally depended on Iris' voluntary consent and participation. She could withdraw at any time and I felt dependent and uncertain many times. This was the unpleasant and worrying aspect of research on a single subject. In my case, voluntary input became crucial to the research's continuity.

In mid-2002 the research's second phase was designed to gather new data from Iris. The plan comprised two phases using two different techniques: first, an oral history – open-ended interviews fully tape-recorded, based on Iris's memories of her dramatherapy four years after it terminated, and second, Iris' reflections on the transcribed material, her written memories and responses after reading the transcribed encounters. Our joint decision was she would write down material in her free time and on her own. Iris concentrated better when she was alone, without anyone to disturb her with their presence. She also thought being without me would give her privacy for this intimate process and avoid the bias my presence might cause.

Unfortunately this component of Phase 3 could not be fulfilled because of Iris's personal difficulties in writing up her reflections without re-summoning her suffering. So she withdrew from any further contribution to the research (see her last letter Appendix 6: June, 2003). Despite my disappointment resulting from this unexpected change, my first concern was Iris's welfare. As a naturalistic researcher I was obligated to the client's rights and the ethical considerations involved; while I remained flexible and open-minded: *'Forever, adapt and accommodate'* (Lincoln and Guba, 1985: 249).

I adjusted my research plans and simply gave up this particular component. I went through a painful separation process from what might perhaps have been the research's most original fieldwork evidence.

Summary

The issues of time-line, sequence, and design were explained, including the reasons for the changes that occurred, as a result of the client's retreat from the original design; this caused partial reframing of the research's plan two years after it began.

Part III of this thesis established the methodological background for the fourth part – a detailed description of the fieldwork, the twenty long dramatherapy encounters, accompanied by the client's photographed artefacts, demonstrating the non-verbal dramatherapeutic processes.

PART IV: FIELDWORK

Introduction

This part of the thesis provides a thick description of the therapeutic encounters collected during the fieldwork. It depicts the events as they occurred in the real–life microcosm of the dramatherapy encounters during the period between September 1997 and May 1998. The evidence gathered in these sessions provided the data basis for the research analysis and interpretation.

Chapter ~~16~~15 provides the reader with the scenery within which the research took place. Beginning from the macro-level of the State of Israel and descending to the micro-level of the researcher's home and the therapy room, it describes in detail the conditions under which the dramatherapy was conducted.

Chapter ~~17~~16 introduces the transcribed encounters, excerpts from over three hundred pages that documented the twenty dramatherapy encounters, including both verbal content and detailed dramatherapeutic activities, with a focus on the transformation that Iris (the C.PT) underwent during these encounters.

Chapter 15: The Fieldwork Setting

Introduction

This chapter describes the fieldwork setting. It begins with a description of the area of Israel in which the therapy took place. It describes the local surroundings of my home; including details of the therapy room which, according to the client, was an important component of the therapy (See Appendices 4 and 5). The chapter also discusses the issue of data-collection and some crucial and technical obstacles that were encountered during this process.

The Fieldwork Scenery

Israel is a small country of about 21,000 sq. km. It can be divided into three main zones. The South, the Negev region, is a hot yellow place and almost a desert. The central part constitutes a humid plain that runs along the shoreline of the Mediterranean, and the North includes the Galilee region contiguous to Lebanon, and the Golan-Heights contiguous to Syria and Jordan. Picture 15.1 below is a map of the Golan Heights and Sea of Galilee. This part of Israel is the greenest, coldest, most mountainous and rainy. It also contains Israel's water sources. The Golan-Heights, an area 70 km long and 20 km wide (1,160 sq. km.) was settled after the 1967 war with a variety of settlements: kibbutzim (communal settlements), villages, co-operative settlements, regional centres and one city. The mixed religious and secular populations total 18,000 Jewish and 17,000 Druze residents. The second picture 15.2 focused on the landscape seen from the Golan Heights near to my living place presents Meshushim Stream, Jordan River and Sea of Galilee. Photographs have been included with the text to help readers appreciate the context of this research and understand where my fieldwork occurred (see pictures 15.1 The Golan Heights, Picture 15.2 Meshushim Stream, Jordan River and Sea of Galilee, Picture 15.3 The Rural Centre Ben Yehuda and Picture 15.4 Our Room below).

Picture 15.1 The Golan Heights
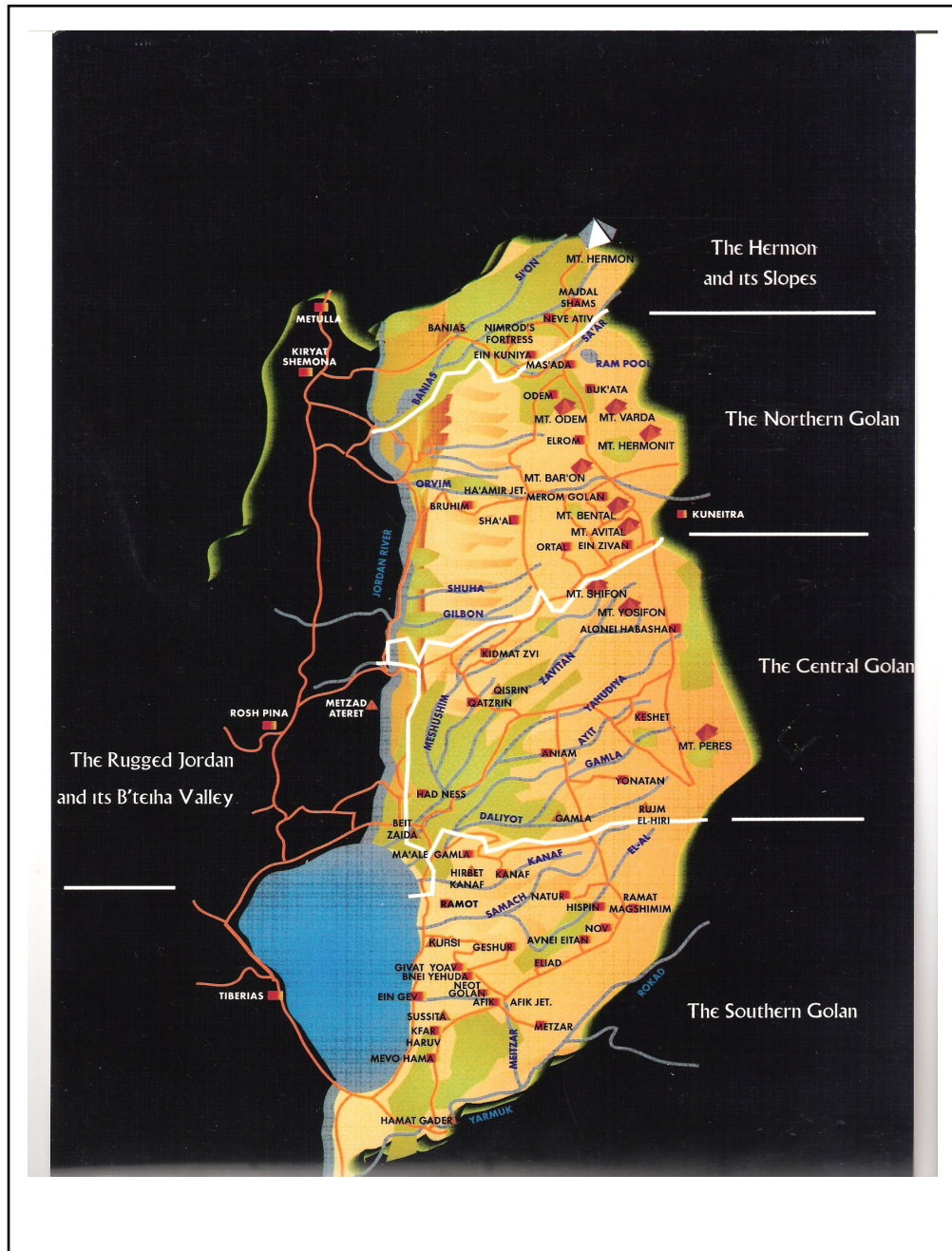
Source: Tal and Haramati, 1997.

Picture15.2 Meshushim Stream, Jordan River and Sea of Galilee

Source: Tal and Haramati, 1997

My dear late husband and I began our life in the Golan Heights in 1978. Our home is situated in Bnei-Yehuda, which is a secular regional centre in the south of the Golan (see Pictures 15.1 and 15.3). This whole area constitutes one of the most spectacular landscapes in Israel, combining valleys, mountains and the blue Sea of Galilee that together produce a very calm and quiet environment (see Picture 15.2). Most families live in private houses surrounded by grass, trees and flowers.

B'NEI YEHUDA   A thriving regional center in the southern
overlooking the Sea of Galilee. The community bears the na
the village which was established nearby during First Aliya da
inhabitants of S
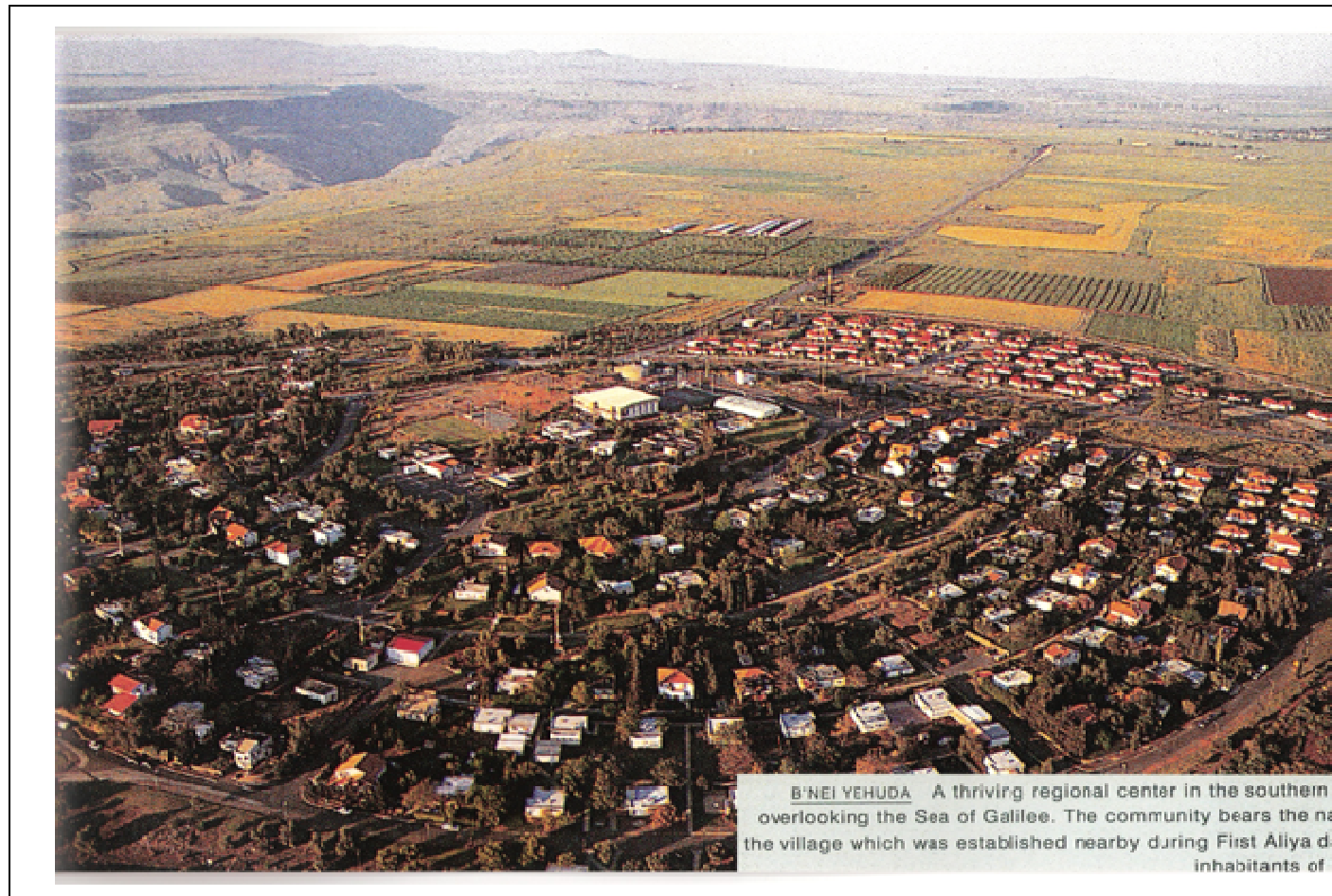
Picture 15.3 The Rural Centre, B'nei Yehuda (Source: Tal and Haramati, 1997)

The scenery where the dramatherapy took place reminds me of Woolf's (1981:9) metaphoric description: *'on the off-river side the willow trees were weeping in always-grief … the river reflected all it chose to reflect on'* that accurately describes this research's afflicted story.

We did not have a river, only trees but we had *'a room of her own, if she wants to write literature'* (Woolf, 1981:7). The room in my house was the professional location of the therapy. Originally my son's room, it was turned it into a therapy room. It was very important for me to create a special atmosphere that was inviting, playful and colourful. At the time of the therapy, I was unaware of the special significance that this particular room represented and how Iris was affected by it during the therapy period. This only became apparent, in our first oral history in 5/98 (See Appendix 4). Over the years, Iris continuously mentioned and emphasised this fact and it became clear that the 'room' was an important component that made her feel welcome and comfortable. This was another connection with Woolf's concept of the need for a special room. My son Amir is a creative writer as was the client and my ideas and thoughts concerning the writing of this thesis started to emerge when I encountered Iris in this room. Moreover, she suggested after a few encounters that *'we should write a book together'.*

The room itself is quite large 3 metres x 3.80 metres, shown in Picture 15.4 below, which I named 'Our Room'. It is full of light and the trees' leaves flutter against the window-panes with birds singing in the background all the time. The furnishings consist of a sofa, covered with a selection of dolls and stuffed toys and teddy bears, a wooden chair and a desk. A wide assortment of three-dimensional objects - dolls, small toys and the like - are displayed on the numerous shelves and the open floor-to-ceiling bookshelf, they are shown below in Picture 15.5 which focused on the objects used mostly in the sand tray. Picture 15.6 describes another angle of the room and focused on the blue sand tray, size: 40 cm. x 60 cm. is set on wheels and located in one corner. The walls are covered with pictures of dolls, witches and animals and the floor is carpeted.

Picture 15.4 'Our Room'

Picture15.5 The Objects

Picture 15.6 The Sand Tray

Our first dramatherapy session of one hour took place on the hot summer's day of 18th September 1997. The complete treatment lasted eight months and ended on 13th May 1998. It included twenty long encounters of 3-4 hours; termed Time Adjusted Encounters (TAE). The length of the treatment was not planned, nor was the number of encounters except for my offer to double the conventional therapeutic time of 45-50 minutes, due to her unbearably stressful situation. I thought it important to adapt the time-frame to her needs and so enable her to work until she felt that she had exploited the whole process and it had reached its natural closure. This was something that we considered differently at each encounter. The first twelve sessions were held from 18th September 1997 to 25th December 1997. The next five sessions took place from 8th January 1998 to 26th February 1998, and the last three sessions spread between 9th March 1998 and 13th May 1998. Rapid improvements in the client's situation during the first phase testified to the validity of this treatment's frequency and intensity. According to her later evidence, it enabled her to feel that she was in control and could space our encounters without feeling overwhelmed or helpless.

Data-collection

My data-collection was conducted in three periods: the therapy period 09/97-05/98, the first oral history 05/98 and the second oral history 07/02. It took place in two locations: at my home and two interviews at Iris' home. The methods of data-collection were direct and participant observation, use of physical artefacts and documentation of written material. In addition, in-depth unstructured open interviews were held which, in the context of the treatment, were considered as therapeutic conversations between the client and me.

In these conversations, the intention was to focus on the client's stories, which I viewed as one of the most important components in the therapy. Shkedi (2003) has suggested: *'Telling a story is basically a process of giving meaning, each word the informants use in their stories constitutes a microcosm of their consciousness'* (p.71).

The post-therapy testimony was collected from two oral histories that were based on in-depth unstructured interviews. Sanger (1996) asserts that such an interview

is *'the predominant means of data gathering even more than observation … its flexibility and negotiability make it uniquely attractive to researchers who are pursuing longer term goals involving human action … in life'* (p. 61). In this case, these interviews were preserved in their authentic structure without editing or reduction in order to retain the evidence as it was told by my client. The rationale for this was the *'will to understand the experience of other people and the meaning they provide regarding this experience'* (Shkedi, 2003:69) (See Appendices 4 and 5).

The occurrences of the dramatherapy are presented in rich descriptions named 'Stillborn to Reborn' presented in Chapter 16, with rare insights into the client's posttraumatic inner world. Their content provided the research with a unique opportunity to understand the most confidential area of the client-therapist relationship, allowing other readers - and myself - to see this web of relations as if through a 'virtual camera' (Hammersley, 1998:21).

At first, I tried to document the sessions using longhand notes. However in our second session I explained to Iris that I would like her to be the subject of my MA thesis. Having obtained her consent, I used a small Walkman tape recorder from our third session onwards. My intention was to collect data in real-time without the distraction of note-taking, so that all my senses and attention would be focused on our conversation and interactions. This, I believed, would ensure that essential non-verbal evidence was captured and my client's verbal responses were recorded accurately. The advantage of using a recorder was that it could allow me to transcribe these recordings for later analysis.

Throughout these months of the therapy 09/97-05/98, I never listened to the recordings – I blindly trusted the equipment. This was a mistake. It was only at the beginning of writing-up the MA in 06/98 that I started to transcribe the first six encounters included in this research. The writing process was difficult to handle due to the poor quality of the recording. This process became even more disastrous during the work on this PhD in 2002, when I listened to the fourteen recorded encounters which were not included in the MA, and tried to transcribe them. I felt that the tape recorders had become a trap. It was almost impossible

to transcribe from the recordings; some cassettes were hardly audible and others were partly blank. This setback was a catastrophe and during the first two years of the PhD I considered abandoning the thesis. I knew that this evidence and the data were central keys to my research and I was afraid that anything less than the complete records would not be worthwhile since the study would lose credibility and worth.

Despite this obstacle, the 350 pages that were eventually transcribed exceeded what could be reasonably included in this thesis. I saw this evidence as a rare documentation of the data from a clinical case study, which provided a thick description of chronic PTSD treated successfully via dramatherapy. As a result, I insisted on encompassing the entire therapeutic story in my fieldwork evidence for the thesis, instead of putting the complete transcription in the appendices. My task was therefore to reduce it to a reasonable number of pages by scrutinizing the text and removing obvious verbal duplications. It was obvious that most of the data would be based on each of our long therapeutic verbal conversations which each lasted about two hours. Moreover, the research's conceptual framework focused on dramatherapy processes and activities which differ from verbal psychotherapy. Thus, it was reasonable to depend on them as the important part of the fieldwork and to relate less to their complete verboseness. The additional choice in condensing the data included consideration of the therapist's conduct. This conduct was not emphasised due to the fact that the research did not aim to explore the topic of the therapeutic relationship nor the therapist's role in the therapy's successful outcomes.

The data from the second phase of the research, after the therapy, was based on two oral histories. The first one in May, 1998 consisted of a four-hour in-depth interview and the second was conducted in July, 2002 and took one hour. However, in the second interview I used more reliable equipment and checked whether the interview was audible. The format for these interviews was established to *'open up a wide area with a broad statement or question'* allowing Iris to respond in *'as open and as general a way as possible'* (Plummer, 1983:97).

The transcription itself became a traumatic event that badly affected both Iris and me. In March, 2005 she volunteered to help me with the transcription due to my hearing impairment. One of the research's intentions was to include the client's written reflections, based on her reading the transcription from all the therapeutic sessions, five years after therapy terminated. When Iris transcribed the encounters she felt tense, angry, confused and lost (See Appendix 5). Therefore, she decided to withdraw from her consent to write her reflections concerning the whole transcription. She sent me a letter on 12th March, 2006, expressing her difficulties that resulted from the transcription and her desire to stop the interviews.

I felt very guilty and asked her to discontinue her voluntary transcription and she agreed. This left me with no alternative and I needed to change part of the research's conceptual framework. This process entailed beginning a new lengthy quest for the other meaningful components that characterised Iris's case, research which I hoped would be an original contribution to the field of dramatherapy. My search was accompanied by many emotional and intellectual difficulties; I lost my creativity, felt blocked and was unable to find satisfactory ideas for a long time. My guilt feelings towards Iris and the difficulties caused to her as a result of her participation in the transcription made me feel responsible for her distress, which prevented me from moving forwards with the research for almost a year.

Table 15.1 below shows the chronological calendar of therapy sessions between the years 1997-1998.

Table 15.1: Chronological Calendar of Therapy Sessions, 1997-1998

Encounter No.	1 start	2	3	4	5
Date	18/9/97	25/9/97	1/10/97	10/10/97	20/10/97
Encounter No.	6	7	8	9	10
Date	30/10/97	6/11/97	14/11/97	20/11/97	4/12/97
Encounter No.	11	12	13	14	15
Date	11/12/97	25/12/97	8/1/98	15/1/98	22/1/08
Encounter No.	16	17	18	19	20 end
Date	5/2/98	22/2/98	9/3/98	2/4/98	13/5/98

Table 15.2 summarises occasional significant occurrences between the years 1998-2009. The first five items influenced my choice to study Iris' case at the doctorate level. The most important events that enabled my research intentions to be fulfilled were her son's birth and her consent to be the subject of this Ph.D.

Iris' Informed Consent form for her participation in the Ph.D. appears as Appendix 7.

Table 15.2 Calendar of Important Events 1998-2009

21/05/98	First oral-history interview with Iris
08/98-1O/99	Occasional meetings with Iris for the MA. Final reading before submission
09/99	Iris' spontaneous pregnancy without undergoing medical fertility treatments, which she stopped at the end of 2008
25/05/00	Iris's son was born when she was 46 years old
03/01/01	Iris consented to be the subject of the Ph.D.
04/07/02	Second oral-history interview with Iris four years after therapy termination
10/02-06/03	Occasional meetings with Iris gathering additional information from Iris for the Ph.D.
05/03	Iris volunteered to transcribe several audio tapes for the Ph.D. fieldwork.
12/06/03	Iris sent a letter that expressed her difficulties and her wish to stop the interviews and she withdrew from writing any more reflections (see ethical considerations)
12/04	Iris left Israel and returned to her homeland. Since then we have communicated by emails.
2009	Iris read the completed thesis and approved it.

Summary

This chapter depicted the setting of my dramatherapy fieldwork. Emphasis was given to the room's description, due to the importance of its atmosphere for the client's convenience and wellbeing. In addition to the research evidence, the data gathered within the fieldwork detailed the meaningful occurrences and the obstacles I tackled over the years and how despite these difficulties I was able to move on and complete the research. Overcoming these set-backs led to the creation of a new conceptual framework and the abbreviated 'Stillborn to Reborn' story which relates the PTSD recovery journey and is presented in the next chapter.

Chapter 16: 'Stillborn to Reborn'

Introduction

The transcribed encounters are a result of the reduction of hundreds of pages into comprehensible vignettes of twenty real-life occurrences. They constitute the primary fieldwork for this thesis. The twenty encounters were divided into three periods, according to their thematic content and the prominent transformations in Iris's situation.

The first section tells the story of the beginning: the client's traumatic grief expressed through somatic and emotional afflicted symptoms – weep, freeze and zombie states; while establishing a therapeutic alliance and developing a warm, close relationship. The first period contains Encounters 1-6 and is entitled**: 'Stillborn'.**

The second section focuses on the curative journey from chronic PTSD toward recovery, featuring many descents, falls and subsequent ascents; results of the recurring failure of fertility treatments. The period between Encounters 7-15, contains the core of the curing dramatherapeutic processes entitled- **'Struggle and Triumph'** which describes Iris's efforts to recover. Within these encounters Iris completed two questionnaires: the first one was from the Internet (What is trauma?) her own initiative between Encounters 7 and 8; and the second derived from the DSMIV (1994) PTSD criterions which I asked her to complete between Encounters 11 and 12. The questionnaires clearly illustrated the transformations in Iris' situation.

The third section describes the reconstruction of Iris's creativity and positive energy; the last transformation process of becoming alive, no longer dead-and-alive hence, Encounters 16-20 are entitled **'Reborn'**.

Photographs of pictures and trays produced by Iris are numbered and included chronologically to illustrate the artefacts produced in the therapy.

'Stillborn' (Encounters 1-6)

Encounter I

When my new client, Iris, arrived at my home for her initial appointment, her outward appearance clearly indicated her inner turmoil. She was dressed inappropriately for the summer weather. Her hair was unkempt and her pale face was etched with pain. Her back was hunched and her hands gripped the straps of a heavy rucksack she carried on her back. Her whole body was frozen, bent, closed and tight. I invited her to share her story with me. She sighed deeply and tears appeared in her eyes as she began to speak:

> *Three years ago I became pregnant, it was my first pregnancy, and I felt healthy, happy and blessed. In the evening of the last day of week 41, the baby kicked really hard and then stopped. I consulted my pregnancy books and read that when the baby drops into the birth canal there is often little or no movement. I had a show of blood, so the birth seemed imminent. The following morning, I told my husband that I wanted to go to the hospital.*

> *The attending nurse checked for the baby's heartbeat and failed to find one. I was shocked. A woman doctor also failed to find the baby's heartbeat. I was then taken to be examined by ultra-sound. The ultra-sound technician then told my husband and me that something was seriously wrong. There was a 90% chance that our baby was dead. I was distraught. The technician brought another doctor who repeated the diagnosis. This doctor ordered labour to be induced and then he disappeared. I was given some medication to induce labour and even though I could hardly stand up, I was told to walk to the delivery room.*

> *It was the worst day of my life. I was disorientated by drugs and shock and I lost all sense of reality. My husband had vanished or been banished and I was left alone in the hallway. There were no doctors present in the delivery room, so the two midwives made an exception, and allowed my husband to remain with me during the delivery. I am grateful for their*

kindness, without him, I think I would have died. 3 or 4 hours later my daughter was born.

Even though she was born dead, I insisted on holding her in my arms. My husband kissed her brow and I kissed her fingers. The moment did not last long and she was whisked away from my aching arms. I had the impression that she was wrapped in a green cloth and her body was dropped in a large green garbage container, but my husband says this is not true. I do not know, I just remember thinking how heartless it all was. Eventually, a lady doctor came to talk to me. She reassured me that by next year I'd be back with a new baby and everything would be fine.

During this whole outpouring of her story, Iris wept with her whole body. I felt a personal bond of identification and empathy with her ordeal, since I had had a miscarriage in the fifth month of my first pregnancy. I urged her to continue:

Two years ago I started fertility treatment. Each session has left me feeling as helpless and vulnerable as that day in the delivery room.

Here I am, three years later, and I still have no baby.

I am so unhappy; I used to be a successful career woman in charge of writing for large advertising companies. But these days I'm not as inspired or creative as I used to be. I find it difficult to concentrate and I am losing valuable clients. I no longer enjoy the company of my friends. My husband has told me that he has reached the limits of his patience with my problems. I feel anxious and beset by fears and nightmares. I desperately need to regain some control over my life.

I told Iris that I appreciated her sharing her story with me and that I empathised with her pain. I was encouraged by her motivation to change her life. I suggested that we meet weekly for a two-hour session. Together I hoped we could help release the pain of her difficult past that prevented her from moving forward. I noticed that Iris' body remained frozen all this time and she did not stop crying.

Encounter 2

I started this encounter by asking Iris how she felt after allowing her memories to resurface and sharing her story with me in our last encounter. She started to cry and replied that she has not moved on in the past three years and constantly dwelt on her memories:

> During our first session I felt it was the first time that anyone really listened to my story without interrupting or advising me what I should do. Until now I have had no one to talk to about the way I feel. Nobody wants to hear my story because it's a painful one. I feel that everyone wants me to get over it and move on with life, but I feel trapped. When I am asked if I have children or what happened to my baby, I feel so angry and emotionally upset. People are often insensitive to my feelings and keep saying 'don't worry, you'll have another baby.' They have no idea how much I long for a child, or how much I suffer during fertility treatment.

Even though she was crying, and motionless I asked Iris if she would like to express herself with objects, rather than words, in order to illustrate how she saw her own world.

I placed a large sheet of paper on the floor and several objects in front of Iris that I felt she might find interesting namely, pebbles, marbles, toy cars, plastic cartoon figurines and jewellery. She looked at all the objects and chose several pieces that she placed carefully onto the paper. Whilst she was concentrating on her creative work she stopped crying. When she had finished I asked her if she wanted to tell me something about her work and what it expressed:

> The chain necklace delineates the Sea of Galilee, I live near its shores and I feel safe and secure in such a beautiful and peaceful area but it is a little bit empty. I prefer to stay at home a lot since I have abandoned my friends. This small plastic dog depicts my own dog Ozzi, who is my constant companion. The button with two musical notes is my husband – a musician, but he does not play music as he once did, just as I am not the same as I used to be. This big blue button is me and the half clam shell is also me this is the most closed item.

I prefer to stay home and not to see friends. This pebble is hard to place because it is not my baby; it is the grief that remains. The two brooches are my garden. The green Jo-Jo (cartoon figure) is hope. I have also included a ladybird to depict the humorous side of life I miss (see Picture 16.1: First Object Sculpture – 'My World Now')*.*

I then asked Iris if she would create an image of her future world with these objects. She readily agreed and worked with alacrity. When she had finished she explained this work:

The Sea is colourful and tranquil. My dog Ozzi stays as before. I have depicted myself as a pot and the pink bed, which shows me as a more fulfilled person. This figure, Ernie from Sesame Street (children's TV programme) is my husband, who has become a funnier and happier person. The two little bears are our two future children. This little pebble between the two bears and the pot is my grief for my daughter; it has become a bridge, not a gap, joining me to the outside world. The toy car represents the driving licence I should get. The left corner of the picture shows the ties I have to my own homeland. Lastly, I have tried to create an image of fullness, balance and completeness, so the golden button depicts my bright future.'

Iris's colourful picture did portray a full, balanced and optimistic future (see Picture 16.2 Second Object Sculpture – 'My Future World'). I observed that her face lit-up with pleasure at this new map of her future. Then she returned to her painful story and began to weep:

Three years ago my yet unborn baby was the most valuable part of my existence. I was placed in the maternity ward the night after her 'birth'. I was awoken from a deep sedated sleep and asked what I would like to do with her body; did we want the hospital to handle the matter, or did we wish to handle it ourselves? I could not consult my husband since it was the middle of the night. I thought only of the Jewish religious law which demands burial as soon as possible after death; I asked if they could take care of the arrangements. I was so exhausted and groggy from sedation.

Why did they ask me when I was so weak? That was the last we ever heard of our child. I blame myself for not asking when, where or how she was buried; we were too shocked to talk about it.

The following day I was cared for by two sympathetic English speaking nurses and I was moved into another ward. I began to gain my strength and the impact of my loss began to take hold. The nurses inaugurated the now ever repetitive mantra, 'it's okay, don't think about it, you'll have another.' A young, cheerful doctor discharged me from the hospital and glibly remarked that our child's death 'was just a chance accident with her umbilical cord,' as if to reassure me that I should have better luck next time.

The following year I contacted the hospital to enquire about where my baby was buried, I received a vague reply. The year after I contacted the Israel Association for the Bereaved and they clarified the place of burial.

Throughout this period my friends advised me to adopt a child. Their comments, although well intentioned, made me so angry and resentful towards them.

While Iris talked she wept and stopped crying when she continued to create the spectrograms (for further details regarding this therapeutic tool, see Chapter X). She looked as though she was exhausted by all the emotion that flowed from her. I suggested that we close our encounter with a Six-Piece Story Making (6PSM - a method of assessment) which I believed would give me additional information about Iris. However, Iris only finished her story when she felt that she had released a detailed narrative from her fertile imagination. When she arose from the chair to leave she was dry-eyed and happier.

The 6PSM from which the BASIC Ph components are derived is a method for assessment in dramatherapy developed by Lahad (1992). In the 6PSM the client follows a set of instructions to create, tell and discuss a fictional story. The assumption is that *'in telling a story based on elements of fairy-tale and myth, we will see the way the self projects itself in organised reality in order to meet the world'* (Lahad, 1992:157).

This method attempts to identify the six dimensions on which the client's coping style is founded. These dimensions form the acronym BASIC Ph:

B – Belief, **A** – Affect, **S** – Social, **I** – Imagination, **C-** Cognition, **Ph** - Physical. The number of times each dimension appears is counted; the dimension that occurs most frequently is predominant. This method can also be used to identify underlying themes and conflicts in the client's narrative, of which they may not be fully aware (Lahad, 1992:161).

The guidelines for the writing of the story include two requests and four questions:

1   Think of a main character-hero or heroine.

2   The mission or task of that character.

3   Who or what can help the main character if at all?

4   Who or what obstacle stands in the way of his/her ability to carry out the mission / task?

5   How will he/she cope with this obstacle?

6   Then what happened?

Iris' story (according to the above requests and questions)

1. Sarida is both a magician and a human, aged 25-30. She looks beautiful, dainty like a fairy, big like a human, with a fairy–like atmosphere. She is not a hundred percent present as a human being. She loves Merlin, but she can't live in his world all the time, because she has to do things in the other world, and his world is a little bit heavy for her, because she is like air.

2. Her mission is to save the other world, from which she comes by an accident with space (her world, not ours).

3. She will be helped by her father, her brother, her friend, her dog, her wisdom, her charm, her imagination, her speed, and her strong will, till the end.

4. She lives in a world where they don't believe in the space or in cases, they don't understand that a catastrophic accident can happen; they don't believe her because she is moving from world to world. The residents in her world don't believe her.

5. She can't leave the space by herself; she needs the residents' faith in her, and also their help. They can build some sort of electric magnetic reservoir that throws power out to space. She needs everybody's energy and the engineers' wisdom, and she needs everybody to work together. In the meantime they don't work together, and because they don't see the space they think it doesn't exist. She needs to change the residents' perspective and after that to organise them together to create a solution, and they don't have much time to do that, they have some time but not much. She organises a performance one evening. One passenger comes from a village to the city. The dog, the father, and the brother perform – an example for the space and the other world. Everybody enjoys it and laughs and in the end she tells them it is not only the show (play) but it is really happening. Then she organises enough people to start the project to build something electric to combat the space. But there are still people who don't believe and they are against this.

6. It will be all right. She has lots of problems changing opinions, and only the fact that she is a magician and can disappear enables her to succeed in living, because there are people who want to kill her. When they come, her dog barks and she disappears and then her brother and father continue to work with engineers on the electric instrument. People have a lot of respect for her father, some think his daughter is crazy, but because of their respect for him, they continue to work for him, and it is not just a hope. Her brother has a shop and he sells very special things that people need very much and they must come to him, because this is the only place where they can buy them. He tells those who are not willing to work with them: well you cannot buy anything here, and then they want to kill him and she is able to save him with her magic and intuition. At last they succeed in building the power station and they zap to the space with the power, and the space goes in another direction. Finally

she is a hero and is free to be with Merlin and to do whatever they want, together.'

Picture 16.1 First Object Sculpture - 'My World Now'

Picture 16.2 Second Object Sculpture -'My Future World'

Encounter 3

When Iris arrived I was amazed by her transformation from a dowdy miserable figure into a new stylish woman. I complimented her on her outfit and new hair style, but she dismissed my admiration saying:

I had a very difficult week and I do not feel I look that good. My moods swing from hopeful to hopeless. The IVF treatments are physically and emotionally draining and I feel lifeless.

I lack the consistent creativity I used to display in my work; my whole routine is disrupted by the treatments. Most of my time is spent sitting with my dog and staring at the lake.

While she talked about her despondency I was taken aback by her regressive demeanour. I suggested that she could express her feelings on paper by drawing. She chose crayons for her first drawing and sketched silently (see Picture 16.3 First Crayon Drawing – 'Here and Now Feelings'). She began to tell me about the drawing, and while pointing to a blue spot of colour on the paper she said:

That is me, the circle, I feel blocked in by two walls; one of pain and sadness (orange line), and the other of the issue of pregnancy (red line). Behind these two walls are my children, family, and my ideas that draw strength from the water and the shady trees of my garden. An all seeing sky covers the garden and watches us.

I suggested that she could say something more metaphorically about the circle. Iris looked again at the drawing and described the blue circle, its temperature and the landscape she visualised as the background:

The blue circle is a small pond that exists in a cave on the Golan Heights. Inside the cave the atmosphere is damp and dank and the temperature is below zero.

Then she had an outburst of weeping, and I remained silent for a long time. After a while still crying she continued:

It also reminds me of a cedar wood box my friends sent me from my native land. Inside of it I placed the gifts I received for my daughter. I keep the box in my bedroom beside my bed.

Her voice was barely audible, she was bent over and continued to weep. I handed her another piece of paper and encouraged her to draw the box and the gifts inside (see Picture 16.4 Second Crayon Drawing – 'My Memory Box'). When she had stopped crying and finished drawing she described each gift and who had sent it:

The box is something I cherish; in it there is a picture of the ultra-sound scan of my baby, it is the only tangible evidence I have that I was pregnant. You may think it's a bad thing to live with this constant reminder, but I have no grave to visit where I can go and cry and talk to my baby. She was buried in a collective grave without a headstone.

I wanted to visit the grave but have never succeeded in doing so. I tried to create a Zen garden dedicated in her memory, but I have not been able to do that either. Time passes but my grief stays the same.

Towards the end I invited Iris to draw again and then describe her new picture (see Picture 16.5 Third Crayon Drawing – 'Garden and Growth'):

My new perspective shows changes. Now the orange line from my previous drawing is not sadness, but anger. I have portrayed a beautiful garden that is alive and growing. I also want to capture the beauty of the trees and sunset reflected on water. When I started drawing I felt silly drawing with crayons. I know that this comes from my assumption that crayoning is childlike. But now I feel that it is a very powerful method and I can do as you say and express myself unreservedly.'

Picture 16.3 First Crayon Drawing- 'Here and Now Feelings'

Picture16.4 Second Crayon Drawing - 'My Memory Box'

Picture 16.5 Third Crayon Drawing- 'Garden and Growth'

Encounter 4

Iris brought her diary to show what she had written a day after Encounter 3.

Dramatherapy with Rachel

Yesterday we talked a bit, and then we began to work with drawing. I drew the memory chest that my friends had sent me (from overseas) and as I started to draw what was in it I started to cry. Rachel asked me if this box was in my room and if it was good or not that I saw it all the time. And it is not (good). I will put it away, with love, but away.

Then I drew a picture of how I am now … and a picture (later) of how it could be afterwards. How much I want to bury the past and how hard it is to do it. How much I want to go to the grave. Why I don't exactly know, I feel that I must. At least once! Rachel gave me a good idea and one which I guess I half-heartedly had for months and tried but didn't succeed - either from fear, guilt or shame; would someone laugh? - To make a grave at our house: so that she can be with us and I can be at peace. I felt shaken to the core to realize how small and shallow my life had become - how immense were the barriers of rage and fear and pain - how forgotten my husband is and how invisible I am myself. How colourless, shapeless, empty. I could not draw more into the first picture 'I have no strength, desire'. Empty. What more could I draw? I felt so stupid to do this little idiotic drawing and then so shocked to see how much it <u>really</u> was me … or at least how I saw the world.

When I left, I still felt shocked – shaken-inside. ALL DAY But, also kind of optimistic, because I know what I want to/ have to do. It was also exhausting. I popped right back in time and had many, many flashbacks of that time. But this time many of them were more objective, as if I was a third party. I also had a big dream - a long and complicated one - don't remember anymore - but it was one I felt. I lived.

After reading, Iris started by telling me how she felt after our last session together:

I was shocked by what was displayed in the pictures I drew, I was not aware that I was in such a bad state. Since then, I feel as though I have been woken up to my feelings, I was so excited to uncover these truths about myself. I am also aware of feeling optimistic again. The blue circle I drew in my first drawing portrays me as such a small person who is unable to traverse the high wall that surrounds me. However, by my last drawing, I was actively open to all options in order to reach the other side of the wall.

I interjected that all her drawings had exposed important primary emotions that were deeply hidden, which she had covered up with less dangerous feelings. I reiterated what she had said about the orange wall representing pain; later this pain was replaced with a wall of rage and anger. She agreed:

Intellectually I am familiar with the fact that depression is caused by anger turned inwards, but I felt that in my case it was pain and not anger that was stopping me from moving on with my life.

I encouraged Iris to continue speaking about the unresolved issue of her infant's gravesite. Her distress was apparent, but she did not dissolve into tears as she had done when we talked about the subject previously:

It was the Jewish New Year when we eventually went to the cemetery. It was an upsetting experience since the graveyard is a long way from home. Unfortunately, it was closed. I never entered the cemetery gates and I still do not know the exact location of the grave. When I saw it was closed I felt further victimised by society because this place too was closed to me. This morning I found a small stone that I intend to place in a memorial garden. I am going to create a special place in my garden where I can speak freely and feel her presence in my life.

Iris gained some control over her life from this project. The stone she intended to place in her garden gives shape to the memory she wished to preserve.

I asked her if there were any other changes in the way she was feeling about her life and how was she expressing them. She then told me about a dream she had

had, even though she did not recall all the details she was relieved that it was an ordinary dream and not a nightmare.

I complimented her on her progress, recalling a time when the blue circle in one of her early drawings made her cry. She replied that she thought that this was connected to her feelings of isolation and loneliness:

> I feel optimistic and want to continue to apply all that I am learning to my daily life. All week I have thought about the cedar box and whether its presence by my bed was doing me more harm than good. Now I want to put it away and only take it out if I need to remember the good things inside. So, I have brought the box and its contents to show you. Here is all the evidence of an episode in my life, which I sometimes wonder whether it was all a dream.

She opened the box to reveal what each item meant to her. Although we talked of painful issues, Iris remained dry-eyed throughout the whole encounter.

Encounter 5

Iris arrived two hours late for her encounter. She looked upset; her clothes were dishevelled and her face was contorted with emotion, generally she looked as she had when the therapy began. She explained that her husband was to blame for her lateness because he forgot that he had to drive her here today.

She recalled the first time she had gone with her husband to the hospital for fertility treatment; they had arrived late and she became so upset by the criticism she received from the hospital staff that she had become hysterical.

I could see her anger building as she continued to focus on her fertility treatment. So I reminded her that we were also dealing with unresolved and prolonged grief that could be linked to her present suffering. She started to cry and shared the pain and debilitation of the fertility treatments with me. Today this recollection makes Iris angry and she seems to blame her spouse's lack of support for a lot of their problems.

He keeps telling me that my problems are all in my head. I come here in order to improve my mental and spiritual health, but I rely on him for a lift. I am totally dependent on him for many reasons, whereas in my native country I used to be so self-sufficient, here I just feel isolated and alone.

She told me how her mother lost a stillborn child as she cried. She talked of nightmares she suffered for months after the stillbirth and how supportive he used to be; she wished he felt more empathy towards her and said:

When someone passes away, naturally or tragically, it is sad and a shock, but one is able to sit with friends who knew them and reminisce and somehow maintain a shared reality. I barely have a shared reality with my husband since his memories are minimal; although, his hands had touched her through my belly, and after her birth he had held her and kissed her on the forehead. All the other memories are mine alone.

I believed that she was crying also for other losses in her life. Presently, I was able to draw her attention back to her drawings from our previous session. She said:

I was shocked to discover that I viewed myself as being so small. My life used to have purpose, I was talented; I was a writer. At school I used to use words as a tool against bullying. I was so pleased that I could make a worthwhile career out of words. I loved it, but now, I lack the will power to write at all.

I offered her a choice of materials to work with. After showing signs of deliberation between a sand tray, plasticine or clay, she chose the latter. While she kneaded the clay she continued to talk:

When I met my husband I was a different person. I had it all; money, career and all the trappings of success. When I first came to Israel all his friends loved me and thought I was great, they loved my humour. But since I lost the baby I stopped caring about friends or work. It is only now that I feel I am rebuilding my life.'

When she had finished moulding the clay she declared it to be a power station (see Picture 16.6 First Clay Piece – 'Power Station') and laughed:

Most of the time I feel powerless; I lack the ability to communicate properly because my Hebrew speaking skills are abysmal. I work in a man's world of advertising and I cannot express myself, swear or even crack a joke in Hebrew.

Iris continued to mould the clay into the shape of a bird (see Picture 16.7 Second Clay Piece – 'Free as an Eagle'). She smiled as she worked the clay. I asked her what the bird meant to her; she replied that she wanted the bird to be similar to the one in her previous drawing:

Eagles fly effortlessly. When I used to write stories, and when I was pregnant, everything came easily to me. Today I am gathering strength to emulate this bird so that I can fly again.'

Iris amused herself until the end of the encounter with words and clay while shaping *Zap to Space* the third clay work, using the symbol of fighting back, that had appeared in her 6PSM (see Picture 16.8 Third Clay Piece – 'Zap to Space').

Picture16.6 First Clay Piece - 'Power Station'

Picture16.7 Second Clay Piece- 'Free as an Eagle'

16.8 Third Clay Piece- 'Zap to Space'
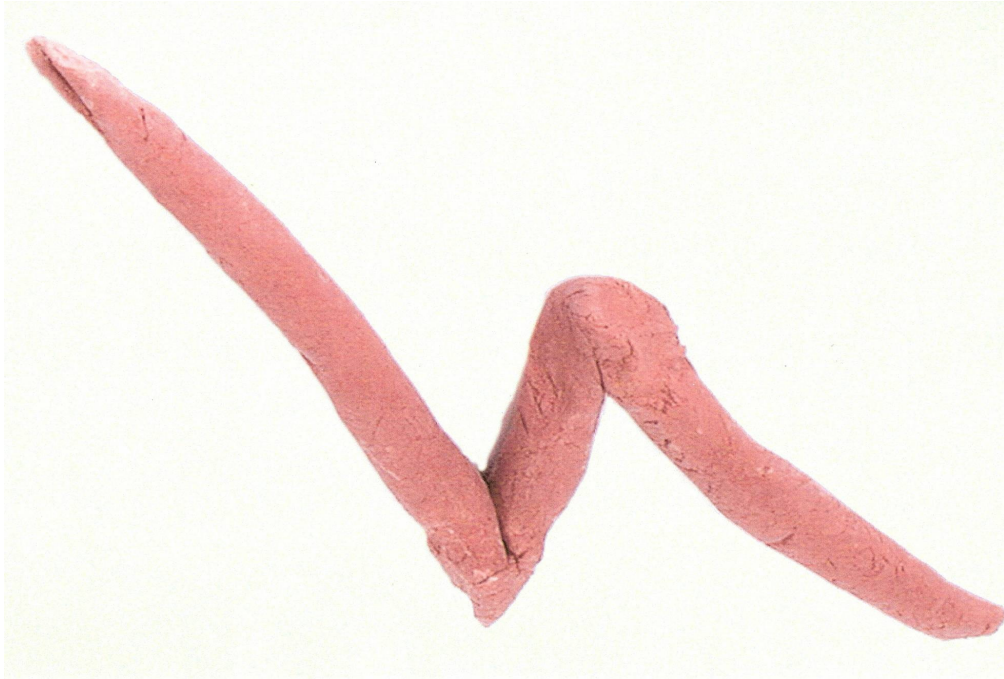
Encounter 6

Iris arrived early and seemed in a good mood with an energetic appearance and upright posture. She immediately began to talk in a strong and clear voice:

> This week I took the unprecedented action of telephoning one of my husband's friends to talk. Unfortunately, she became very dictatorial, telling me that I should accept my lot and get on with life.

> I became very angry. I was not able to explain that I am trying to get better and speaking to friends is part of my journey back to the person I once was. People think that if I have another baby I will move on and erase the fact that my baby ever existed. Since I find it difficult to accept their attitude towards me, I feel much better with my pregnant friends or with those who have children.

I was surprised to hear her say these words, she said she too had not realised it until she had met her best friend who was about to give birth soon, this friend suggested that they walk together. Laughing, she continued:

Yes, me actually walking and talking to a woman who is pregnant, and feeling unafraid. I admit that it has been impossible until now to even speak to this woman who has been so kind to me or anyone who is pregnant or has a baby. I feel elated, as though I have passed a test. I have learnt that there is something on the other side of grief. Instead of just thinking about my loss, it has become very important to me to put my symbolic stone in my memorial garden, so that I will have a place for her in my life.

I was very pleased to see Iris make such rapid progress. I had noticed that each time she created something with her own hands it sharpened her reality and opened new avenues of thought and awareness. She had decided that she would like to use finger paints as a medium to express her anger although she looked happy. She sat on the carpet, touched the paints and took three colours, yellow, red and orange and made circular movements with her fingertips. I suggested that she took more paint, or perhaps closed her eyes and let her fingers express her feelings. She closed her eyes and moved her hands in a violent circular motion whilst she talked:

I do not know where I am going with this whirlpool of emotions; it feels like torrents of murky water gushing around and around. I cannot stop it, just as I cannot stop the whirlpool I'm in, nor can I stop these feelings of anger (see Picture 16.9 First Finger Painting – 'Whirlpool')*.*

She talked about her frustration and anger at having to live with anger in her life. I asked her to identify her anger:

I'm not sure where these feelings come from, although injustice has always made me angry. Once upon a time I could channel my energies in a positive direction; I have been motivated by anger to write and rewrite scripts. Nowadays I do not even have the energy to write a letter, so I have stopped doing what I love to do. Like the whirlpool, my anger goes around and around. I need to re-channel my emotions in a positive direction in order to get rid of it.'

I remarked that the painting looked quite tame and gentle to me, and asked her if she was sure this was her anger. I felt that she was using her head rather than her heart. She replied that she had always had a problem expressing anger. She took another sheet of paper placing orange and black and worked with both palms not only her fingers, and said: *'You know Hiroshima; it is like an atomic explosion* (see Picture 16.10 Second Finger Painting – Atomic Explosion)*.*

Although it expressed more anger I encouraged her to take another risk and suggested she let herself play with the paints spontaneously. On a new sheet, without thinking she covered it with forceful hand movements using red and black. Then, she scratched the paint with her nails and hit the paper with her fist and then slapped it with her whole hand (see Picture 16.11 Third Finger Painting – 'Anger and Chaos'). Her suppressed anger was surfacing and her face became contorted with rage. She was not channelling, but fighting directly with her 'opponent' saying:

> *This is my chaos and anger, my disorder. It feels good fighting back with my hands and fists. I have never fought back; I was oblivious to what was happening to me. I do not want to hold on to anger and grief any longer. Now I can see I have to find my way out, I desperately want to put it in the past and reconnect with life. I was too afraid to reveal my anger because I might regret my words or actions. I am carrying around this heavy burden of anger and now suddenly I know that I can let it go.*

Iris sounded satisfied with her progress. She smiled and sat up straight. She asked if she could end the session by altering a previous picture of a 'power station' she had not succeeded in creating. She then started another picture with finger paints in a deep blue (see Picture 16.12 Fourth Finger Painting – 'Power Station' saying:

> *I have been thinking all week about this sapphire blue stone that will be my power station. Whilst I was teaching my new pupils I had been thinking about this power station and it has given me a strength that I did not know I had. It has given me self-confidence, symbolising that I am not small and weak, I have inner strength. Dramatherapy has helped me visualise what my*

pain is comprised of and I feel a tangible empowerment after each session. I feel I can enact my ideas and take a pro-active part in my life again. As you suggested, I have made an appointment for a body massage to help me further connect my body and my spirit.

I watched Iris' surprising transformations, both emotional and physical, and invited her to end with a story entitled: *'A good friend talks about Iris'*. I felt satisfaction seeing her new appearance as she left the room smiling to herself.

The story 'A good friend talks about Iris'

I've known Iris for many years and I never knew where all her energy came from. Like her mother, she seemed to have boundless energy, especially for creative projects or things she liked to do.

Over the past couple of years, since her baby died, she hasn't been herself. Other than a few times when some 'glint' of inspiration literally forced her to create something novel, she seemed content just to sip her tea and sit with her dog looking out over the Kinneret [the Sea of Galilee].

Today something special happened in her session with Rachel. She finally realised that rage drives her on and that the power of her creativity comes from the fire in her belly, in her soul, that rages against injustice and for humankind. Such haughty sentiments from one little person! Who does she think she is? She has asked herself and me this question many a time.

The fact is that she is who she is – someone who was given the ability to write and create along with the unique asset of also finding pleasure in these activities. The fact that the outcome may help in some way and also affect mankind is secondary.

So in fact she hasn't felt deserving of this gift or the pleasure it creates in the past two years. Like some kind of prisoner of guilt or remorse, allowing herself only morsels of creativity, she has cloistered herself and her talents away - and it's no wonder that the rage has built up and up and up.

Today I think she has realised that she must free herself from that prison and touch the fire with her bare hands - let it transform the chaos into creativity and let it be for the good.

Picture 16.9 First Finger Painting- 'Whirlpool'
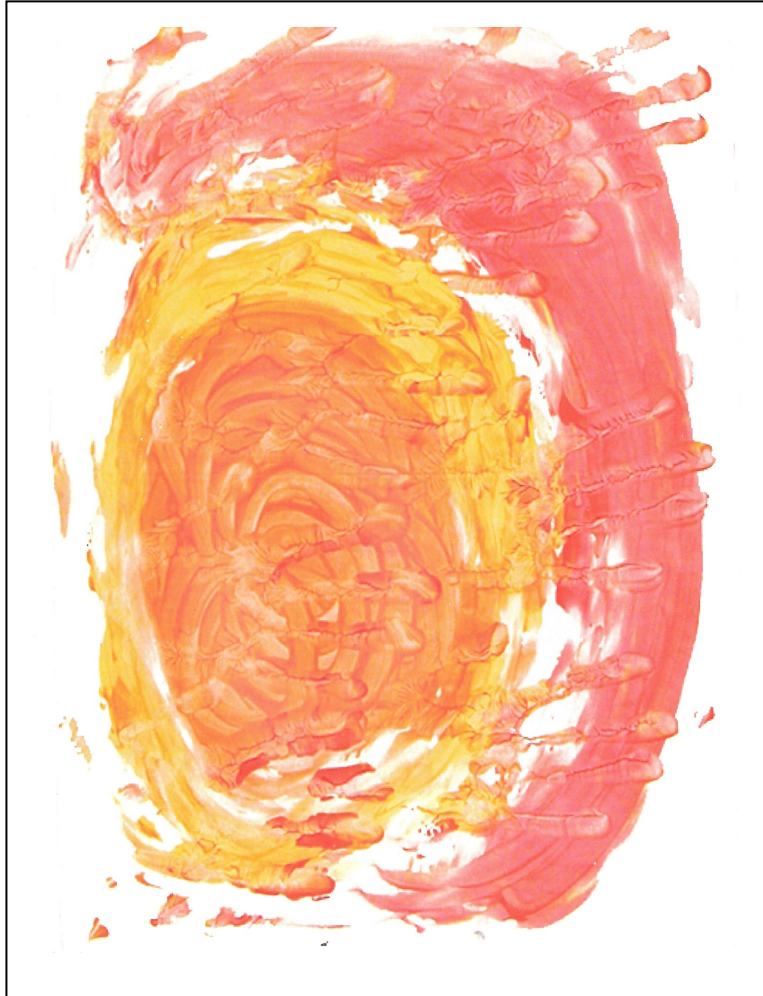
Picture 16.10 Second Finger Painting-'Atomic Explosion'

Picture 16.11 Third Finger Painting –'Anger and Chaos'

Picture 16.12 Fourth Finger Painting- 'Power Station'
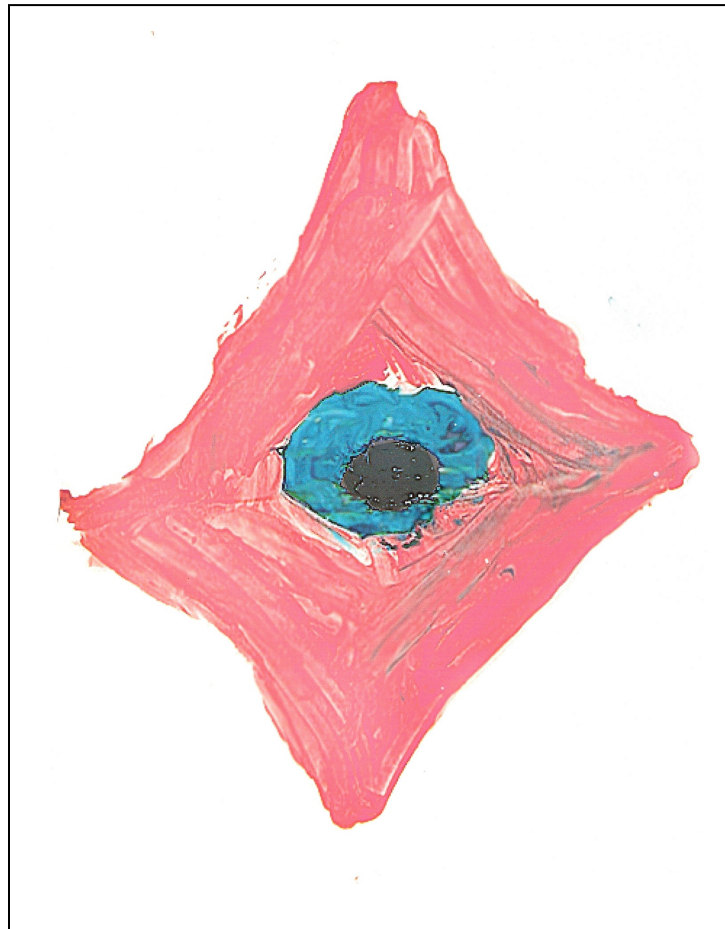
'Struggle and Triumph': Encounters 7-15

Encounter 7

Iris arrived late for her session. I was shocked to see her so different in comparison to our last encounter both emotionally and physically, she looked as she had done in our first encounter. She spoke in a weak and apologetic voice and blamed herself for her lateness. Her appearance was unkempt and her demeanour was sad, she was on the verge of crying and explained:

I am not feeling very well; my husband is away on Reserve Duty in the army. Today I saw a centipede in the garden. Of all insects, I hate them the most. Centipedes remind me of a time before the end of my pregnancy [sighing], *when we moved into a basement flat. My husband had had a bad accident and the flat was in a mess. It was in that damp, ugly basement, with no windows, that I caught sight of a centipede - it gave me an awful fright and I screamed. I somehow managed to put the creature into a jar, even though I wanted to kill it, and I threw it outside.*

Yesterday I was given a lift to work by a person from a nearby settlement. I talked to him about living in such a beautiful place with superb views of the lake. He said that nothing felt beautiful since his son had been killed in an accident in the army a month ago. I told him about losing my child. He said that his daughter had been born black due to lack of oxygen, but he, as a physician had been able to revive her. I felt miserable. When I returned home from work the whole mess of my life overwhelmed me. Although I have striven for more independence, I feel so alone and I miss my husband not being here to help me. I used to be so independent, even as a child I coped with being alone. My father was self-employed and I only saw him when we ate together at noon. Winter was the worst time of year, when my brothers, who were both several years older than me, went out and about with their friends. I somehow thought that I was used to being left alone in the house.

Iris's feelings of desolation and loneliness were overwhelming her and she wept. I was confused and almost cried. We stayed in a long silence. Presently, when her tears have abated, I suggested that she take a look around the room and choose some way of physically expressing her feelings at this moment. She rose slowly and with halting steps, her head bent over, she collapsed onto her knees and covered her head with her arms. She then cried for a long time and moved into the foetal position.

I gently asked her which part of her body would most powerfully describe her feelings, since I wanted her to acknowledge which part of her body is dominating her actions. She pointed to her stomach and explained that in English one's stomach or *'guts'* are also words related to *courage*. *'I feel as though I have been punched in my guts and I cannot catch my breath.'*

I asked Iris if she could give the feeling a name, which word would best describe that feeling. Iris explained that:

> *If a person gets a kick in the belly, it removes the air from their body and they double-over gasping for air.* [She then proceeded to demonstrate the kick-boxing action] *I feel emptied of air.*

I asked her if she could enact a statue of the emptiness she felt. She enacted a sad face with her shoulders bent over her sagging limbs. She rocked from side to side whilst leaning up against the wall for support. I then asked her to use her whole body to express the opposite of this 'emptiness.'

Iris moved into the centre of the room and stood with her arms wide, with one leg far in front of her and the other behind. Her back was straight whilst she stared upwards. I suggested that she act like a ballerina and jump-up in the air. We both laughed when Iris jumped in the air and she continued laughing. *'What would you call this expression?'* I asked. *"Freedom!"* she declared.

I asked her: *'Even though freedom is not exactly the opposite of emptiness, your movements portrayed that it is. What do you think?'* She said: *'I feel that a better word for "emptiness" would be "derelict", like a hopeless person whom no one cares about.'* She went on to say that *'freedom brings fullness which is the opposite of emptiness'.*

I then asked her what she would like to do with the issues that she had represented. Would she like to continue using her body, taking the roles of 'emptiness' and 'fullness' and making a dialogue between them? Iris created a play and two poems. Iris enacted both characters of her play which took only a few minutes. She acted as if she were on stage, her participation in both roles

involved language, facial expressions and different tones of voice, although they were inaudible to me.

She stood against a wall for a long time with her shoulders hunched and her body bent over, her body and face expressing sadness and misery as she rocked back and forth. Suddenly she left the wall and transformed herself into another character that had come to offer help to the first figure. Dramatically, she offered him help in the form of food and shelter, and hope for the future. Presently, I asked her how it felt for her to use movement to express her emotions. She said that she would like to continue working on the play at home. However, she did create two poems the first called '*Empty*':

<div align="center">

<u>Empty</u>

When an autumn leaf

golden rich

auburn

falls

lies and dies

crumples

crushed

beneath uncaring

careless feet

now its morsel

veins exposed

blacken

necromantic pose

ooze and slime

return to dust

where no one

must remember.

</div>

Iris read out her poem on emptiness in a hushed voice. We spoke at length about the significance of colour in nature, the circle of life and the significance of the earth beneath our feet, to which all life returns. She continued reading the next poem:

Freedom

It's hard to leap
like a gazelle
when trapped knee deep
in mud.

But maybe just
pulling yourself out -
crawling across it even
maybe just getting
flat
so you can roll away
is a kind of freedom
when compared to
cement slippers.

Don't fight too hard
you'll only get yourself in deeper
try to go with the flow.
Crawl on all fours
till you reach
that safe shore.
Then wash away the black goof,
then rest,
then dance,
then do,
and then she flew.

The meaning behind Iris's second poem was more difficult for her to talk about. We laughed together at how amazing creative energy is. How, without a script or direction one can create a meaningful dialogue.

Between Encounters 7 and 8

New evidence and data were surprisingly added to the regular encounters. They were presented in the Internet PTSD checklist, which Iris filled in between Encounters 7 and 8 and brought to show me in Encounter 8. It was her idea and initiative which reflected her strength despite her vulnerable, desolated situation. I regarded this information and especially the use of her own initiative as an important improvement in Iris' state (What is trauma? at the Self-injury site. Internet checklist of PTSD symptoms)

What is Trauma?

The psychiatric definition of 'trauma' is *'an event outside normal human experience'* (Martinson, 1996-2002)**.**

Trauma generally leaves you feeling powerless, helpless and paralysed. It tends to be sudden and overwhelming; it 'owns' you. You cannot think clearly during and after a severe trauma; at the same time, you are forced to focus your consciousness in any attempt to deal with it.

These phenomena refer to one-time traumatic events, but most of them also apply to prolonged, repeated traumas as well. Some instances of one-time trauma are: natural disaster, rape, assault, muggings robbery accidents, fires. The symptoms' definitions appeared in the on-line checklist and had been divided by Iris according to three periods in order to present the differences she saw and felt in her situation:

1   After the trauma, 10/1994;

2   Beginning of dramatherapy, 18/9/97;

3   Between Encounters 7 and 8, 6/11/97-14/11/97.

Table 16.1 shows Iris's description of her symptomatology at various stages, according to the checklist of the Internet source. The words marked with a star (*) describe the PTSD symptoms as they appeared in the Internet source (Martinson, 1996-2002).

Table 16.1

Iris's perspective on the question: What are the immediate effects of single—instance trauma? At different stages after her trauma

1 Emotional

1. <u>Immediately after the trauma</u> ***Shock, including numbed emotions, questioning of perception *memory disturbances** ***Denial, which helps reduce terror, helplessness, and fear of dying or being abandoned to manageable levels. *Confusion and disorientation.** ***Numbness. *Panic * Weeping. *Extreme anxiety and insecurity, *Inflexibility. *Dissociation, feelings of unreality**
2. <u>Beginning of therapy18/9/97</u> ***Questioning of perceptions**-*'couldn't distinguish between when I 'm feeling blame for something, and when I'm not to blame /have guilt'* ***Helplessness and fear of dying or being abandoned**,- *'Each time I saw babies, movies about pregnancy, bar- mitzvah circumcision I wept and felt extremely anxious and insecure. All the symptoms mentioned in section 1 happened to me each time I entered a hospital or when I was treated with fertility treatments I.V.F. I couldn't understand Hebrew, sometimes I couldn't even understand English or to talk'.*
3. <u>Situation after Encounter 7 6/11/97</u> ***Questioning of perceptions** – *'very different now*'.

2. Cognitive

1. *Disbelief, another protective device *Disorientation and confusion.*Difficulty thinking and concentrating *Unwanted thoughts - traumatic memories may intrude on everyday living and in dreams, leaving you out of control.*Perceptual problems the world may seem unsafe, unsteady, unpredictable, and unfair *Traumatic memories - intense, clear vivid images*Forgetfulness

2. ***Difficulty thinking and concentrating** – '*when I came here it was very horrible'*.

*Unwanted thoughts – *'traumatic memories till now, but less'*.

*Perceptual problems – *'I didn't realise that I was so attached to my home and my dog because I feared the world. The world seemed unsafe, unsteady, unpredictable and unfair'*.

*Traumatic memories and vivid images- *'Sometimes, almost disappear'*.

3. ***Difficulty thinking and concentrating-** *'It is still on-going, but now it is less intrinsic, more like I am watching a movie '*. * **Traumatic memories -** *'Sometimes still today*.

3. Hyper arousal

1***Trouble sleeping *Trouble concentrating *Heightened vigilance**—*'never experienced his symptom'*.

* Easily startling *Being wary *Sudden tears or anger or panic

*Increased alertness and anxiety

2 ***Sudden tears or anger or panic -***'Since the beginning after my daughter died, and it kept on coming back in hospital in I.V.F treatments. It continued to be more and more prevalent because the numbness disappeared. ***Increased alertness and anxiety** when I came here it was very horrific. It disturbed me a lot when it happened'*.

3. ****Trouble sleeping –** *'Sometimes, but less, didn't have nightmares like then, that people came to kill me*'.

4. Body

1.***Gastrointestinal symptoms *Headaches** – *'none'* ***Allergy symptoms** – *'none '* ***Menstrual problems**
2. *'***Gastrointestinal symptoms *Headaches** ***Allergy symptoms** –*Did not exist, none '*.
3. ***Menstrual problems** –*'None, good question, has a connection to the pregnancy issue'*

5. The Inevitable Review

1.***Trauma survivors spend a lot of time thinking about what they could have done differently. Truth is, they couldn't have done it differently - the body takes over. And the important thing is not what you did - it's that you survived**
2. *'Till now but less. When me and my husband had argues it came back very strongly*
3. *'None'*

I was surprised by her act of initiative and by the transformations that had occurred in Iris's state in such a short period.

Encounter 8

Iris looked much better than the last time although she was experiencing the same feelings of rejection and abandonment she experienced years ago when her husband worked away from home and she lost her baby. Iris told me that her husband did not understand her need to express her feelings:

> *When I am undergoing fertility treatment I am unable to control my emotions and all my fears of abandonment return. After I lost the baby I was treated by a psychologist who helped me control these feelings, but now these fertility treatments in hospital bring back all my wild emotions. I'm racked with guilt and cannot stop crying. I am tormented by self-*

doubt, I feel helpless and abandoned. I think this could stem from what happened to my parents.

I encourage Iris to talk about her feelings of abandonment by her parents:

My family does not deal with grief and abandonment. My father lost his father when he was eight years old; he and his mother were on their way back to Europe by boat, when they heard that he had been killed in a plane crash in America. My father only saw his father's grave for the first time when he was an adult.

My mother was about eight years old when her mother died in childbirth. My mother took care of her younger siblings until she was thirteen years old. At thirteen she travelled, on her own, from America to Europe to care for her sick grandmother. When my mother married she lost her first child, a girl, in stillbirth.

When I was nine years old my mother went out to work. I was left in the care of my brothers who were supposed to care for me, but they wanted to go out and play with their own friends. I was left alone. I adore my father. He has always been a source of comfort and would hug me and hold my hand, but when I was younger he was always too busy to spend time with us children.

I found it difficult to talk to my mother about my feelings. Before I came to Israel she gave me her mother's wedding ring, saying that when I touch it I will think of her. This made me cry but she acted as if it was unimportant, even though the ring must have been very precious to her. I think both of us are afraid to talk of our emotions to one another.

By keeping her emotions to herself Iris needed to find a way of expressing and sharing her inner world. I suggested that she should look for a theatre play that discussed issues of mothers and their daughters that were similar to her issues.

She added:

> In my native land I wrote scripts for television, I enjoyed the work enormously but we all would drink a lot together and I used to get depressed. Once I was abandoned by a boyfriend and was inconsolable. Also, when my husband and I moved into a new house I felt so lonely that I went to see a therapist. We discussed issues of emptiness and loneliness and alcoholism. That is when I started to write a play about an alcoholic. I also got myself a dog as a companion.

I asked whether she would like to remain in this moment and express some of these emotions by working in the sandbox. Iris laughingly took some figurers off the shelf, placed them in the sandbox and started to tell a story:

> This is the world of the penguin that lives alone in a white, icy cold wasteland. One day Penny, the penguin, woke up and looked around to discover that all the other penguins had vanished. They had gone to the iceberg and left Penny alone. Usually this would not bother Penny, but suddenly his eye caught sight of movement on the ice. Penny knew that ice does not move. There stood a big polar bear that could smell but not see the penguin.

> The penguin was scared when the bear started to move towards him. Penny thought of all the awful things that could happen to him, like in summer when big flies buzzed around his head and when he dreamt of monsters in his head. He wished that someone would help him, but he did not know who could. He remembered a scientist who had come to study him and had hung a metal monitor around his neck. He had fed Penny and left. The scientist did not really care about him he just wanted to use him to find out how penguins lived. The scientist always had a mascot with him that looked like a little bear. Penny liked the mascot and they got on well together. The scientist was more like a robot.

> Penny is sure that he is going to freeze to death because he is too afraid to move forward or backward. Behind him are high dangerous rocks and in front of him are dangerous pitfalls. The penguin realises he is in

trouble. At any moment the polar bear may catch sight of him. Penny hunches down and tries to become part of the scenery, he lays on his back so that his white belly blends-in with the snow. The penguin did not move and lay there for hours hoping that the danger would pass, shivering and wishing someone would help him get away, but no one did (see Picture 16.13 First Sandplay – 'The Lonely Penguin').

New strong somatic reactions emerged while Iris worked in the sandbox yawning constantly and sensing coldness. It was puzzling; therefore I asked her if she would like to tell the story in the first person, guiding her with these words: *'What feelings are aroused, are you protecting yourself? Do you feel the cold and the fear?'*

Yes, I am caught like the penguin; I ask myself, 'how can I get out of here?' I wish I did not feel so scared, maybe if I was stronger I could think of a solution. I'm feeling so cold and alone and far from help. They didn't tell me that there was no one to turn to; I didn't know they were leaving me alone!

Presently, the penguin thought - I will die of the cold or the bear will kill me. I have laid here waiting too long; will I stay here and die without a fight? I want to survive! Better to die fighting than to die for nothing. So he got up and saw that the bear was still there, but it didn't matter to him anymore. Slowly he started off in the direction in which he thought the other penguins had gone. It was a cold and difficult walk, but soon he felt stronger and started to run in the direction of the sea.

Finally, Penny the penguin jumps into the sea and immerses himself in the freedom of the water and joins all the other penguins.

Next time Penny will know that if he is left alone without protection he will survive. Both he (and I), have got the strength within ourselves to fight for our lives.

Picture 16.13: First Sandplay – 'The Lonely Penguin'

Encounter 9

At the beginning of this encounter Iris informed me, in a hushed voice, of the difficulty she was having with her fertility treatment (IVF). Whilst she was undergoing these impersonal and invasive treatments in hospital she felt isolated and abandoned. By enacting these emotions with figurines in the sandbox, Iris was able to visualise and verbalise her feelings of victimisation:

A year ago I started the IVF treatment programme. When I undergo this treatment, which creates a hormonal imbalance in my body, I feel victimised. Now, just thinking about my failure to get pregnant and repeating the whole process over again makes me go cold with dread. For me victims are people who do nothing to help themselves.

In situations where I have felt victimised I try to think of Joseph, from the Old Testament, who after being abandoned by his brothers and sold into slavery, arose out of his dejection and built an empire, in addition he fathered two of the Tribes of Israel. I also think of Hagar who is closer to my definition of a victim, who became the matriarch of a nation.

The personalities of my characters in the sandbox today incorporate elements of heroes and victims. Previously, the lonely Penguin represented this dichotomy; he was frozen and immobile, but his intellect and self-preservation forced him to take heroic action.

The big strong polar bear, also on his own, was not compelled to act, so he became a victim. I have tried to unite the characters and objects in the sandbox to create roles for all the characters. The Penguin, Strong Man and the Mouse go into the forest for a picnic. The tall trees and the dense greenery make them anxious. The Mouse declares that he senses a cat nearby. The Penguin tells him that it is more likely to be a Lion that is waiting to attack them all. The Strong Man (whose idea of fun is a fist-fight), declares heroically that he will fight and protect them all. Cautiously, they sit down and eat their picnic. The Penguin asks the Strong Man why he enjoys fighting. He replies that he only fights in self-

defence. But the Mouse thinks that something else must be bothering him, since he does enjoy fighting so much.

The Strong Man notices a Monkey hanging from one of the trees and the Mouse wants the Lion and the Monkey to join the picnic. No one wants the Lion, but the Monkey is welcomed. The Monkey has fun jumping from tree to tree while telling funny jokes. He jumps onto the Strong Man and tries to kiss him, then greedily makes off with all the sandwiches. The Strong Man tries to catch the Monkey without success. They then hear a noise that sounds like a Snake; the Mouse is afraid and asks for help. The Strong Man throws a rock at the snake and kills it.

They all want to leave the forest, however the Penguin cannot progress very fast on his feet and the Strong Man must carry him. Just then a hungry Lion appears. In order to save his friends, the Penguin wants to offer himself as a sacrifice, but they will not hear of it. The Mouse then advises the Strong Man to throw the dead snake at the Lion, which he does and the Lion is frightened away. Then the Strong Man summons a giant Fly to fly them far away to the island of Hawaii (see Picture 16.14 Second Sandplay – 'Heroes and Victims').

Following this sandbox story, Iris revealed several ideas concerning the characters and the role she saw herself playing in the story:

All the characters have negative qualities; the Penguin is aware that he has no hands, nor can he fly, also his ability to walk is limited. The Strong Man is always ready to fight his way out of every scenario. Ultimately, he is able to resolves the whole dilemma, not by fighting, but by summoning the Fly; a resolution that does not come from using his physical strength. The Monkey is a new character, even though he is a nuisance, he is free and can come and go as he pleases.

I see myself as playing the role of the Monkey. I can do whatever I want to do; I come and go as I please. I can leave the ground and leap from tree to tree and no one can stop me. But the Monkey did not go to Hawaii on the back of the giant Fly; he had to make his own way by boat. When

he arrives in Hawaii the others are glad to see him, they are all happy to play together on the beach and in the sea.

Today I present a more intentional connection between the characters, they each become interdependent. The Penguin no longer has to fight his battles alone and even the tiny Mouse has the capacity to help the group survive. I feel that this week's activity in the sandbox is more satisfying and enjoyable than last week's. I did not feel intimidated by the presence of the Snake nor of the Lion, since I knew that somehow the group would be able to save themselves from these life threatening dangers. These friends are no longer lonely individuals who lack confidence in themselves and have to fight their battles alone; when the group is working together they are very strong.

I had noticed that the yawning and the sense of being cold had appeared again while she was working in the sand tray. Nevertheless, Iris left the encounter feeling empowered by the feelings of strength and freedom she had awakened from within herself.

16.14 Second sandplay- 'Heroes and Victims

Encounter 10

Iris continued to experience feelings of anguish in her private and professional life that sometimes overwhelmed her:

I live in chaos, my mind and body are constantly in a state of confusion, and even my dreams are troubled and negative. I have taken on projects at work that I do not have the time or energy to carry out properly. In my native land I used to know what to do and how to reach my goals, but here success seems to elude me. I would like to talk to my co-workers about it, but I feel intimidated by their attitudes towards me. I am sure they do not want to listen to me questioning myself, and I do not want their pity. I just cannot cope with life!

I suggested that perhaps it was the pressure of work that had brought about this imbalance in her emotions, or maybe it was the other way around. Iris was still suffering from the symptoms of post-traumatic stress disorder and she needed to be kind to herself. I advised her to relax and tell a story using the illustrated *Persona Face Cards* to express her present discontent with life:

The blue face is that of an alien. I am that alien. I feel I should be moving forward and realising my dreams. But I am not. My life is not at all as it should be.

Once upon a time an alien landed on earth from a far away planet. He could not return home because his space ship was wrecked when he landed. He looked around for assistance, but the inhabitants would not speak to him and kept their distance.

The alien came from a world that was entirely blue. This blue world was calm and bluetiful; he called it 'bluetiful' and everyone was kind to one another there. He suddenly experienced pangs of hunger, whereas, on his planet this did not happen, since provisions came from the sky and were absorbed into one's body without having to eat or drink.

He arrived at a Chinese snack bar where the waitress, a tired looking Chinese girl, was very kind to him. However, she told him she was not

his friend; it was her job to be nice to the customers. He added that all Chinese people must be very fond of her, because she is one of them. She replied, 'no!' they were not all fond of her. 'Well, maybe you are not one of them; maybe you are one of us!' She laughed and brought him food.

All the strange colours around him made him nervous, but he continued on his journey, until he saw in the window of an art gallery, a painting called 'Girl in Blue.' He immediately wanted this blue painting because it reminded him of home, but he did not have any money to purchase it.

The alien decided to go to a university science laboratory to find the solution to his predicament. However, he accidentally walked onto the sports field and was nearly hit by a javelin thrown by one of the athletes. The athlete apologised and gave the alien a drink and explained that he was training for the Olympics. The athlete inquired where the alien wanted to go and agreed to take him to the science lab. He told the alien that he could not decide whether to focus his attention on sport, or become a scientist, 'I do not know whether it is best for me to run around a track for the rest of my life, or to go to the moon.' The alien told him that he had been to the moon and it was overrated, the athlete was amused.

The athlete introduced the alien to his science professor, who was thrilled to meet someone from another planet. The alien was very pleased too, to meet someone who welcomed him. The professor introduced him to his secretary and her son. They all explained to him that on earth when a person says they feel 'blue' it means that he feels sad. The professor made up alien jokes about the blue planet and finally the alien started to laugh and the professor showed him how jokes make people feel good.

This was a new concept to the alien who considered taking these jokes back with him to his planet. When he recalled that his space-ship was totally lost, he felt blue again even though his new friends did not want him to leave earth. The athlete talked about his girlfriend, and the alien

told them that they do not have an opposite sex on the blue planet. The athlete considered the blue planet to be very dull place, whereas the alien thought earth was a very chaotic place.

They all wanted the alien to feel at home on earth, so the professor's secretary invited him to lunch to meet some of her female friends. One of her friends was from India and was dressed in a traditional sari, and the other worked as an upmarket executive in an advertising agency. The Indian lady enjoyed the alien's company and told him that in India there are people like him called yogis, whose spirit travels from place to place. The advertising executive added that in her business too there were people who did the same, only they did not know what they were doing! The alien realised that jokes are not always intended to be funny; in fact sometimes they can be cruel.

He became anxious when he realised he could not get back to his own planet, but the beautiful Indian lady, whom he liked, offered to take him home with her. She admired him and felt that they could live happily together on earth. Whereas, in the beginning he had felt lonely and helpless; a victim of circumstances beyond his control, these negative feelings disappeared after having experienced laughter with friends who helped him feel at home (see all the characters from the Persona Cards below in Pictures 17.15, 17.16 and 17.17).

When she finished the story, Iris looked relaxed and felt loose. Her imagination, creativity and the talent for telling stories amazed me once again.

Picture16.15 Persona Cards – 'The Alien' (1)
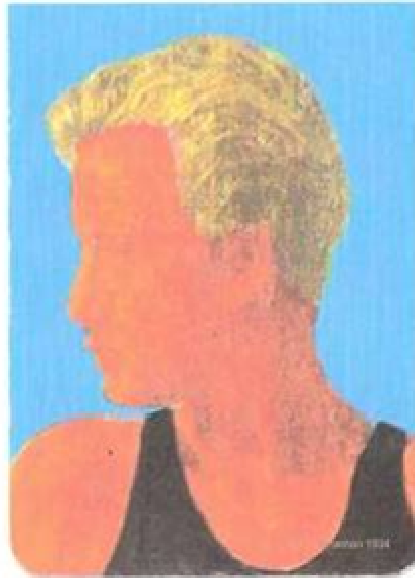
The Alien   The Athlete   The Science Professor

Picture 16.16 Persona Cards – 'The Alien' (2)

The Indian Friend   The Son   The Secretary

The Waitress   The Advertising Executive   The Painting 'Girl in Blue'

Encounter 11

Although Iris was tired after a tough week at work, she recalled our last session together:

The image of the Advertising Executive, from the Face Cards in our last session, has stayed in my mind all week. I see myself as this self-confident persona. I do not like her, but I admire her professional exterior. I feel that she is too cynical and aloof to be part of my own character, but maybe her cynical expression is an essential part of surviving in the cut-throat world of advertising. I see that I was driven by ambition like the Advertising Executive. She is helping me become a sensible manager of my talent.

But I have become disillusioned with overbearing clients, who demand that I provide them with evidence that I know what I am doing, when they clearly do not know anything about advertising themselves! I have always prided myself on giving my clients my all. Now I realise that I give them too much of myself and they neither want nor appreciate my best work. These days I feel I do not belong in the heartless world of advertising.

This Face Card reminds me of a time when I felt I knew it all. Since then, life has taught me so many painful lessons that have battered my self-confidence. Or did it just go underground after so many failures and disappointments?

You have said that fertility treatment is not your field, but I do feel, that if I can find a way to manage the stress of my professional life, as well as the grief of my baby's death, then I think I have a good chance of getting pregnant.

Iris turned to the sand tray arranged the figurines, started to yawn and felt cold. She told a new story (see Picture 16.18 Third Sandplay – 'Happy Today'):

I have placed a Soldier in the sandbox today; he is lost and is wandering alone in the desert. He is concerned that he will be caught by the enemy before he reaches his army camp. He comes across a camel and together they walk through the searing heat of the day. The Soldier sees a Man and shouts: 'halt, who goes there?' The Strong Man explains that he has come to help the Soldier find his way. But the Soldier is concerned that the Strong Man is insufficiently dressed against the sun. The Man declares that he is so strong that he does not need the protection of clothes. But the Soldier is adamant and explains that the power of the sun is stronger than he is, and he could die.

Just then a snake slithers by, the Strong Man wants to kill it with his bare hands, but the soldier raises his rifle and shoots the snake dead. The Soldier says that a clever person never touches a snake. The Strong Man heeds the Soldier's good advice and also accepts a cover to shield his head and shoulders from the rays of the sun. The Soldier tells the Strong Man that he would do well to join the army.

Together they spy a Monkey. The Soldier wants to kill it to provide food for them both, but the Strong Man disagrees; he thinks that monkeys are clever and that they know things that humans do not.

The Monkey is clever and tries to barter for his life; he offers to be their guide. The Soldier declares that they do not need a guide, he has a compass. The Monkey informs them that he has information that is worth the price of his life, eventually the Soldier agrees to spare the Monkey's life. The grateful Monkey tells the Soldier that they are standing on a magnetic rock which points his compass in the wrong direction, into enemy hands. The Monkey also knows the territory well and tells them where all the water holes are. He guides them back safely to the army encampment.

On his return, the Soldier reports to his superior that he lost his way. The Soldier then learns that the Monkey was sent out to find him. The army officer explains that he could not spare another soldier, so he sent a monkey who knew the territory, to bring the Soldier back to base. The Monkey adds that the Soldier is an idiot because he wanted to kill him.

Later, when they all sat down together to eat and drink, the officer informed them that they are moving to a new encampment called 'Happy Today.' The Strong Man offers to carry everything the officer wants to be moved. But the officer informs him that the army needs more than a man's strength. Then, by the power of magic, a magician transforms the Strong Man into a leader who is strong, capable and intelligent.

Iris explains that 'Happy Today' is not only a place but a state of mind. It is the place that she is trying to reach.

Picture 16.18 Third Sandplay-'Happy Today'

After this encounter, I asked Iris if she would like to answer the diagnostic criteria for Posttraumatic Stress Disorder as they appeared in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders DSMIV* (1994:427-429). I was interested in her responses according to a reliable source after she had related to the Internet check-list a few encounters ago; and I also wanted to compare any alterations in her symptoms since then. This official reliable and valid source, constituted additional data reflecting the improvement, positive transformations and the reduced symptoms in Iris's situation. Iris filled it up between the eleventh and the twelfth encounter.

The following criteria were adopted from the *DSMIV* (1994:427-429) PTSD criteria which are divided into six areas.

A. The person has been exposed to traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others

2. The person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions

2. Recurrent distressing dreams of the event

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episode, including those that occur on awakening or when intoxicated)

4. Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

5. Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings or conversations associated with the trauma

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma

3. Inability to recall an important aspect of the trauma markedly diminished interest or participation in significant activities

4. Feeling of detachment or estrangement from others restrict range of affect(e.g., unable to have loving feelings)

5. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep

2. Irritability or outbursts of anger

3. Difficulty concentrating

4. Hypervigilance

5. Exaggerated startle response

E. Duration of disturbance (symptoms in Criteria B, C and D) is more than a month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more duration of disturbance 3 years.

Specify if: With delayed onset, if onset of symptoms is at least 6 months after the stressor.

Table 16.2 documents Iris's reflections on the PTSD criterions as they appeared in the *DSMIV* (1994). She referred to them as two periods, firstly, after the trauma (1994) and when the dramatherapy started (18/9/97); and secondly Encounters 11 and 12 (11/12/97-25/12/97) after 3 months of treatment. Her reflections were significant evidence that brought to light the real experience of a mother who had experienced stillbirth; accurately describing the occurrences in ways that extended beyond the generally monotonous language of the official criteria.

The following table, Table 16.2 provides her detailed consideration of these criteria and the extent to which they described her situation for the two different periods.

Table 16.2 Iris's two descriptions of *DSMIV* criteria and her feelings

DSMIV Category	After the trauma (1994) and at the beginning of treatment (18/9/97)	Now, between Encounters 11 and 12 (11/12/97- 25/12/97) 3 months after treatment began
A 1	'It was a fact that my baby died, completely unexpectedly, and was stillborn in the 41st week. Thus I witnessed and experienced her life and death directly and personally and the horror of delivering a body, not a living baby.'	'It is still a fact that my baby died'.
2	'At the <u>time,</u> I felt a great sense of helplessness because I couldn't help or save my baby and I couldn't escape from the reality of having to deliver her dead. This was also horrific. (Note: my mother's first baby –also a girl-was also stillborn. I think there were additional levels of fear or helplessness because this family tragedy had occurred in 2 generations) The sense of helplessness subsequently permeated my life- particularly (but not only) in any medical setting, but also in stressful situations where meeting new clients I would suddenly be unable to concentrate, and my ability to speak or understand Hebrew would vanish suddenly, I would started breathing shallowly and would not be able to write afterwards - couldn't remember and couldn't create – and couldn't focus. These symptoms were the reason I sought help (particularly after breaking down completely in an IVF treatment) and after several work failures and clients' dissatisfaction. Also my husband told me I was 'crazy for acting this way.'	'I can now attend medical clinics without such problems - I still have some flashbacks but the anxiety attacks have virtually vanished. My work has returned to its professional level and only in very rare circumstances (when I am caught unawares with questions about children or marriage) do I feel any such anxiety or do I start to 'lose it '.Also, today I can simply fend off overly curious Israelis by telling them LIES (which I could never do before). I just lie and tell them I have 2 children who are in the army or that I just got married last month'.

B 1	*'All'*	*'Almost none'*
2	'Random dreams but very graphic nightmares that 'they wanted to kill me'*.	'No more dreams like this, even had dreams where I woke up laughing'.
3	'Flashbacks, especially in medical settings of IVF, or near newborn babies, but also all the time'.	'Very few flashbacks and they do not make me agitated-I am an outside observer'.
4	'Intense, psychological distress sudden inability to speak or understand Hebrew, shaking, crying'.	'Sometimes I feel uncomfortable but I am able to take care of myself (leave, change the topic etc.)'.
5	'Physical reactions'.	'Minor anxiety at hospital breathing quickens and rubbing of hands'.
C 1	'Efforts made to avoid thoughts in all setting except writing - for myself, and letters to friends'	'Only avoid jerks'.
2	'Avoided everyone I could'.	'Now even go to circumcision ceremonies'.
3	'Remembered every detail'.	'Still remember'.
4	'Did not care about anything or anyone but my dog'.	'Have new jobs and new friends and new interests, found courage to go to home to my home land'.
5	'Really felt alien all the time'.	'Feel different but not an outsider or strange'.
6	'Big marital troubles'.	'Marriage dramatically improved'.
7	'Felt there was very little use in most things'.	'Still feel life is short, but now I try to enjoy it more, minute -by-minute'.
D1	'Sleep was OK except the nightmares'.	'Sleep great'.
2	''Was very edgy and angry'.	'Seldom'.
3	'Very hard to concentrate'.	'Can focus intensely whenever I want'.
4	'Hyper-vigilance'	'Comfortable'.
5	'Really jumpy. My husband used to get mad at me for "overacting" or "over reacting" '.	'Now normal reaction'.

Again I was surprised, that despite recurrent repeated complaints, Iris reported such meaningful changes and pointed out that several symptoms had vanished.

Encounter 12

Iris had shed her last vestige of embarrassment at working in the sandbox, which she had considered to be childlike, and was enjoying being able to empower her sandbox characters:

> *This Monkey will instinctively poke fun at the serious side of life by performing acrobatics and amusing his audience. He performs tricks and shows-off in front of anyone who will pay attention to him, just as I like to do! However, the Commanding Officer has a serious job. He cannot joke around, his orders must be obeyed. He has to set tough objectives for his men and must inspire them to achieve their goals. He needs to keep his men going forward and to make sure they reach the 'Happy Today' camp. He motivates them by giving them incentives and challenges that will push them towards their objectives.*

> *However, his men are grumbling and complaining and oppose his orders. They claim that it is too much effort and hard work to move to another camp. They are happy enough to stay where they are and idle away their time. They need to be persuaded to work harder to make their situation better and achieve something for themselves.*

> *Also, it is the Officer's responsibility to convince his men that their tasks and duties are fine and worthwhile accomplishments and not necessarily unpleasant work that they are forced to do. He wants to help them to work together and move forward to forge better lives for themselves. The Officer further explains that if they stay where they are they will achieve nothing in life. Later, when they have performed their duties they will be entitled to take time off to rest and relax* (see Picture 16.19 Fourth Sandplay – 'The Commanding Officer')*.*

Once again the yawning and coldness had appeared when Iris played with the figurines and told the story.

I feel that the Commanding Officer is a part of me, at least a part of my professional life; I go for my objectives, like men do. I have got the guts to do so because I am good at working independently. I have found a new place of work that I really enjoy and I get a lot of positive feed-back from it. But, at the end of the day I feel annoyed that I am pouring so much of my time and energy into work.

In my private life I am often told that miracles can happen and I will still conceive a child. I am a woman who genuinely believes that to be a mother of a child is the most important thing in the world. I feel stunned and empty without a child. However, I am dependent upon my husband, and yet I am resentful that my husband does not always support me with the IVF treatments. Sometimes, even when he is physically present in the hospital, I feel that emotionally he is indifferent to my feelings. Now, I realise that he simply does not in actual fact know how much I suffer, both physically and psychologically, in order to conceive a child by IVF. I do not get much in the way of feed-back from this part of my life, the treatments are a huge burden on our resources and I am still not pregnant.

Sadly, at the back of my mind is the nagging concern that failure to produce a child is grounds for divorce, and I could lose my husband too. Regardless of outside opinions, I am now totally aware that both my husband and I are doing the best we can, in our own way, under these difficult circumstances that we both face.

I felt overwhelmed hearing the powerful pain she expressed and doubted my ability to help her in such an afflicted, continually recurring situation.

Picture 16.19 Fourth Sandplay- 'The Commanding Officer'

Encounter 13

Iris looked more energetic when she arrived.

Good morning, I am pleased to tell you that my new job is going really well. I am at last using my artistic talents, and I enjoy working with my new crew. The bosses appreciate my efforts since I am very committed to the job. However, I sometimes become a little obsessive and I find myself working all hours of the day and night.

On the home front, a male friend came to stay with us and he broached the subject of my childlessness. Because of the position I am in, I am forced to listen to everybody's opinions and remedies concerning conception. This friend was very tactless and insisted that I was not doing enough to produce a child. My husband and I ended up bickering about our commitments; I cited his indifference, at times, to my feelings and his lack of support. He had promised to help and support me, but I feel that he has not always been there when I have needed him.

He hides his feeling behind his obligations towards his work, which according to him, provides funding for our lifestyle and IVF treatments. However, he did add that he does not know who I am when I become so distraught over the IVF treatments. He sees only my dark side and does not know how to placate me.

I find it difficult to sympathise with my husband. I feel that the IVF treatments have become my sole responsibility. Sometimes I feel I would be better off not relying on him to be there to support me, especially as he does not want to become emotionally involved.

He does not share the same vision of family that I have. I am separated from my family abroad, and he is my only connection to my future family, my children. He does not see that we both are going to have to experience unpleasantness (not just me), to achieve our future together. This is a taboo subject with my husband. Now he is angry that his friends

know his private business, and angry at me for saying anything to people who know him.

Working through these issues with you really helps me understand his point of view, because if I did not understand it, I would abandon hope of ever reaching my goal. Sometimes it all gets too much to cope with. Life is not unfolding the way I assumed it would; I want to scream 'IT'S NOT FAIR'. It is as if, when you are down, people, my husband, our friends, kick you simply because they can. I feel threatened by his attitude towards me. Sometimes he and his friends treat me like an enemy.

I have to face the fact that some women have IVF treatment and never succeed in becoming pregnant. Yet, there are others who eat all the wrong foods, smoke, do drugs or alcohol, and nevertheless have no problem conceiving a child.

Until now the IVF treatments have cost us a lot of money. Now it transpires that the clinic is saying that my age is a major factor in whether I can continue or not. When I lived abroad I was defrauded by a client I worked with and was left bankrupt. This person messed up my life and I did not know what to do except to go forward, even though I was constantly afraid of failure.

Then I tried to help her to connect with the last sessions and asked her who she would like to associate her character with in the sandbox.

I associate my character with the character of the Commander in the sandbox. I would like to call him Mark. He is a young, smart career soldier, who is adaptable because he has experience in difficult situations. Adaptability and flexibility are his most important assets. He commands a small unit, like a Special Force. They go into a situation, a tight spot, and then get out quickly. As commander, he has to make his own plan and make important decisions in the field. These decisions may be contrary to his senior officer's orders, but he is flexible enough to adapt his prior orders to suit each new situation.

Iris told me about her employment and how it paralleled army life. I asked her if she had ever used that working role in her personal life. She confessed that she had not. She was confident in her working abilities, yet happy to close the door on work at the end of the work day.

> At work I know what is best for me, the team and the project. Sometimes, in order to meet deadlines, I must keep the crew working late, against their will. At home I do not want to be responsible for those hard decisions. Ideally, I feel my husband should take a dominant male role and make the major decisions. The Commander is teaching me to rethink my old fashioned attitude; this is the moment when I have to change my thought pattern.

> It comes as a surprise to realise that I have always expected my husband to be strong, and to know better than I do about major issues. His criticism of me struck in a place where I am most vulnerable. I felt threatened by his criticism. So, instead of wallowing in self-pity, I know I have to take charge and say that we must continue on until the job is finished. Even if it is against his will at present.

> I feel a sense of freedom when I say that I am going to take charge of my strategy in the IVF programme, because I have always felt like a victim. I have always bowed to my husband's better judgement and doubted myself. I will use the persona of the Commander, who is my shield of armour; I will give him shape and strength in my life. The person I used to be, in my early life, used to be strong and independent. However, nowadays I am dependent on my husband for so much, to the extent that I have given him control over my life. I want to take control of all these issues that are making my life very difficult. It gives me great self-confidence to think that I could take on the role of the Commander at home.

Iris was continuing to build up her strength to take control of her life, adopting new roles through the sandplay symbols that she regarded as significant progress, as was her new job.

Encounter 14

Lively, Iris began immediately:

I am very excited to tell you that, in my efforts to have a child, I have decided to start another form of treatment in the form of artificial insemination by a doctor. I still need daily injections, but my husband is giving them to me. I am pleased that I do not have to undergo general anaesthetic in hospital for this treatment. It is not as reliable as IVF, but the chances of getting pregnant are higher. I have read a lot of good things about it on the Internet and the success rate is higher than that of IVF for people of my age group.

I was supposed to start the treatment already, but first I had to go to a gynaecologist to have my ovaries checked for cysts. Whilst at the local clinic, my husband and I became tangled up in bureaucracy. We encountered several people who told us that we were in the wrong place at the wrong time. When we eventually reached the doctor, she was also accusative and said, 'Why don't you organise your life better!'

A while ago I would have had a list of excuses ready to justify myself and have started crying. But, what actually happened was that I got as close as I could to her and said with fury in my voice; 'who do you think you are, I came here to do a medical examination, who are you to tell me how to organise my life!' She was taken aback and said 'I don't need this from you' and I replied 'I, don't need this from you either.' Then my husband butted into the conversation and angrily wanted to know why the doctor was making stupid remarks. I am happy to say that because I stood my ground, she performed the examination.

Afterwards, when we had to fill out my health insurance forms there was another disagreement over the tests the clinic claimed they had performed. My husband became involved again because we had to pay out money unnecessarily; my simple medical procedure had become a bureaucratic hurdle. Anyway it transpires that, according to the ultra-

sound, I do have a cyst on my ovaries; it could be preventing me from conceiving.

However, I was very proud of the way I responded to the doctor's criticism; I felt powerful standing up for myself and claiming my right to be there. I also liked the feeling that my husband was there to back me up. I have noticed that since my language skills are not totally fluent; people often assume I am stupid because I cannot articulate all my thoughts.

Now that I have gained a certain amount of self-confidence I am aware that I live with the sword of Damocles over my head. Firstly, I am now 43 years of age and am getting beyond child bearing age.

Also, there are cracks in my marriage due to the constant stresses we endure. Lastly, is that I am now afraid of the prospect of becoming pregnant with another child at my age; I do not know if I will be able to bounce back physically and mentally as I was once able to do.

I fear I will be unable to handle pregnancy. In my mind, pregnancy is no longer a happy carefree experience, now it is fraught with dangers for both mothers and babies. I am concerned that what happened to me before can happen again, both my mother and I have suffered loss through still-birth. Life is so fragile. I shudder at the thought of more suffering.

Impressed by what she had told me, I said:

In order to push aside the distressing thoughts and bad memories that plague you, you require a shining star. I suggest that you evoke one of your new role models next time you require strength and hold on to the thought of what they would do in those circumstances.

We then had a long conversation before Iris again started working on the sandbox. Iris worked with her body without music. She was sitting on the carpet all bent over with her head very near to the carpet and her hands above her head. After staying a while in this position she started to take out one hand and

slowly raised it. Then she raised the second hand and slowly tensed her hands one after another with closed, clenched fists. Slowly she started to get up, all her limbs were tight and all her muscles were noticeable and much effort was appreciable in every movement. It looked as though she was climbing from some place with strength and effort, as if someone stretched her from above.

She worked in the sandbox for the fifth time. She didn't change the sand's position only chose the objects, working for a long time on this day. She said she wanted to put in other characters and not to use the old ones from the previous encounters (see Picture 16.20 Fifth Sandplay – 'The Magician'). She was yawning a lot before starting to work and during her work her yawning increased without stopping. The big black spider was thrown out of the sandbox after the mouse had slipped away from him. At the end she again took the spider and stepped on it

> *This is something I always wanted to do this is the director from my homeland who torpedoed my work and that's it now he's dead'*

Unfortunately this sandbox story was completely inaudible on the tape-recording so that it could not be transcribed. Finally, I gently guided her in a relaxation exercise with music:

> *The pure blue water and the sun's rays are cleansing you entirely, from top to bottom and leaving you very calm and peaceful; without any pains and without the things you want to get rid of. You remain only with good, pleasant feelings and your body is relaxed as you deserve.*

She said that she heard me but she felt as if she was in a trance, she didn't know where she had been … to me she looked as if she was falling asleep.

Picture 16.20 Fifth Sandplay - 'The Magician'

Encounter 15

Iris's energetic appearance was an encouraging sign; she went straightaway to work with the objects in the sandbox. Whilst she worked she articulated her thoughts:

This is the story about the road to the future. It starts from a place of memory; here some of the saddest things happened, yet also, some of the best things happened. This is a beautiful, little secure garden. Within the garden there was once a big, heavy rock, the rock was difficult to accept and look at.

Today the dark and heavy rock reverberates with colour. It has become a beautiful monument that vibrates with life. The garden has taken on elements of colours. It is imbued with spirits. These colourful spirits have limited but positive power.

I am able to go forward into my power station, where I can write and use all my creative talents. A powerful light, mystical energy emanates from this vibrant blue place that nurtures my power.

The magician is coming along with me, just for the sheer enjoyment; we can create together. Even though there may be problems, we are going to take it easy and enjoy ourselves together. Free to roam, the pressure has gone; we have laid down our burdens and left them behind us. We are as free as the spirits of the air. Now, is our time, we are going to enjoy the rewards of life, professionally and soulfully.

We have the company of a friendly elephant who will provide his stamina for our move forward. He will never forget the past that has brought us here. He has imbued us with faith and power to get us what we want and to go where we want to go. We are now able to imagine the possibilities life offers. Now we have the freedom to start on our journey together (see Picture 16.21 Sixth Sandplay – 'The Road to the Future')*.*

Iris explained the roles she had projected through her work:

Today I am not tired, I feel inspired to create. There is no battle raging inside of me, I have colour in my life now.

There are new facets to my being and each one symbolises something else. We have talked about the body having a memory, now my body will have something else to remember.

The elephant and the bird are symbols of earth and air. The bird is hope, leading the way, rising up like a Phoenix out of the ashes, out of the pain of the past. This is my way out of the ashes. The bird needs the trees and air just as I need my freedom; I have lived too much in my head, in my own thoughts without expressing them. I have set my thoughts free to fly like a bird in the sky.

Definitely Iris expressed new themes and strength, a serious change from our former encounters. I thought that she might be ready to terminate the therapy and asked for her opinion. Iris wanted to continue for a while, since she intended to reconstruct her creativity and energy.

Picture 16.21 Sixth Sandplay – 'The Road to The Future'

'Reborn': Encounters 16-20

Encounter 16

After two weeks during which we had not met, I was happy to see Iris in a good mood. Following her body work in free movement, according to her feelings, Iris drew two pictures with coloured crayons. One was of a rather menacing male, (see Picture 16:22 Crayon Drawing - 'Security Guard') and the second of a girl fleeing (see Picture 16.23 Crayon Drawing – 'The Fleeing Girl') both opposite roles that had appeared in her movement. She explained them by telling a story:

> In my later life my potential and creativity has been restricted by a very special Security Guard. His job was very clear to him; protect this girl from the pain of great or high expectations.

> In the big, wide world it is always possible to fail, maybe more possible to fail than to succeed. So, instead of trying to succeed the Guard kept her safe and kept her from failing. That is how the Security Guard understood his job. He also loved her creativity and potential, but he guarded it so that no one else ever saw it.

> The 'idea' stage was not a problem, because ideas do not involve action. But, the Guard would not allow Creativity to move on, because it was too dangerous. Therefore, he said it is much better to shut it down early on in the process, so that there would not be any nasty incidences like rejection or failure, which would dash her hopes. Nowadays, the Security Guard tries to stop Creativity on her way out of the door; he likes to keep Creativity at home 'where she belongs.'

> But, today my new General Manager stood by the door and said 'there is no reason for Creativity to stay at home.' In fact the General Manager promoted Creativity to an external leadership role. He then demoted the Security Guard to a position where he had to keep an eye on all the small projects. The Guard used to feel so smart watching out for every detail of Creativity's existence. Creativity used to feel so frustrated, constantly halted by his protection.

The Manager realised that the Guard had not been doing his job correctly; the Guard had been too diligent. Creativity had never left home, even when it was vital that she should. He had been overdoing his protectiveness to the point where Creativity was destined to fail, become demoralised and give up. The Security Guard had prevented Creativity from growing and developing and using her talents for the benefit of all. Naturally the Guard was very disappointed to be demoted in this way.

The General Manager hopes he will realise the value of his new job and will concern himself with real security issues. The General Manager was surprised by the Guard's incredible ignorance regarding his job description. Luckily he realises that it is not too late, the doors are open and Creativity can move on and grow. She is smart and experienced enough to look out for her own pitfalls on the road ahead of her. Creativity flees as fast as she can on the road to freedom, to fulfil her destiny, whatever it may be.

This was a moment of profound and productive awareness for Iris.

Picture16.22 Crayon Drawing - 'Security Guard'

Picture16.23 Crayon Drawing - 'The fleeing girl'

Encounter 17

Iris arrived early. She was smiling and happy, she told me that her new job was very fulfilling. I handed her an article about a book written by a woman who had experienced stillbirth. Upon reading it, she dissolved into tears and her good mood vanished. I felt guilty for causing her unnecessary suffering. She wept for a long time, identifying completely with this mother. I asked her how she would like to express her own pain.

She chose to draw with crayons and wept while she drew (see Picture 16.24 Crayon Drawing 'Me in my Garden). She explained:

> *This is a picture of me sitting in my garden. Opposite me is a big tree with flowers growing around it; this is the memorial I created for my child. I did not know that the black stone was so large; I thought it was smaller. I feel guilty that for two months I have not had the time or energy to tend the garden.*

I asked her what role or character would she like to add to the drawing that would help her and act as her inner guide.

> *I would like to add the face of the Indian woman from the Face Cards. Her face gives me the impression of acceptance; it emanates a relaxed peacefulness* (see Picture 16.25 Persona Cards – 'The Indian Woman')*.*

The colours in Iris's drawing matched those of the Indian woman's Face Card, except for her dominant colour, yellow. Iris stopped weeping and added a figure radiating yellow light to her drawing. Whilst she drew, I was reminded of the Angel Meditation Cards and invited her to use them. She selected four Meditation Cards without examining them; Kindness, Flexibility, Harmony and Power (see Picture 16.26 Four Angel Meditation Cards). Kindness and Flexibility both have an identical figure in them and both cards closely resembled the colours and landscape of her drawing. She added these four powerful words to her drawing. She smiled at the results and her good mood was restored.

Picture 16.24 Crayon Drawing - 'Me in My Garden'

Picture 16.25 Persona Cards - 'The Indian woman'

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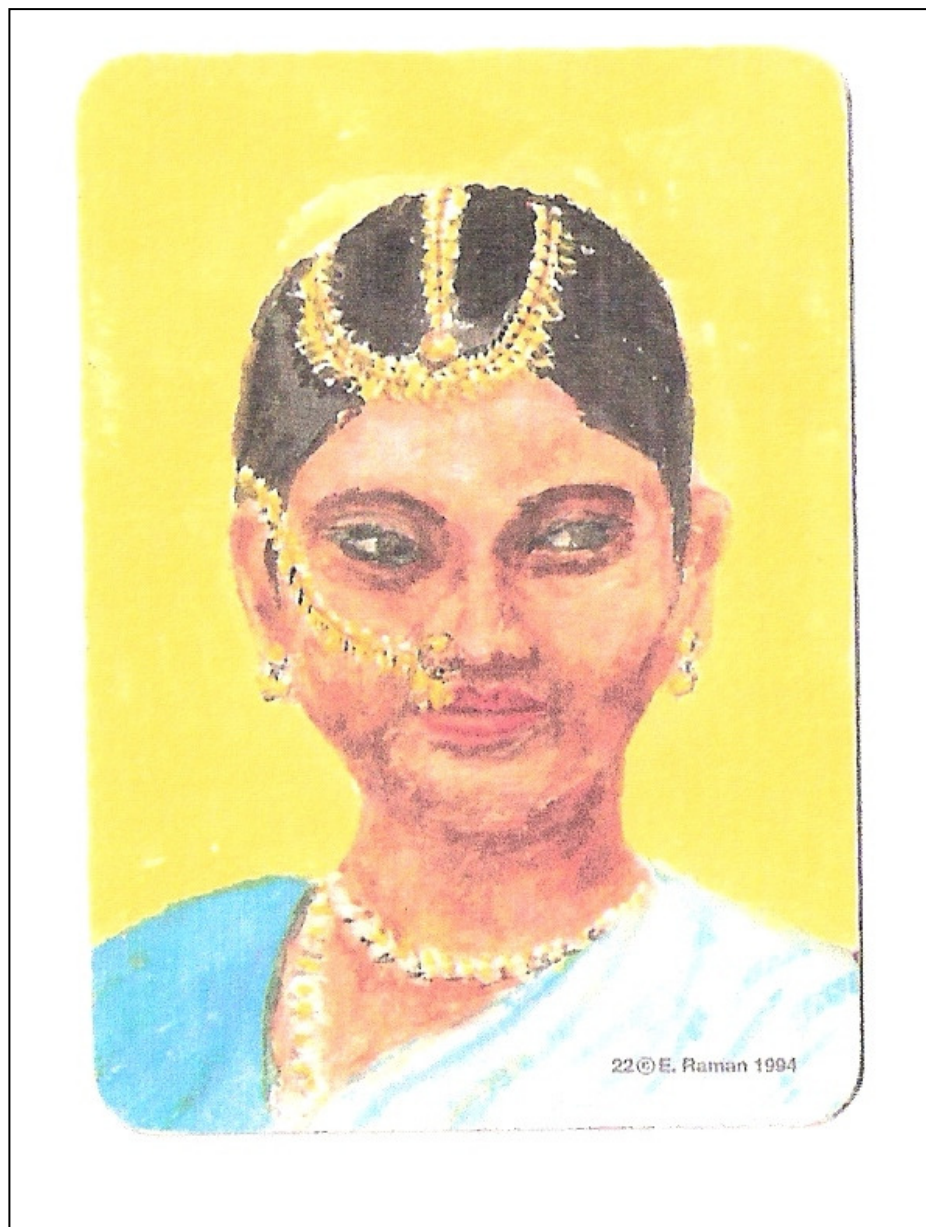
Picture16.26 Four Angel Meditation Cards

The Angel of Harmony

I am living in harmony with universal laws; I am creating harmony at each moment of my life.

To be in harmony with the Universe is to live in tune with joy, love, and spiritual power. As we learn to live in tune with the universal laws, we realize that we are an inextricable part of Nature. People who live together in total support of each other open the way so Angels' spiritual energies can flow in their lives and bring harmony.

The Angel of Purpose

I cooperate joyfully with the purpose of my life.

When we have a purpose, our Soul's work is accomplished in the best way possible through our bodies and personalities. A clear purpose gives no room for doubt because we identify immediately with all that leads us toward our goal. We become aware of all that would turn us away from it. The flow of energies in our lives is immense when a clear purpose is always present. Do you know what is your purpose in life?

The Angel of Power

Infinite Power, heal me! In my real beingness I am strong, happy, and peaceful.

Our Soul's power is revealed to the personality as a clear purpose and the capacity to decide for the good of everyone involved in a situation. Soul power is never over someone or something. It is a power shared with all involved. That means a sharing of spiritual blessings that emerge when we tune in to the divine purpose of our lives.

The Angel of Flexibility

I am ready for the surprises of life.

When we are in tune with our Souls, we get the inspiration that will help us not to harden or crystallize in relation to our thoughts, concepts, habit patterns, or conditionings. When we are able to follow the flow of intelligent energy in the daily affairs of our lives with flexibility, we create an openness for the Spirit within us to come and make our burden light.

Encounter 18

Iris arrived in a disturbed state; she was exhausted and recalled mistakes she had made in the past and how the pain of them was pressing upon her. She said that she did not have a clear picture of her future in her mind. During our session following a session of guided imagination entitled 'The Wonderful Gift' she painted three watercolours (see pictures 16.27 First Water Colours-'The Wonderful Gift', 16.28 Second Water Colours- 'The Hidden Ruby' and 16.29 Third water colour – 'The Revealed Ruby'),and revealed the story behind the paintings:

> *This story is called The Ruby. This ruby is a rare and exquisite jewel, maybe once in a lifetime one comes across such a wondrous object. Its rich, red glow is the colour of love. It is a sweet colour, not harsh; it is syrupy like the colour and taste of Grenadine, and inviting like the sensation of a cherry liquor chocolate spilling out its liquid centre.*

> *The ruby was stolen from the safety of an underwater castle. It was only found by chance, when a glimmer of red light revealed the jewel amongst the big black stones at the bottom of the ocean.*

> *The ruby had been searched for, yet could not be found until a clever dolphin located it. Only he was capable of diving to the depths of the ocean and retrieving the jewel. When the ruby revealed itself, the dolphin caught it up between his lips and joyfully took it back to the safety of the undersea kingdom. Back to where it had laid safely before it was stolen.*

> *All that the dolphin wanted in return, was the knowledge that this gift of love had been returned to safety. Happy in this knowledge the dolphin continue swimming throughout the seas of the world, on its life's journey. The ruby was restored to its place of honour. Again sunlight shone upon it and cast a warm, rose-tinted rainbow that reflects the light of love throughout the world.*

This lost gem of love and abundance was the gift she had received through the guided imagination. I thought it represented a huge transformation in her inner world; in comparison to the small blue light symbolised by her stone in the first encounters.

Picture 16.27 First Water Colour Painting -'The Wonderful Gift'

Picture 16.28 Second Water Colour Painting- 'The Hidden Ruby'

Picture 16.29 Third Water Colour Painting- 'The Revealed Ruby'

Encounter 19

After a month we met again, Iris looked content. We started this encounter with a conversation about other people's lives and how others experience ups and downs in their relationships. Iris wanted to talk about her friends' (husband and wife) unconditional love for each other. Also, she wanted to discuss hypothetically, how other people manage their interpersonal dealings:

> *My best friend, who lives abroad, and with whom I communicate via telephone and e-mail, is pregnant with twins. She is older than me, so it is good, in as much as it gives me hope, especially now that my age has become a major issue. She would not tell me if it is the result of treatment or not. I hate to think that this fall when she was pregnant, I was relating all the ups and downs I was experiencing through dramatherapy to her, when she was actually pregnant. All the time she was listening to my story, she hesitated to tell me her own story. She took the time to listen and commiserate with me, while being able to separate her own story from mine. Evidently, she did not want to hurt me even though it still does hurt - I want her life, I wish that I was as good and kind as her and pregnant with twins! I admire her while being jealous of her.*

> *However, I do feel stronger now and more in control. I do not remember the last time I felt drawn down to the depths of malaise that had become my way of life. I think that dramatherapy has given me a way of creating my own way out of the abyss I was in. However, when I come here now, I feel drawn back into the past, and I have to sit in those feelings that I have tried so hard to change. I am tired of being a person who is wounded. I want to stop being the wounded one. I desperately want to say 'I am cured' and go forward with all the experience I have gained. Except that when I leave here I become enmeshed in my way of life again.*

I am thrust backwards into the past where I lack the clarity and single mindedness to move forward, which is what I thrive off when I am here. I just have to figure out how to keep a constant watch over my thoughts as well as my feelings. I want to go on with my life and not bother about what others say and do, but I still suffer and I still cry a lot. As you suggest, I need to cherish the past whilst looking to the future. In order to bring happiness and richness to my life, I am considering adoption. I have spoken to parents who have adopted children; however, the greatest obstacle is that my husband is against it, and I cannot dissuade him.

Iris chose to work with the Persona Cards. I asked her what she would like to tell me about the character depicted in the card she had selected (see Picture 16.30 Persona Cards – 'The Clever Man'):

This one is clever, not only intelligent, but he is quick and can think ahead. He has good judgment and can assess future possibilities with success and is determined to fulfil them. Having assessed the facts, he has the ability to say 'no thank you', when he is being pushed in a direction he does not want to go in. He does not wait for life to dictate his fate; he goes out and gets what he wants. He does not take any notice of the people who say he cannot do such a thing; in fact he does not hear them, because they are not on his wavelength. The future does not frighten him, there are opportunities out there and he has confidence in his ability to face life, wherever it may take him. He is attracting success into his life because of the person he has become. He is actively reaping the rewards of the new and infinite possibilities that lay waiting beyond his immediate self.

Iris had projected her new roles through the card and felt optimistic when she left.

Picture16.30 Persona Cards- 'The Clever Man'
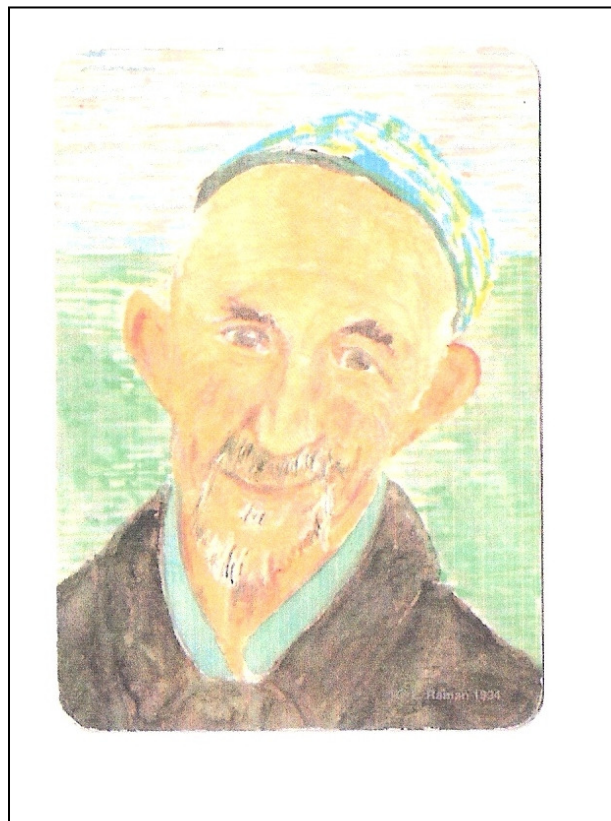
Encounter 20

A month had passed since our last encounter Iris arrived early and was cheerful. I did not know that this was to be our last encounter.

Iris was a different person than the woman who had first walked through my doors. She was happy, energetic and talking about her forthcoming trip to visit her family and friends in her mother country.

She constructed a spectrogram with small objects (see Picture 16.31 Last Spectrogram – Object Sculpture – 'The World is My Oyster'), a representation of her life (previously explored in Encounter 2), she explained:

> What I have created is called 'The World is my Oyster'. My world is inside
> a frame. I am a part of all that is in this frame. It is a safe place which I
> have depicted with an open oyster shell. I am no longer small or pale blue
> in colour. I fill the frame and shed a rainbow of colours throughout. This
> is my sea of options. I can sail or I can swim with the fish. All the fish are

my close family and friends who swim with me. Deep down in the sea there is treasure to be discovered - silver and gold, exotic jewels and lasting serenity.

This ceramic brooch is an island. There is a wise man and a woman standing there, these are my parents. They are passing on their wisdom to me. These bears are my husband and I, standing close together. My daughter is depicted by the little hedgehog; when I touch it, it is painful. A flower enclosed in glass, illustrates the past that I cannot change. My dog and my cat are here, both clever and wise guides in my life. There is a seal, which stands for aspects of fun, relaxation and action in my life. The turtle is my outer shell; it keeps me from harm and protects me. There is a road with a bridge of memories, and a cave that represents my childhood home. The sun is shining; I set my sails away from shore so that the wind carries me on my journey into the future.

Iris had written a poem about her feelings of closure and farewell called *A Part,* which she read out:

Meetings

Life is full of greetings
and 'good' byes
and 'bad' byes.

The 'good' byes
when you never want again
to see that slimy face
and yet
how memory holds that
which the soul wants to expel.

The 'bad' byes hurt.
Stretched or torn asunder.
The good of the bad
lies in what was

like fishes out of water we gasp

flopping in a puddle of tears

Until it becomes

a sea of sorrow

And drowning in it

We breathe again.

Like God's first creatures

returning to our watery womb

And swimming through each day

The past

When we were together

A part of the whole

and now

Apart

And still together

still

A part.

Iris had also drawn a colourful picture depicting her feelings of separation and closure:

In the centre of the picture is a heart; it is open on both sides which means it is open to love but still can be hurt. It has two separate sides drawn in the same colours which depict two circles of life. Each side holds the ability to help the other, even though tears of sadness are falling from it into the sea. We are all swimming like fish in and out of each other's lives. We live very busy and demanding lives; other fish are reflections of ourselves. You cannot always see the fish but you know they are there, like memories. There are bubbles of air and sunlight shining through the waves to sustain me (see Picture 16.32 Last Crayon Drawing – 'Separation')*.*

I am going home on holiday to visit my family after being away for four years. I want to see life from another perspective. I have become locked into a hard life here, I need to breathe different air and face my past before I can go forward. I am closing the circle. I dearly want to see my father; I have lost a part of who I used to be because I do not have him in my life. I do not want to hide myself or my feelings from those who make up my life. I am looking forward to going home; I am the phoenix rising out of the ashes!

Iris said that after the healing process she had undergone, she felt that she was at long last ready to face her family and move forward with her life. At the end of the meeting we decided to meet at her home to create an oral history of her treatment, before the trip to her family abroad.

Picture 16.31: Last Spectrogram - Object Sculpture -'The World is my Oyster'

Picture 16.32 Last Crayon Drawing- 'Separation'

Summary

This chapter has presented the dramatherapy 'Stillborn to Reborn' story. The story described Iris's journey towards recovery from the tragedy of the stillbirth, through her struggle to feel better, till the conclusion of triumph over the symptoms and rebirth, after she had lived as dead for three horrible years. Iris depicted her dramatherapeutic experience as resembling *'the phoenix rising out of the ashes'*. The additional fieldwork data, which refer to the post-therapy collaborative evidence, are the client's reflected memories on her therapy period and appear as Appendix 4 and Appendix 5.

Appendix 2 represents the chapter – Who am I? Telling my own history and demonstrating my different roles within the research context.

This Part has provided the foundation to what follows - the Findings derived from the transcriptions of the encounters and a Discussion which analyses and interprets the data in light of the conceptual framework.

PART V: FINDINGS AND DISCUSSION

Introduction

This Part discusses the findings presented in Part IV and interprets the lived experience of the therapy, answering the research questions and attempting to determine how the identified variables and dramatherapy contributed to the client's recovery from PTSD. It relies on an analysis and interpretation of the latent knowledge found in the C.PT, IEZ and TAE components of the conceptual framework.   It explains the recovery outcomes by comparing them with the theoretical propositions.

Chapter 17 considers the interpretive strategy used to analyse the findings, while Chapter 18 is a discussion of the findings.

Chapter 19 answers Research Question 1: How did the interaction between the C.PT personality structure, actions and IEZ contribute to the client's recovery? This question concerned the interaction of IEZ and C.PT; the client's strengths, traits and virtues: how dramatherapy brought them out and employed them; the unconscious aspect and the C.PT's activities within dramatherapy.

Chapter 20 then answers Research Question 2: How did the interaction between the TAE and the C.PT contribute to the client's recovery? and Chapter ~~22~~21 answers Research Question 3: How did the interaction between IEZ and TAE contribute to the client's recovery?

Finally, Chapter 22 answers Research Question 4: How did the interaction between the integrated components C.PT, IEZ and TAE contribute to creating a CZ and recovery from PTSD in this particular case?

Chapter 17: Interpretive Strategy

Introduction

This chapter explains the interpretive strategy chosen to analyse the characteristics of the real-life experience and the holistic nature of this case study. It discusses and portrays the interactions and relations between the core variables in order to explore 'how' questions; which *'are explanatory and likely to favour the use of case studies'* (Yin, 1994:6-7).

Interpretive Strategy

Four research questions provided the imperative for this study:

1. How did the interaction between the C.PT personality structure, actions and IEZ contribute to the client's recovery?

2. How the interaction between TAE and the C.PT contribute to the client's recovery?

3. How did the interaction between IEZ and TAE contribute to the client's recovery?

4. How did the interaction between the integrated components C.PT, IEZ and TAE contribute to creating a CZ and recovery from PTSD in this particular case?

To answer these questions I needed to understand the meaning of the researched phenomenon. As Van Manen (1990:53,70) explained: *'to make a study of lived experience and phenomena such as love, grief, illness, faith, success, fear, death, hope, struggle or loss, one needs to orient oneself in a strong way to the question of the meaning*.' I therefore engaged in *'the process of finding meaning in the data'* (Shkedi, 2003: 102), using the thesis' conceptual framework and my professional and personal experience, plus leaning on *'theories that supply perspectives, ways of observation or interpretation intended to enable an understanding of the researched phenomena'* (Shkedi, 2003:37). Hence, my interpretation of the treatment was conducted from a dramatherapeutic clinical

perspective, using its terms and processes as they were expressed in the fieldwork.

Yin (1994:103 -104) explains that theoretical propositions:

> … *Help to focus attention on certain data and ignore other data, the propositions also help to organise the entire case study and to define alternative explanations to be examined. Theoretical propositions about causal relations answer how and why questions and can be very useful in guiding case study analysis.*

My interpretations of the findings were set out in Part IV and drew on several sources:

- the study's theoretical perspectives which included: dramatherapy theory, positive psychology, classification of the client's character strengths and virtues, sports psychology, flow theory, self-determination theory, personality trait theory, Winnicott's theory, Frankel's theory, and the neuroscience of PTSD;

- the transcribed encounters;

- the client's artefacts;

- the client's two oral histories and her on-going reflections on the therapy;

- participant observation;

- the latent unconscious dramatherapeutic processes;

- professional knowledge.

However, the interpretations presented here were not derived from psychological analysis but from the artistic language of dramatherapy since the client lived this experience through dramatherapeutic treatment.

In this sense it appeared reasonable to establish the research argument from the viewpoint of Van Manen (1990:63 and 65) understanding that *'it seems natural that if we wish to investigate the nature of a certain experience or phenomenon …. we focus on a particular example or incident, of the object of experience describe specific events, an adventure, a happening Try to focus on an example*

of the experience which stands out for its vividness or as it was the first time. Attend to how the body feels, how they smell(ed), how they sound(ed) etc.'

I drew on my understanding of the client's PTSD memories, which, etched in Iris's amygdala, limbic system and the right hemisphere, were expressed nonverbally in her encounters with me. They were also reflected in the language of colours, odours, sounds, sensations, pictures, emotions and taste that were noticed and recorded (Joseph, 1988: Van der Kolk and Saporta, 1991; Ledoux, 1997; Joseph, 2001).

I also interpreted the data in dramatherapy's own terms, processes and concepts. Furthermore, this provided an interpretation of the therapy culture as it appeared in my fieldwork from a clinical point of view. One source that enabled me to interpret the data was what my client said (Shkedi 2003:65-66), as explicitly exhibited and literally told in the previous part. The other source was found in implicit findings that needed to be explained. These were the C.PT, IEZ and TAE, schematically presented in Figure 17.1 below. The interactions are represented by the overlap areas between C.PT and IEZ (AB), between C.PT and TAE (AC), and between IEZ and TAE (BC) and between all three components (D).

Figure 17.1 illustrates how the components C.PT, TAE and IEZ represent building blocks to understand the phenomenon that creates meaning in AB, BC and CA. As a Venn diagram, the significance of D is that it is the summation of the interactions from these lower level relationships. My strategy enabled me to understand D when the lower sets of relationships were themselves understood. This summation of meanings in my data provided the insights that were necessary for me to find from my fieldwork data.

Figure17.1:   Representative Schema for Analysis of the Findings
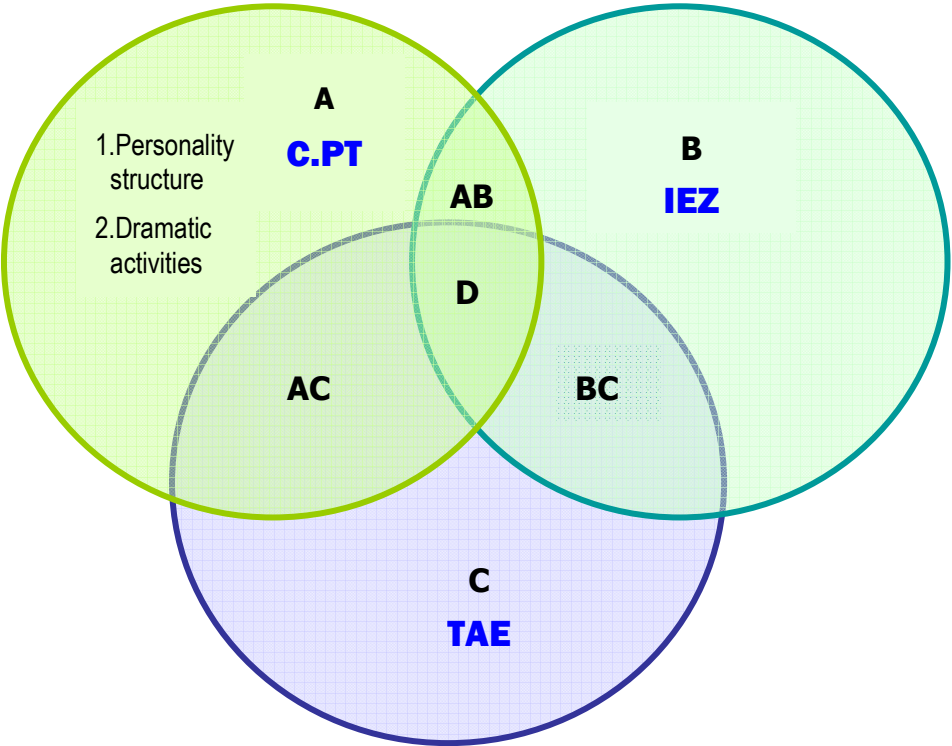
Source: Trafford and Leshem (2003:6)

Summary

This chapter discussed the chosen interpretive analytical strategy that employed my theoretical propositions; a strategy which was found appropriate for the nature of this study. This foundation of theoretical propositions established the groundwork that enabled the research questions to be answered. Additionally, it assisted the formation of interpretations concerning the interactions and relations between the core variables, while using dramatherapeutic artistic-dramatic language to explain the recovery outcomes. This interpretive strategy is used in the next chapter to explain, analyse and interpret general aspects of the findings as they were revealed in the fieldwork.

Chapter 18: Discussion of the Findings

Introduction

This chapter discusses the findings of the fieldwork from two points of view. The first relates to the lived experience expressed in dramatic activities and analysed according to three parameters: intensity of colour, motion and fullness. The second relates to the varying C.PT parameters - emotional expression, body language and imaginative language as they were revealed at each encounter and influenced by the dramatic activities. Each parameter was graded according to five levels. Graphs were employed to summarise the recovery trends according to all the parameters as they appeared in the table and these were then analysed and interpreted. This chapter describes the general trends that occurred within the dramatherapy framework, through the analysis and interpretation of the various parameters. It shows my understandings of the changes in these parameters and how, respectively, they influenced the successful outcomes of the therapy.

Lived Experience

The clinical data presented in Part IV are regarded as the primary source of information for this exploration since it was directly received from the key actor. Hence her original authentic experience as it was felt and expressed by the client is presented through two channels: the first includes her literal descriptions, explanations, thoughts, perceptions and attitudes (Shkedi, 2003:67). Iris portrays this lived experience as follows:

> The IVF treatments made me feel worse. They resemble the life-and-death environment that I had experienced during the delivery of my stillborn baby. They are horrific, mess up my life, very traumatic, frustrating and frightening, I have nightmares I feel helpless, lonely, unable to work, unhappy and vulnerable.

The second channel is expressed in artistic-dramatic non-verbal creations. However, the focus is on the second source, representing the significant core of the dramatherapy mode which is the rational and natural basis on which to establish the discussion.

The dramatherapeutic evidence shows that the C.PT, TAE and IEZ were directly connected to the alleviation of the PTSD symptoms. Van Manen (1990:74) sees: *'the art as a source of lived experience'* - as lived by a person at a given time, in a given place, and involving the totality of life. Other central aspects in the fieldwork data were summarised in the findings and enhanced their validation. These aspects included:

1. The client's verbal reactions during the encounters reported on her state and how it was affected by the dramatherapy;

2. Changes in the artefacts represented by the parameters of colourfulness, motion and fullness and the reflection of the client's feelings and thoughts in these artefacts through emotional expression, body language and imaginative language parameters;

3. The PTSD symptoms tables that the client completed on different occasions indicated the reduction and eventual disappearance of these symptoms;

4. The fact that the client began a new job after twelve encounters, demonstrated a significant transformation in her overall feelings, functioning and behaviour;

5. The client's two oral histories with their detailed reflections providing evidence of the encounters further supported and strengthened the research focus and answered some of its questions.

Hence, the client's lived experience was demonstrated in a variety of ways directly expressed by her, both verbally and nonverbally as well as being observed by me.

Findings relating to the varying C.PT Parameters

The C.PT component contained two kinds of parameters, which were varying and measurable but also fixed qualitative non-quantifiable. Both components are discussed in different modes, in order to explain the PTSD recovery. This chapter focuses intentionally on the general trend that occurred within the dramatherapy frame by analysing and interpreting the varying parameters. This approach enhances understanding of how the changes in these parameters led to the successful outcomes. The following table, Table 18.1 presents the findings for twenty encounters, detailing the state of the parameters relating to the artefacts: intensity of colour, motion and fullness; and to the C.PT: her emotional expression, body language and imaginative language. Each parameter is divided into a progressive scale of five degrees from 1 to 5 in which 1 represents the unhealthy PTSD state and 5 represent the healthy state. Intentionally, instead of using DSMIV (1994) clinical terms, I preferred to use the client's own words. This approach, enabled the symptoms to be described in dramatic-artistic language and relate to observed conduct, thus avoiding repetition of the two symptoms tables that were presented in the description of the fieldwork. (Tables 18.1 and Table 18.2) These varying parameters were carefully selected, since they reflected the repetitive themes in the art works produced by the client's actions, and the themes reflected in her behaviour (Shkedi, 2003) in each encounter.

Table 18.1: Presentation of the Findings

Encounter No.	Dramatic Activity	Artefacts' parameters			C.PT parameters		
		Intensity of colour	Motion	Fullness	Emotional expression	Body language	Imaginative language
1	None	None	None	None	**1 2 3**	**1 2**	**1**
2	2 spectrograms 6PSM	a – **1** b – **3**	a-**1** b-**3**	a-**1** b-**3**	**1 2 3**	**1 2**	**4** **5**
3	3Pastel drawings	a- **2** b- **1** c- **3**	a-**2** b-**1** c-**4**	a- **2** b- **1** c- **4**	**1 2 3**	**1 2**	**3 4**
4	None	None	None	None	**3 4**	**3**	**1**
5	3 Clay works	a-**3** b-**3** c-**3**	a-**3** b-**3** c-**2**	a- **3** b- **4** c-**2**	**1 2 3**	**1 2**	**3 4**
6	4 finger paints Story	a-**3** b-**4** c-**4** d-**5**	a- **4** b-**3** c-**3** d-**3**	a-**3** b-**4** c- **4** d-**5**	**4 5**	**4 5**	**3 4**
7	2 Role play 2 Poems	None	None	None	**1 2 3**	a-**1 2 3** b- **4**	**4**
8	Sandplay Story	**2**	**3**	**4**	**3**	* **3**	**4**
9	Sandplay Story	**1**	**2**	**2**	**3**	* **3**	**4**
10	Therapeutic cards+ story	None	None	None	**3**	**3**	**5**
11	Sandplay Story	**3**	**3**	**2**	**3 4**	* **3**	**5**
12	Sandplay story	**4**	**3 4**	**4**	**4**	* **4**	**4 5**

Encounter No.	Dramatic Activity	Artefacts' parameters			C.PT parameters		
	(Started new job)						
13	None	None	None	None	**4**	**4**	**2**
14	Sandplay Story	**3**	**3**	**3**	**4**	**4**	**4 5**
15	Sandplay Story	**5**	**5**	**5**	**4 5**	**4 5**	**4 5**
16	2 pastel drawings, story	a **3** b **4**	A **2** B **5**	a **3** b **5**	**4**	**4 5**	**5**
17	Drawing + angel cards	**4**	**4 5**	**4 5**	**4**	**4**	**4 5**
18	3 water colours drawings Story	a **4** b **4** c **5**	a **3** b **4** c **5**	a **4** b **4** c **5**	**4 5**	**4**	**5**
19	None	None	None	None	**4**	**4 5**	**2**
20	Pastel drawing spectrogram 6 PSM	**4 5** **4 5**	**5**	**4 5**	**5**	**5**	**4 5**

Table Legend					
Artefact Parameters	**1**	**2**	**3**	**4**	**5**
Colourfulness	Colourless	Pale	Mediocre	Colourful	Intense
Motion	Frozen	Motionless	Some Motion	Moved body	Flow
Fullness	Empty	Meagre	Partially Full	Full	Rich
C.PT Parameters	1	2	3	4	5
Emotion	Crying, Sadness, Depression, Helplessness Anger	Dread Chaos Agitation Anxiety	Insecurity Uncontrolled Lonely Abandoned	Energetic Optimistic Relaxed Confident	Joy Liveliness Self-control

Body Language	Frozen Bent over	Closed Tight	Minimal Movement	Movement Straight Upright	Open Moving Freely Relaxed
Imaginative Language	None	Minimal	Partial	Much	Maximal

Graphs 18.1 and Graph 18.2 summarise the overall recovery trends for both types of parameters.

Graph 18.1: Parameters for Artefacts according to Encounter

Fig. 1 Artefact parameters by sessions
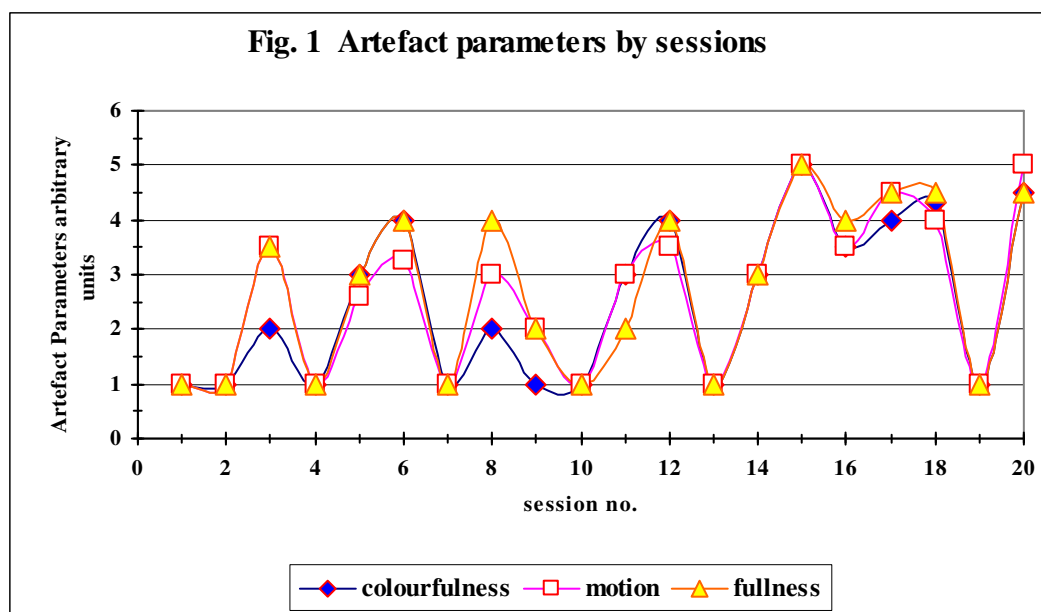
Graph 18.2: Parameters for Client according to Encounter

Fig. 2. Client's parameters during sessions
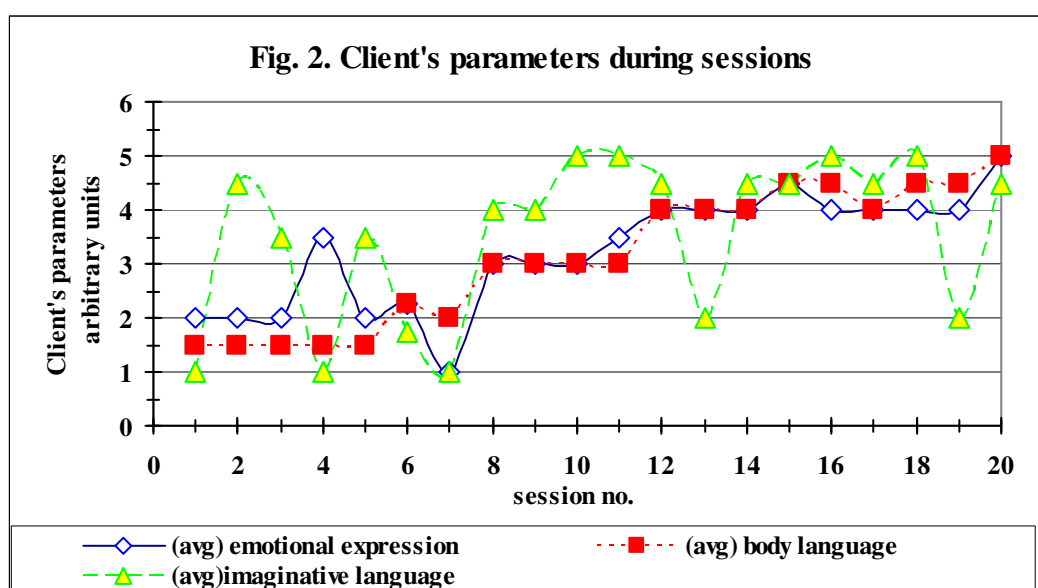
Analysis and Interpretation of the Findings regarding the Parameters

Graph 19:1 indicates the changes in the three parameters: intensity of colour, fullness and motion as a result of the progress in the encounters. Encounters 1, 4, 7, 10, 13 and 19 produced a value of 0 due to the fact that in these encounters there was no dramatic activity leading to the creation of artefacts, and they were only established verbally. Consequently an average was calculated for the three parameters. According to Graph 18:1 the gradient is homogeneous for all parameters and the intensity of the changes is also homogenous for all the three parameters. This indicates the client's positive progress in these three dimensions from 1 to near to 4.

Graph 18:2 shows the values for the three parameters relating to the C.PT: emotional expression, body language and imaginative language as a result of the client's progress over the encounters. An average was calculated for the results, in order to obtain the inclusive characterisation of the therapy.

The following is an analysis of the results for each parameter:

1. Emotional expression. The initial average value was 2, rising to a final average value of 5. The client began the therapy with a low level spirit and afflicted emotional expression. With the progress of the therapy her mood changed in a positive direction till it reached a maximum positive affect.

2. Body language. The initial average value was 1.5 and the final average value rose to 5. The client began the therapy with a frozen closed body language, and with progress it was changed till she attained maximum body relaxation.

3. Imaginative language. The initial average value was 3 rising to a final value of 5. Because of the high starting point in this parameter the extent of the positive changes is the lowest. It can be noted that even in this parameter the client reached the maximum value at the end of the therapy.

Graphs 18.1 and 18.2 show the overall tendencies of the recovery process in relation to the six parameters, all of which are strongly evidenced in the data. An interpretation of the occurrences is that each time when verbal interaction alone took place no symbols were present. This can be contrasted with, the critical incidents, turning points in the client's awareness, and insights that always emerged through involvement with symbols, metaphors and dramatic activity. Hence working with symbols was the bridge for the client to ascend into IEZ enabling the use of imaginative language to occur.

This evidence suggests that there are two possible explanations regarding the transformations in the client's state and the changes in the artefacts as expressed in the findings. Firstly, the more she used imaginative dramatic language and nonverbal communication the symptoms decreased, the emotional expression and body language drastically changed. Secondly, as she began to feel more 'in control' and alive, the artefacts exhibited more intensity of colour, motion and fullness. This was prominently evidenced in the sixth encounter, when part of the PTSD symptoms had already vanished (Yovell, 2001). It correlates with the recommendation of treatments for PTSD, which refers to the need to bypass the verbal channel because the ability to communicate experience in words is not accessible for a C.PT (LeDoux, 1993; 2003; Van der Kolk, 2006). This rationale

was also supported by the client's comprehension during the encounters and in her reflective oral histories; asserting that her insights and changes had always occurred under the influence of deeds and not in spoken words (Levine, 1997; Benathen Wiesz, 1999; Johnson, Lahad and Gray, (2008).

The sharp descents that appear at certain points in the graphs indicate severe regressions in the client's state during the twenty encounters. The identified reason was the failure of IVF treatments, which brought about the reliving the PTSD symptoms. Despite these regressions the curative outcomes were successfully achieved with the assistance of dramatherapy. It can be argued that this appears to be an effective method for the relief of PTSD symptoms, in complicated and chronic situations. This view is supported by Winn (1994:54) who worked with C.PT's groups in dramatherapy and witnessed the transformations of the PTSD symptom among her clients. Nevertheless, this is only a partial interpretation regarding the explicit findings, because the extra-therapeutic components of C.PT, IEZ and TAE expressed implicitly in the findings are also viewed by me as crucial to the recovery within this manifest dramatherapeutic frame.

Summary

This chapter explained, analysed and interpreted the findings revealed in the fieldwork. Two indicators were highlighted: the relations between the lived experiences expressed in the dramatic activities of the encounters and the changes that occurred in the varying parameters relating to the C.PT. The overall recovery trend exhibited in the graphs' portrayal of the changes in the parameters demonstrated the positive transformations that had occurred in the client's situation; whereas the changes which appeared in the dramatic activities mostly reflected her emotional state. A partial understanding of the reasons for the successful outcomes was therefore achieved. On this basis, the next chapter will answer the first research answer, noting that the client's personality structure encompasses the parameters of her fixed traits and virtues and interpreting how her dramatic activities interacted with the IEZ.

Chapter 19: Answering Research Question 1

Introduction

This chapter analyses and interprets the dramatherapy assessment exhibited in the client's BASICPh story-making written in the second encounter in relation to Iris's coping resources. Then her strengths, traits, virtues and unconscious journey will be explained as they were expressed in the dramatherapy and the outcomes. The interpretation also relates to the client's use of the diverse dramatherapeutic activities, clarifying the recovery processes through nonverbal modes. Relying on these elements, the chapter answers the first research question: *How did the interaction between the client's personality structure, dramatherapy activities and IEZ contribute to her recovery?*

Coping Resources

Iris told the B A S I C Ph 6 pieces story making 6PSM (Lahad, 1992) during our second encounter in order to assess her coping resources. *'When we tell a story or listen to 'a good novel, we are given the chance of living through an experience that provides us with the opportunity of gaining insight into certain aspects of the human condition'* (Van Manen, 1990:70). However, for the first time she stopped crying when she told it and the fluent, effortless storytelling was accompanied by more relaxed body language, after all she was doing the thing that she knew best. The story was analysed as follows:

The key words and verbs used in the story which indicated the C.PT's resources are shown in Table 19.1 below.

Table 19.1: Presentation of the Findings

Themes	Conflicts
To be	Not to be
To save	Need to be saved
Believe	Without belief
Can, capable	Not able, incapable
To do	Not to do, passivity
Should	Want
Want	Should
Work	Unemployed
Failure	Success
Disappear	Appear, live

The resources - **B** **A** **S** **I** **C** **Ph**

19   3   21   13   69   37

The numbers refer to the frequency with which the word belonging to each resource appeared in the story. The themes were based on repeated dominant verbs and key words that appeared in the story; while the unconscious conflicts are represented by the opposites of the overt themes which may also be attributed to the latent substance of the story.

Interpretation of the Story

Iris's dominant communication channels and coping resources at this early stage of the therapy were: B, S, I, C, Ph and a few A's. This was an outstanding finding and quite rare in my professional experience. It indicated a highly positive picture of her strengths and virtues although she was still in much distress; the significant change was that now she had begun to cope with it. Her roles as they appeared in the two first encounters reflected the posttraumatic state. According to Landy's (1993) taxonomy the impression was that she was performing the 'tragic hero' (200), the 'zombie' (201) and the 'lost one'. Whereas at the end of the second encounter after three experiences in the IEZ, using dramatic nonverbal language she created two sculpted objects. During this process, as she recalled in the two oral–histories, and the storytelling she was mostly affected by sprouts of a new role which succeeded in emerging and moved away from the zombie role so that a more 'alive' role was expressed. This transformative process underscored my initial sense that Iris had unique strengths. It confirmed my intuition that it was preferable to maintain the role of 'enabler', 'witness' and 'follower' and construct the therapy on her strengths, coping resources and free choices in the course of the encounters (Landy, 1992:107; Johnson, 1992:114; Duncan Hubble and Miller, 1997).

The A (affect) resource only appeared three times in the story, although until she told the story she was weeping all the time, a fact that indicated the existence of A. It seems that her painful prolonged grief and the devastating PTSD symptoms had blocked the expression of this resource inside her. The 6PSM analysis was conducted in accordance with Iris's verbal and nonverbal communication including her appearance, body language and emotionality. With respect to the resources B (belief) S (social) and I (imagination), they emerged explicitly, despite Iris's repeated complaints that she was: lonely, avoiding friends, losing her creativity, unable to act as she used to, losing her belief in herself, her self-esteem and confidence; descriptions that typify people with chronic PTSD, who *"lose their way in the world"* (Van der Kolk 2006), or lose their creativity and live as dead (Levine 1997:27-42)

Within the AB area, that refers to the client's coping resources we can see that Iris was using imaginative language at grade 5 although the other parameters were registered at a lower grade. This situation was possible because the client's highly imaginative talent and her use of the storytelling enabled her to ascend to an IEZ; while the artistic medium served as a bridge and simultaneously held her in the IEZ and drew her nearer to the CZ (Levine 1997:41-42). As Iris described in the second oral history four years after the therapy:

> *I thought I would play in the sandbox for just a few minutes of my time and then we would get on with the real therapy; that was always in my mind that first we would do this exercise and THEN we would have the session but, having gone through it now, I know that it* [the sandbox] *WAS the session.*

It should be emphasised that personal imaginative resources are not a prerequisite for staying in the IEZ: it is a matter of mental choices and free will (Frankel, 1981). In therapy, anyone can use any kind of artistic medium to experience the qualities and influence of the IEZ, including mentally challenged and psychologically damaged people. Imagination is part of a network of activities, which includes mental picturing, and which sustains visual thinking.

> *Imagination has qualities of perceiving, a power to convince or tendency to produce belief,* [it is] *able to be represented by a picture,* [and has] *the capacity to put together (giving us access to or informing us about) important, or meaningful aspects of (ways of viewing) the world* (Lieberman, 2003:25, 30).

In neurological terms:

> [the] *limbic system, amygdala, hippocampus (the part in the brain connected to different kinds of memory) and the right hemisphere in general, are directly involved in the production of memory, visual imagery, and the expression and perception of most aspects of emotions* (Joseph, 2001:111-112).

The IEZ, which has been described as a spiritual phenomenon, as well as a realm of imagination, is also associated with the activation of these cerebral organs. Winnicott's theory (1971) and neurological research can both be used here to understand the PTSD state. The loss of the capacity to imagine and the zombie state are both clearly presented in Iris's appearance, behaviour, and emotionality.

The symbols depicting the client's real life suffering were given by her in the second encounter: *'this is me, a large flat button, light blue; the half clamshell is the most closed item. I preferred to stay home and not to see friends'.*

Levine further explains that for Winnicott

> *… to be alive is to be able to live in the imaginative and playful space of experience and to be capable of being creative; when we lose the capacity for imaginative life, for play, then we 'die' to ourselves, we experience a living death which is often masked by a compliant outer shell … psychological wounds can only be healed by the aid of the imagination* (Levine, 1997:27-42).

The interaction of IEZ and the Underlying C.PT Personality Parameters

There are studies on the 'heroic client', which assert that the client is in general the most potent contributor to outcome (Duncan, Miller and Sparks, 2004; 2007) and some indicate that the client is the most important common factor for success (Bohart, 2000). However, neither of these types of studies refers specifically to PTSD successful outcomes, nor to the client dynamics, in this case the interaction of the TAE, C.PT with the IEZ as a contribution to recovery, even though features of the IEZ do figure in Joseph's (2001) basic neurological research. In this section I explain how the fixed but unquantifiable and extra-therapeutic component - the C.PT personality, interacted with the IEZ to bring about her own recovery. 'Personality' relates to the client's own coping resources, the strengths, virtues and character traits which are considered underlying parameters, which contributed to her recovery.

As already noted, it is evidently meaningful that all the critical incidents in Iris's therapy, all the turning points in her awareness, all the key insights she achieved always occurred during her use of symbols, metaphors and dramatic activity. Symbols, storytelling and imaginative language formed her bridge into the IEZ and held her there, enabling her to draw nearer to the CZ (Levine, 1997:41-42).

The transformations in the client's state and changes in her artefacts represent a two-way process: the more she used imaginative dramatic language and nonverbal communication the more her symptoms decreased, and the more her emotional expression and body language changed and loosened, and she felt more 'in control' and alive, while her artefacts exhibited greater intensity of colour, motion and fullness. Consequently some of the PTSD symptoms vanished after the fifth encounter, probably because she was able to bypass the verbal channel since words are usually not available to a C.PT (LeDoux, 1993:2003; Van der Kolk, 2006). The client's own understanding reinforced this claim: her oral histories asserted that insights and changes always occurred under the influence of actions and activities and not through speech and conversation.

A literary illumination of this point is *The Never-Ending Story,* which recounts the hero's psychic adventures into a fantasy world in order to find rebirth and return to reality:

> *When human beings and children come into our (fantasy) world from their own free will this is the right way. Each human being that was here learned something that can be learned only here and went back to his world a different person* (Andha, 1984:123).

Similarly, the heroine of the story told in this study was willing to use dramatherapy activities in order to experience the IEZ and so gained rebirth after three years of *'living as dead*', since the IEZ encompasses powerful qualities, which liberate intra-psychic transformational processes to create new strengths, adaptation, coping and creativity (Frankel, 1981; Lahad, 2003; 2007).

Given the above, it is clear that within the therapeutic encounter the longer the individual can remain in the IEZ the closer they will come to a cure (LeDoux, 1993:2003; Van der Kolk, 2006). Explanation of the neurological basis of PTSD

and the theories of Frankel (1981) and Winnicott (1971), enhance the understanding that people with PTSD have damaged imagination; paradoxically, they regain their sense of being alive and can be healed with the aid of the imagination.

Eliciting the Client's Strengths, Traits and Virtues

According to Peterson and Seligman's classification (2004) of Character Strengths and Virtues (CSV) Iris had all six virtues and twenty-four character strengths. All of them were expressed both explicitly and implicitly through her artefacts, the coping resources she displayed, her verbal communication, and the telling and retelling of her stories. Despite her afflicted emotional state and her frozen body, these virtues and strengths had been retained. The major problem with PTSD clients is that their symptoms freeze their ability to function, act or behave according to their strengths and virtues (Levine, 1999; DSM IV, 1994; Herman, 1997).

Given this paradoxical state (Chandler, 2005) can it be argued that Iris's personality resources contributed to her recovery? For Iris, the verbal channel was the natural way for her to express the cognitive and emotional strengths which form the basis of a positive psychology (Peterson and Seligman, 2004). The long therapeutic conversations that took place at each encounter, revealed her need to display competence, relatedness and autonomy, as described by self-determination theory. This need even took priority over other needs (Brown and Ryan, 2003). The retelling of her story (Jennings, 1998) was her way of coping with the unresolved traumatic grief of the stillbirth and the IVF failures. She had to vomit out the painful distressful content which, till then, she had had no one to tell (Jacobs, 1999). Although the context was dramatherapy and not verbally-based psychotherapy, this retelling constituted a significant contribution to her recovery. The verbal channel had to 'have its say' because it took time for Iris to agree to move towards nonverbal activities. Iris refers to this point in the second oral history:

When we were talking you were always offering me options of other kinds
of things to do and where to go or asking me about how I felt and how it

affected me. I think giving me that lead gave me a sense of personal power, not power over you, but it gave me a sense of being capable of something in a way. It suddenly forced me to be capable of something, I had to take a step because you gave me the option, and it worked very well.

The dramatherapist's choice to play an accommodating role - being there, offering options, permissive and nondirective management - was attuned to the client's state and needs and suited her personality. They gave her some sense of power and so assisted recovery.

I felt more as if I was working/talking with a friend or associate. I remember sitting on the floor, being very comfortable on the carpet and being able to be open up, and if there was something I didn't want to talk about, I didn't feel as though I was being cornered to talk about it. Yet somehow it would come out anyway but through the work. Dramatherapy is like a different sense of light, of comfort level. I started looking forward to it' (Iris, Second oral history, Appendix 5).

Thus, even in the first encounters, Iris was able (enabled) to feel her strength, her self-determination and intrinsic motivation. She began to be able to express her potential and seek out progressively greater challenges and this corresponds with the findings of Deci and Ryan (1985, 2000), Ryan and Deci (2000), and Brown and Ryan (2003). This strategy and explanation is supported by positive psychology and researches on subjective well-being by Diener et al. (2003), which assert that people's choices and judgments indicate what they value, what they find good and positive. In spite of her difficulties, especially her sense of helplessness, Iris could appreciate the positive feeling and transformations she was undergoing:

I have been thinking all week about this sapphire blue stone that will be my power station. Whilst I was teaching my new pupils I was thinking about this power station and it has given me a strength I did not know I had. It has given me self-confidence, symbolizing that I am not small and weak, that I have inner strength. Dramatherapy has helped me visualise what my pain

consists of and I feel a tangible empowerment after each session. I feel I can enact my ideas and take a proactive part in my life again (Encounter 6).

Her words demonstrate that dramatherapy and the IEZ work through symbols and metaphors, helping the client to visualise her real situation; it was best to emphasise the qualities of the IEZ over verbal communication. This is one example of the interaction between the C.PT and the IEZ. The IEZ environment invites the person in pain to experience visual thinking and the power of imagination and creativity, and in this way to regain strengths.

Further support for the contribution of the client's character traits to her recovery comes from the Five Factor Model (FFM) in Personality Trait Theory (Costa and McCrae, 1995). In line with this model the client exhibited traits of extraversion, openness, agreeableness and conscientiousness. Her neuroticism-anxiety, anger, hostility, depression, self-consciousness, impulsiveness and vulnerability were not personality traits but weaknesses resulting from traumatic grief and chronic PTSD. On the contrary, she had enough stability - courage, calmness, happiness, self-esteem, impulse control and resilience - to overcome her symptoms.

Observation of Iris' use of ritual and risk shed further light on her character resources (Jennings, 1993). Ritualistic behaviour was the 'convenient' verbal retelling of her experiences. Risk-taking was agreement to step into the range of dramatherapeutic activities. Stability and its associated qualities are necessary in order to cope with the unexpected and the unknown on the journey to recovery. After the disappointment of two unsuccessful psychological treatments, the client still had the strength to take risks within a new mode of therapy. This pointed to her basic courage and self-esteem.

Here too I made a choice of roles which Iris noted in her reflections:

> [In the previous therapy] *there was this psychologist and although she was quite nice, it always made me feel like there was something physical* [standing] *between us, you know, I could never cross that barrier and* [I felt] *that she also really didn't want to get too close to me. Whereas in the room we worked in, in your house, the space was open and there was nothing separating us.*

A therapeutic relationship based on equal and mutual partnership, warmth, acceptance, trust, empathy, empowerment, shared experience, and physical closeness, with no desk separating therapist and client, enabled the client to feel that she was understood, to feel contained and safe and so that she could open up and take risks.

This therapeutic relationship that we built was endorsed not only by extant theory (Rogers, 1951; Kahn, 1997; Duncan, Hubble and Miller, 1997), but also by Iris herself in her oral histories:

> *I think one of the first things for me that was very important was that you had a very great sense of empathy toward what had happened to me, and partly because of your similar personal experience. You always gave me the choice of where to sit and somehow that's important because it feels more personal. It felt friendlier; it established more of a sense of trust, I think.*

It is worth noting that after Iris took on the active role of participant in my MA dissertation (after the second encounter) the virtues listed by Peterson and Seligman, (2004) under the category of wisdom and knowledge: creativity, curiosity, open-mindedness, love of learning, perspective, courage, authenticity, bravery, persistence and zest, were brought out by taking this new initiative. Becoming a co-researcher was life-asserting, expanded her sense of involvement and responsibility and definitely advanced the therapy.

Within the IEZ, the client's ability to witness the ways in which her concrete artefacts represented her unconscious content, enhanced her capacity - independent of the therapist's interpretations (Winnicott, 1971) - to discover in herself and by herself new insights and emotions. This happened as early as encounters 2 and 3). As a result she gained a sense of control, a highly important element in PTSD treatment (Yovell, 2001). Her statement *'I have inner strength'* (Encounter 6) consciously represents the new role she took ownership of, a role that better fitted her pre-PTSD personality traits. The 'zombie' role disappeared and the healthier one helped relieve her symptoms. The long stay in the IEZ brought out her real pre-traumatic character traits.

It seems that the dramatherapy activities and PTSD sensory language together tapped powerfully into Iris's latent world of events with emotional and somatic significance stored in the amygdala (LeDoux, 1993:2003). Extreme physical reactions were catalysed by emotional memories.

Although the verbal channel did not lead to new insights, the non-verbal activities engendered the client's increased understanding and rapid changes. She could explain this in words only after her senses experienced the sojourn in the IEZ:

> *I was shocked by what was displayed in the pictures I drew, I was not aware that I was in such a bad state. Since then, I feel as though I have woken up to my feelings. I was so excited to uncover these truths about myself. I am also aware of feeling optimistic again. The blue circle I drew in my first drawing portrays me as such a small person, who is unable to traverse the high wall that surrounds me. However, by my last drawing, I was actively open to all options in order to reach the other side of that wall* (Encounter 4).

Once Iris had understood her real state she expressed her feelings in drawings. She used oil crayons to make dramatic projections (Jones, 1996) and looking into these pictures helped thaw out the shrunken frozen traumatised body and psyche (McMahon, 1996). Repetitive themes, colours, symbols and metaphors represented her vulnerability, while richer depictions of a garden (Encounter 3) *'showed her true colours'* of strengths and virtues.

> *Working with creativity outside the self, away from ourselves rather than within ourselves, is less intimidating for many people and may enable them to feel more control* (Jennings, 1998:122).

It seems that staying in the IEZ and using her creativity gave Iris some control over her traumatic condition (Winnicott, 1971; Yovell, 2001). The dramatherapeutic processes of reworking the experience and using visual thinking led to further dramatic projection and deeper comprehension (Lieberman, 2003; Allen 2005/2006) which enabled Iris to direct and control her recovery (Jones, 1996; Jennings, 1998).

It was clear that Iris was determined to be cured and overcome her long bout of suffering. Self-Determination Theory (SDT) of human motivation, that relates to the development and functioning of personality within social contexts (Ryan and Deci, 2000), sheds light on this trait and its significant role in Iris's recovery. Iris was self-determined and intrinsically motivated.

She liked the activities offered to her, although sometimes she *'felt so stupid'* in agreeing to do them. She felt strengthened by the multiple choices, by opportunities for self-direction and the feedback which confirmed that she had performed a task well (Carr, 2004). This significant trait and behaviour also corresponded with the client's and my own humanist beliefs and also to the theoretical assumption which guided the research and the therapy - that people are active organisms. Both Bar-Yitzhak (1999) and Deci and Ryan (1985, 2000) highlight the client's sense of volition and choice as one of the crucial elements assisting recovery.

It seems that in therapy, even in 'impossible' cases (Duncan, Hubble and Miller, 1997), emphasising positive traits and virtues promotes clients' competence to take responsibility for their own psychological growth and development as argued by Deci and Ryan, (1985, 2000) and later by Duncan, Miller, and Sparks (2007). This premise was confirmed by former studies (e.g. Lambert, 1992) which found that the client, as an extra-therapeutic factor, constitutes 40% of the reason for successful outcomes. While recently Lambert, Hunt, and Vermeersch (2004:40) specified that the client's *'severity of disturbance, motivation to change, ego strength, capacity to relate and early positive response to therapy seem at least moderately correlated with therapy outcome'.*

Albeit, treating a client with chronic PTSD non-verbally and basing the therapy on disclosing the client's strengths and virtues when they are shattered, is a complex task. Yet as Iris herself noted, it is possible to make symptom relief and recovery much more likely: *'When you ask someone to make a spectrogram it is more revealing than just sitting talking across a table'.* This view stands contrary to the views of Shalev (1994:100) and James and Johnson (1997:394) who indicated

that the PTSD syndrome is often irreversible and that *'dramatherapy is no cure for Vietnam'.*

The transformations which Iris underwent as a result of the interaction of C.PT and IEZ, in the overlap area AB, can be explained by a combination of latent or tacit knowledge. This knowledge is unexpressed and cannot be put into words since it reveals itself in the way people do things or (silently) understand certain actions; whereas we are obviously aware of explicit knowledge which is apparent and can be expressed in words, charts or mathematic formulae (Polanyi, 1967 in Shkedi, 2003:58).

The changes that Iris underwent highlight the importance in treating people with PTSD by enabling them to release traumatic bodily memories and locked-up energies through visual-dramatic techniques, and demonstrate how these techniques are to be preferred to verbal treatment (Levine, 1999). The findings emphasise the fact that latent knowledge is fundamental and prior to explicit knowledge (Polanyi, 1997). To achieve successful outcomes in PTSD therapy, the therapist should be open to recognise the C.PT's capacity and competence to actively and independently operate in the IEZ. It is evident that the client's insightful revelations during the therapy and her later reflections demonstrate the essence of dramatherapy (Jennings, 1992:12). It is argued that working in the IEZ through nonverbal activity constitutes a viable alternative way for treating PTSD as revealed in neuroscience research (Spinazzola, et. al., 2005; Van der Kolk, 2006; LeDoux, 2008)

The Unconscious

Another element of the client's recovery is her unconscious journey (Jung, 1989) towards a cure. This suggests a second way of understanding Iris's transformation - that her symptoms, actions and dreams, and her 'artistic visions' in the IEZ helped her to disclose her unconscious (Jung, 1989:67) pain and difficulties and thus to cope with them.

Iris described a *'big dream- a long and complicated one – I don't remember anymore - but it was one I felt and lived.'* She had nightmares which usually ended in her near death. The PTSD symptoms of re-experiencing, avoidance and

hyper-arousal (DSM IV, 1994) were very evident. Her unconscious revealed itself in the repeated themes of loneliness, helplessness, isolation, emptiness, being motionless, shut and frozen, and a sense of wilderness *'This is the world of the penguin that lives alone in a white, icy cold wasteland'* (Encounter 8). Other metaphoric descriptions highlighted the unconscious content beneath the PTSD symptoms:

> *The Sea of Galilee is a little bit empty* (Encounter 2)

> *This whirlpool of emotions, feels like torrents of murky water gushing around and around. I cannot stop it, just like I cannot stop the whirlpool I'm in* (Encounter 6)

> *This is my chaos and anger, my disorder* (Encounter 6)

> *When an autumn leaf of a golden rich auburn falls, lies and dies, crumpled and crushed beneath uncaring careless feet* (Encounter 7)

> *Once upon a time an alien landed on earth from a far away planet. He could not return home because his spaceship was wrecked when he landed. He looked around for assistance, but the inhabitants would not speak to him and kept their distance* (Encounter 10).

Each time that Iris used dramatherapeutic activity, unconscious content would pop up in symbols, metaphors, dramatic projection, play roles, drawings and sandplay. The unconscious processes occurring in the IEZ were enhanced and stimulated by the artistic activities, which helped her expand her imaginative-creative capabilities and qualities (Winnicott, 1971). Deeper themes, emotions and ideas, hidden for a long time, slowly seeped into her consciousness in a new insightful structure, that assumingly also occurred in the CZ. Throughout this time Iris's real traumatic situation remained chaotic, confused and could not be verbally understood or discussed (Van der Kolk, 2006). For example, she wrote in her diary after Encounter 3:

I felt so stupid doing this little idiotic drawing and then so shocked to see how much it really was me … or at least how I saw the world. I felt shaken to the core to realise how small and shallow my life had become - how great the barrier of rage and fear and pain and how invisible I was myself. How colourless, shapeless, empty.'

Significantly, her use of artistic words in describing herself fits Jung's (1989) view of the unconscious as an artistic vision, and that her imagination's visual thinking derives meaning from graphic representations (Allen, 2005; 2006:58). I argue that Iris's work in the IEZ catalysed her unconscious processes at an early stage in the therapy and so caused rapid symptom relief. Though this physical and visual understanding directly from the 'core' shocked Iris entirely, at the same time it evoked her strengths, self-determination and drive. She became *'actively open to all options.'*

It was notable that when Iris used only verbal communication she would cry a lot and would never reach the IEZ, but when active in the IEZ she always stopped crying. This fact can be explained by the concepts of 'Dramatic Paradox' (Landy, 1993:11-12) and theatrical distance (Jennings, 1998). Talking about the traumas, she was confronted directly with her traumatic memories and so wept painfully. In the safety of the IEZ, however, she only obliquely approached genuine remembered physical senses, and could do so without being overwhelmed, frightened, threatened or losing control.

This analysis and interpretation of the interaction between the C.PT's personality structure and IEZ is strongly supported by other theoretical propositions (Frankel, 1981; Jung, 1989; Costa and McCrae, 1995; Winnicott, 1971; Ryan and Deci, 2000; Peterson and Seligman, 2004; Van der Kolk, 2006; Lahad, 2007; LeDoux, 2008); and by the client's own reflections. We may conclude that the merger of these two components - the C.PT's ability to exploit the experience within the IEZ - directly helped the coming into being of a CZ and contributed to this case of recovery from chronic PTSD.

The C.PT's Activities within Dramatherapy

This section focuses on interpreting the second element pertaining to the C.PT in Research Question 1, namely, that dramatherapy activities that took her into the IEZ and enabled her to function there. Although the dramatherapy activities are regarded as a bridge to the IEZ, they possess healing potential in themselves (Winnicott, 1971; Jones, 1996; Levine, 1997; Jennings, 1998) from which I assume that the combination of these two components exerted multiple impacts on the CZ and PTSD recovery process. The dramatherapy activities generated many artefacts over the twenty encounters, which allowed me to monitor symptom reduction and the trend to recovery, as depicted in Graphs 19.1 and 19.2

Here, however, only the activities which were the most effective in terms of symptom relief are analysed and interpreted. The selection of activities is also supported by the client's own reflections, which singled them out as bringing about crucial changes, and by theoretical propositions noted in the professional literature.

Spectrograms – Sculpted Objects

The first sculpted objects (Encounter 2) manifested emptiness and were colourless and motionless. A closed and very small world reflected the severe post-traumatic state at the beginning of the therapy confirmed by the client's verbal description of her symptoms. The few objects in the spectrogram represented love, hope, the desire to enjoy and have fun, in other words they reflected Iris's inner strength. In making the spectrogram Iris depicted her present world in dramatic language (Jennings, 1992) rather than verbal conversation. She used a symbol as *'a way of negotiation between inner conflict, outer expression and potential resolution* [that] … *has wider interpretative meaning in its relationship to the client'* (Jones, 1996 p.242). Similarly, Levine (1997:41-42) asserts that the unthreatening artistic activity functions as a *'medium for the imagination'.* Therapeutically, this activity helped differentiate the

two main elements in Iris's suffering, namely, traumatic grief and PTSD: although the symptoms are similar (Jacobs, 1999), the treatment is different.

Sculpting objects opens up the opportunity to work with the body as Levine (1999) suggests and at the same time bridges between everyday reality and the IEZ. It enabled Iris to move into further fundamental dramatherapeutic processes – reworking her experience (Jennings, 1998) through dramatic projection and work with symbols (Jones, 1996). The biggest object in the first spectrogram was a stone which represented her innermost pain, *'the grief that remained from the stillborn baby'*. (It is a Jewish custom to put a stone on the grave at each visit to the graveyard). The stone was the unconscious symbol of the unresolved grief that disturbed and troubled her life, while a blue button and a shell symbolised her small almost invisible existence. Using imaginative creation she could finally become consciously aware of her traumas and find a new way of coping with them.

Spectrogram activity within the IEZ, gave rise to another unconscious powerful process, it activated both the sensory somatic system (Levine, 1999; Chandler, 2005) and the affective response (Adamec, 2000). In this way it dissolved blockages to locked-up energies and penetrated through the cerebral neo-cortex to lower layers of the mammalian brain, the limbic system where it is assumed that the IEZ exists; while the CZ is assumed to be situated in the amygdala where traumatic memories are engraved (Weiss, 2007; Dbięc and LeDoux, 2009). This thaw of Iris's frozen state marked the beginning of her recovery.

Of all the dramatherapeutic activities, Iris singled out the powerful influence of the spectrogram in her two oral histories. The spectrogram, she said:

> *Is letting your inner self tell you what you think about things, especially your life. And I think it is quite amazing how it works. The first one I did really shocked me to the core – shocked me that my world was so small and I was insignificant and it wasn't until I put all these things on the page, THEN I saw what I had put down – I didn't think, I just picked these things and put them there. The dog looked like my dog and so I put*

> it there. But the other things that I put there I didn't consciously say 'Oh, this big giant rock is my baby's death.'

In the second oral history four years after therapy ended she said:

> In all the work we did, the most effective, the most powerful things for me were the spectrograms, with respect to recalling memories. I have to go back to the spectrograms. I can still see in my mind the difference between the two spectrograms.

The second spectrogram: This spectrogram, performed a few minutes after the first one, represented the client's future world. It had fullness, richness, intense colour, flow and motion. It was open and wide.

> When I did the second spectrogram I came up with the idea of how I would like my world to look, which was very intriguing for my imagination. Automatically your mind starts thinking 'Oh how can I get to that' so I think it [the spectrogram] is a very good exercise or treatment, because the person almost automatically starts making the journey from A to B - from how they are now to how they want their future to be. You almost don't have to tell your mind to do much more because it understands much better than the intellectual part … (First Oral History, Appendix 4).

Although she was basically operating with the same bodily and psychological systems as with the first spectrogram, Iris reacted differently to the rich second sculpt. She was less sad, made more movements and expressed her surprise in a different voice, her eyes lightened. Her changed appearance reflected what she had projected into this spectrogram - her wishful hopes for a better world. She felt her strength and positive side, which enhanced her belief in herself and in the good things in life. She glimpsed the option of moving on, of starting the journey toward recovery instead of remaining stuck in emptiness. Most importantly, this was her own activity, sprang from her own latent inner forces and was independent both of the therapist and of verbal communication.

The spectrograms activated the body and Iris could ascend into the IEZ, where the injured imagination made contact with its latent healthy parts in the limbic system and the amygdala. The dynamics of IEZ involve loss of self-consciousness, an altered sense of time, self-rewarding experience and enjoyment of the flow (Nakamura and Csikszentmihalyi, 2001), a flow which could progress into the CZ where the PTSD symptoms vanished; while the effects of dramatic distancing (Jennings, 1992, 1998) and the 'Dramatic Paradox' also play their part. This view is supported by Logan (1988:172-173) who describes the paradox that in situations seemingly *'farthest removed from the enjoyable, namely, solitary prolonged survival ordeals, people … describe having flow experiences'*.

Pastel Drawings

The three pastel drawings on paper belong to the projective stage (Jennings, 1993). They were created in the third encounter and resembled and repeated the two spectrograms' symbols, metaphors, colours and themes. The first drawing emphasised the traumatic state, the third one the repletion of a sunny blooming garden, growth, fullness and colour. The third optimistic picture represented Iris's positive traits and virtues. The healthy parts of her imagination and creativity had been stimulated.

This activity was interpreted as contributing in an identical way to recovery as did the spectrogram and sculpted objects, so that no additional interpretation is offered here.

Clay Modelling

Iris created three clay artefacts in the fifth encounter and, in spite of the blame, anger, confusion, distress and helplessness that she spouted verbally for two hours, new qualities could be attributed to the clay-work. The sensory play in kneading the clay helped Iris express genuine feelings of anger and distress and also gain some relaxation and control (Oaklander, 1994:76), at the same time as she connected unconsciously with her injured emotionality (McMahon, 1996). In the course of her PTSD treatment these three artefacts represented an amazing

development. They no longer displayed traumatic symptoms, or an insignificant invisible self; new roles had emerged, Strengths and virtues were clearly visible. Iris declared: *'It is only now that I feel I am rebuilding my life … it is to be a power station'* and laughed for the first time, proud of her first clay work. She was smiling for the first time when I asked her to continue working with the clay. The second clay artefact - a bird - she wanted to be similar to the one in her third drawing, explaining:

> *Eagles fly effortlessly. When I used to write stories, and when I was pregnant, everything came easily to me. Today I am gathering strength to emulate this bird, so that I can fly again.*

The bird might be explained as a symbol of the human soul and every winged being is considered symbolic of spiritualism. The eagle is also a symbol of heights, a bird living in the full light of the sun and so luminous in its essence (Cirlot, 1995). In creating the eagle, Iris unconsciously projected her strong wish to be connected to her soul and to be able to use her creative writing talent as before the trauma. Iris amused herself until the end of the encounter with words and clay, shaping a 'Z-like shape, and called it 'Zap' the third clay artefact. She used this as a symbol of fighting back, a motive which had also appeared in her 6PSM.

The clay work marked a turning point, when her chronic symptoms began to release their hold on her and gave way to a sprouting sense of increasing power and control. Creating power with one's own hands in the IEZ and experiencing the flow in the 'Zone' (Nakamura and Csikszentmihalyi, 2001) generates an interactive impact. It relieves symptoms and the client explores a novel active warrior role (Landy, 1993). The battle to regain control of one's life has been engaged (Yovell, 2001). This move towards the client's awareness of an inner competence to struggle with the symptoms is a crucial development in treating people with PTSD. In this sense, the more the client uses dramatic sensory play in the IEZ, the more opportunities the client has of reaching the CZ.

This activity was interpreted as having an identical contribution to recovery as the spectrogram and sculpted objects and so no additional interpretation is given here.

Finger Painting

In the fifth encounter the positive results of playing with clay could not have been predicted or imagined. In the sixth, Iris looked, felt and behaved completely the opposite from earlier encounters and she revealed that one of her most difficult symptoms had disappeared:

> *Yes, me actually walking up to and talking to a woman who is pregnant, and feeling unafraid. I admit that it has been impossible until now to even speak to this woman, who has been so kind to me, or anyone who is pregnant or has a baby. I feel elated, as though I have passed a test.*

She felt more comfortable with her grief and *'as if I have finished with this part.'* Encouraged and happy with this astonishing happening, she chose to play with finger paints in order to deal directly with the anger revealed in our third encounter. Finger paints have similar characteristics to clay: they are messy, soft and colourful. It is an unthreatening relaxing flowing activity, demanding no special skills. But when there is extreme emotion (anger in this case) it can provide relief (Oaklander, 1994:28-58).

In her finger-paint dialogue with her anger Iris came the closest, except for her clay-work, to the embodiment stage - the first year of life, when a baby experiences the world through physical exploration of its immediate surroundings (Jennings, 1998). This activity was highly significant both for her traumatic grief (Littlewood, 1996; Rando, 1991) and for dealing with the *'whirlpool, atomic explosion and chaos'* of anger, metaphors characteristic of PTSD symptoms. Firstly, she used bright colours and worked gently with her fingertips. I encouraged her to use more paint and her palms too, till she was fighting back with scratches, hitting with fists and karate blows. She had found a new way of coping with anger, without being afraid of the consequences. Iris continued performing this 'warrior' role, enjoyed it, and found new energy. The finger painting reflected exactly what was happening in her mind and pointed to an inner conflict and role ambivalence, although it was clear that consciously she wanted peace.

One must negotiate with one's tendency to disturb the peace, to do what one needs to give voice to one's anger and listen very carefully to the message. In choosing peace, a place needs to be found for war (Landy, 1993:13-14).

There was no doubt that Iris, playing thus in the IEZ, had grasped hidden messages. She again experienced the flow's engrossing, enjoyable and autotelic nature (autotelic = intrinsically rewarding) (Csikszentmihalyi, 1999). So I asked her to continue with the finger paints, to create 'the power station' she had talked about all week, instead of the one she had made with clay and did not like. Symbolically, she chose to paint an intense blue sapphire to represent the rebuilding of a new image, confidence and strength in contrast to the flat pale blue spot with which she had represented her traumatic state in the second and third encounters.

According to Cirlot (1995: 313-314) the sapphire or lapis lazuli was *'supposed to be able to prophesy by changing its colour'* and is considered to be the second hardest stone after diamond.

Iris may not have known these facts, but she was attracted by the deep sapphire colour and painted it in two different shades of blue, surrounding it with an intense red rhombus or diamond – a symbol of the light, brilliance and treasure representing moral and intellectual knowledge. Could it have been an unconscious prophesy of her future? The creation of this new symbol prompts a wider interpretation of what was happening to the client (Jones, 1996:242): metaphorically, she was finding her way to gather power. Iris commented at the end of the encounter:

I feel that the treatment is very helpful to me, it is concrete and not just words like in psychology, and each time I leave our session, I feel good and I have the power to do things I was not able to do until now.

This is further support for those PTSD studies which have recommended that treatment should not be based only on words and that more effective approaches should be found (Spinazzola et al., 2005:343). Finger painting allowed Iris to use

her sensory system to express and manage her anger, as well as pointing her towards new strategies to cope with her PTSD.

The interpretation of how this activity contributed to recovery is the same as for the spectrogram and sculpted objects and is therefore not repeated here.

Sandplay

In the middle phase of the therapy, when the PTSD symptoms were already partly decreased, my supervisor for seven years Professor Lahad, who guided me during Iris's treatment, recommended in a supervision meeting that I should intensify the therapeutic process. It was thought necessary to concentrate on a few dramatherapy activities instead of spreading the therapeutic effort over a variety. I believe that Professor Lahad's expert advice helped me to cope more successfully with this complicated case. So at this juncture I asked Iris to choose one activity to begin with, one to focus on, and one for closure. Iris decided to open with body movement, to continue with sandplay and to close with guided imagery. For six encounters the therapy was engrossed in sandplay. It became a cluster activity and engendered reactions that no other dramatherapy activity did. It was the second most important activity after the spectrogram. As the client recalled:

> *I also think that working in the sand tray was very useful; because the roles* [I played] *help demonstrate what tools you have within you, and how you are using them - whether …for your benefit or your detriment. Because sometimes you find all these stupid characters that you've put in the sand tray and you are thinking what an idiot this leading figure is going to have all these goofy characters around and they don't know what they are doing or they are not organised, but then you start to realise that 'that's me' and I have all these skills and abilities but I have them all lined up in the wrong order! So you realise you have these strengths that you just aren't using them properly so it is also very enlightening – I think awareness is one of the key elements that helps give you all those options again.*

Four years later she recalled:

When I started working with the sandbox, I thought it was kind of a stupid thing to do because it seemed very childish-you know-like, but in fact it is quite a powerful tool and I was surprised, myself, at how effectively it worked. I remember I always used to end up suddenly yawning in the middle of these sessions and feeling that something was kind of overtaking me. The other day I was thinking about the penguin that I chose, I think, as the first model for sandbox work, and I was thinking what an incredible force my subconscious mind had to choose that character … But in fact, at that time, I was in a situation where my life was really quite frozen in place and really I could not fly, I creatively couldn't fly. I could hardly walk and so there was no creature more appropriate to choose than that.

These quoted memories clearly support Markell's (2002) observations and theoretical perspectives on sandplay, *'The scenes constructed are images of a psychic world, imagined by the client out of her/his conflicts, hopes and dreams'*.

Like other dramatherapy activities, sandplay prompts the conscious mind to relax its control and allow the unconscious material beneath to well up (Kalff, 2004). As Van der Kolk (2002:382, 387) says of PTSD:

PTSD … is characterised by intrusive sensory recollections of traumatic life experiences. But the ordinary things associated with the PTSD event, the smells, physical sensations or sounds are not relived as images. Ordinarily, the remembered aspect … coalesces into a story capturing the essence of what happened …. And when people with PTSD relive their trauma they have great difficulty putting that experience into words.

Iris shaped her sandplay as she wished: it became both a ritualistic and risky mode of working (Jennings, 1998). It can be described as a monodrama in a sand tray. During each encounter, she created a new scene and told a long story, performing the roles of all the different figures, mimicking gestures, facial expression and voice. As she told the story she moved the 'cast' around, moved

the sand and threw out unwanted figures, so that by the end of the story the tray looked very different from the beginning.

Two new somatic reactions appeared as soon as Iris started to sandplay - and only in this activity - she yawned without stop and sensed extreme internal coldness although she sat next to a heater. This happened in five out of the six sandplay encounters. Markell (2002: 239-240) sheds light on the connection between sandplay and somatic reactions which were exhibited by Iris:

> The internal geography that emerges in sandplay, whose somatic aspect often features the revelation of stored memories of pain, grief loss or rage, reveals landscapes that frequently are unspeakable. The meaning is dramatised by the body, often in a repetitive manner, until new meanings can develop. Somatic eruptions are therefore very likely to occur during the sand processes.

In sandplay she simultaneously used images that were symbolic both of the initial PTSD and of new strength, positive virtues and determination. Some of the PTSD-related images went back to her early childhood, to feelings that had afflicted her from then until now. The two most prominent were 'feeling cold' and 'loneliness', for example:

> This is the world of the penguin that lived alone in a white, icy cold wasteland. One day Penny the penguin woke up and looked around to discover that all the other penguins had vanished. They had gone to the iceberg and left Penny alone. Usually this would not bother Penny, but suddenly his eye caught sight of movement on the ice. There stood a big polar bear that could smell but not see the penguin ... Penny was sure that he was going to freeze to death because he was too afraid to move forward or backward ... Presently, the penguin thought - I will die of the cold or the bear will kill me. I have laid here waiting too long; will I stay here and die without a fight? I want to survive! Better to die fighting than to die for nothing. So he got up and saw that the bear was still there, but it didn't matter to him anymore. Slowly he started off in the direction he thought the other penguins had gone. It was a cold and difficult walk, but

soon he felt stronger and started to run in the direction of the sea. Finally, Penny the penguin jumped into the sea and immersed himself in the freedom of the water and joined all the other penguins.

This picture characterised both the client's traumatic experience and her survival. She needed to repeat it in order to regain further strength and control, even though her symptoms had decreased. The sand's warm, gentle, flowing feel enhanced both the somatic curing process and her readiness to reveal new meanings. Apparently, the coldness had been imprinted in her soma since she was a little girl, and yet surprisingly it vanished, together with the other symptoms, within five encounters of sandplay.

By the second sandplay encounter a group of several figurines had united. These friends, the Penguin, the Strong Man, the Mouse and the Monkey *'are no longer lonely individuals who lack confidence in themselves and have to fight their battles alone; when the group works together they are very strong.'* Iris had used her imagination to create a new reality in the IEZ. In the third sandplay she went further: *'I think I have a good chance of getting pregnant'* (this wish was indeed fulfilled later). Iris's sandplay is further proof that the ultimate goal of sandplay is to achieve *'wholeness of ego and self, of body and soul, or psyche and matter'* (Markell, 2002:24).

The next productions in the sand tray encompassed active warrior figures like the big Strong Man, Soldier, Commanding Officer, Weapons, Power Station and a Magician, who by *'the power of magic transforms the Strong Man into a leader who is strong, capable and intelligent',* instead of just enjoying fighting. By the sixth sandplay the fatigue and coldness had disappeared:

I am able to go forward into my power station, where I can write and use all my creative talents. A powerful light, a mystical energy emanates from this vibrant blue place that nurtures my power. The magician is coming along with me, just for the sheer enjoyment, we can create together. Even though there may be problems, we are going to take it easy and enjoy ourselves together. Free to roam, the pressure has gone; we have laid down our burdens and left them behind us. We are as free as the

> *spirits of the air. Now, is our time, we are going to enjoy the rewards of*
> *life, professionally and soulfully.*

Iris had used the qualities of sandplay: performing all the symbolic roles, directing the scenes, witnessing and stage-managing her steps forward, to achieve rebirth.

Sandplay began in the eighth encounter. At that time Iris - on her own initiative - had completed an Internet questionnaire detailing the status of her PTSD, reporting relief of emotional, cognitive and hyper-arousal symptoms. After the eleventh encounter and three sandplay sessions, she declared that further symptoms had vanished and that a significant life transformation had occurred: she had found a job in television, suiting her former career in that it gave vent to her creative talent. The final PTSD symptoms had vanished by the fifteenth encounter, the last time she used sandplay. Together, body movement, the long stay in sandplay, storytelling and guided imagery (Lahad, 2000; Tusek and Cwynar, 2000) helped to release all her remaining symptoms.

In her First Oral History (Appendix 4) Iris wrote of her sand play that:

> *… it opens possibilities … and that's part of its power – and also that it is*
> *fun – it is not threatening – it takes you back into your childhood, it takes*
> *you back into some of the most fun things you have done, which was also*
> *a situation where it was harmless and you felt very protected , so there*
> *you are able to really throw out a possible life – throw it out, look at it...*
> *change it … you realise you can change things. So … you realise that a*
> *good part of reality is in your hands.*

Here she recognises the control that she has just exercised and some of the implications and associated sensations.

Body Movement

In dramatherapy the body is the main tool of communication and expression. It is an essential component needed in order to explore the emotions, individual identity, relationship to self and others, to construct a social persona and to gain an increased awareness of the body's range and potential (Jones, 1996:148-166).

It plays a crucial part in the treatment of PTSD (Levine, 1999). In Iris's case, the combination of body movement and sandplay had a double impact on her symptoms, all of which actually vanished between the eighth and fifteenth encounters. Iris (in her first oral history) has this to say about the importance of the body in PTSD (unknowingly endorsing the theories of Van der Kolk (2006) :

> *Working with the body is like working with the spectrogram because at first you don't think that your body will talk about things that are bothering you. You kind of think 'Well, I am in charge of my body so I can do whatever I want', but as you start doing the performance or physical explanation or whatever, your subconscious just takes over and tells the story that you need to tell … a friend once told me that muscle has memory, so I think the body work is an important part of dealing with it* [PTSD], *because especially painful memories are part of your body – so if you only deal with the head you are not getting to that muscular part.*

> *I also remember doing one session where I was an Indian running through the woods and someone was running to chase and kill me, but I managed to hide and stay free – and when you think about all the bad dreams I had, they were always about someone trying to kill me and I always woke up at the moment they were going to shoot me or something – so I think that was a powerful tool to stop having those dreams, because I don't have them anymore.*

From a theoretical perspective, Thornton (1996:78-80) asserts that *'movement enables us to allow our inner, creative voice to speak*,' and also to express emotions, hidden themes and nonverbal symptoms that are difficult to express in words. In her enactment of different roles, and her body movement Iris expressed exactly how she felt and how the curative transformations of her therapy were being achieved, thus providing a detailed, clear and comprehensible explanation of these feelings in comparison to more general explanations provided in the theoretical literature (Rogers, 1993; Cooper, 1996).

Summary

This chapter has employed theoretical propositions from various fields, fieldwork evidence and the client's reflections to answer the first research question: *How did the interaction between the client's personality structure, dramatherapy activities and IEZ contribute to her recovery?* The answer is that this interaction created a special synthesis among these variables, which together engendered transformation and then erosion of the client's PTSD symptoms. The client's strengths and virtues were unearthed as she used the healing potential of the nonverbal dramatic activities; she could ascend to the IEZ and remain there for long periods under its curative powers; touching up the engraved traumatic memories in the amygdala where I posit that the CZ exists and where the symptoms became extinct (Joseph, 2001; Phelps et al., 2004; Morgane, Galler and Mokler, 2005; LeDoux, 2008; Quirk and Mueller, 2008).

The next chapter discusses the interaction between the C.PT and TAE and how these components contributed to the client's recovery and addresses the second research question.

Chapter 20: Answering Research Question 2

Introduction

This chapter will interpret the connections between the C.PT and TAE in the creation of the successful outcomes. In so doing, it answers the second research question: *How did the interaction between the TAE and the C.PT contribute to the client's recovery?*

Unorthodox Encounters and C.PT

The phrase TAE refers to the therapist's unorthodox and exceptional practice of extending the therapeutic encounters with Iris to three or four hours in length. Shapiro (2000) concluded that therapists could benefit from thinking more creatively about the length of sessions and that variations in their length might further the treatment at crucial times. As I understood it, my client's chronic severe posttraumatic symptoms and three years of unresolved traumatic grief indicated that her encounters needed to be handled in a different and unusual manner; and among other things, they should not be restricted to the traditional 45-50 minute timeframe.

As Winnicott (1971:88) declared '*it can be seen that in a fifty minutes* [session] *any effective work could not be done, we had three hours to waste and use.*' This similar view makes sense if the client's mental health is positioned in the centre and not the rigid setting or the boundaries. More importantly, Winnicott recognised that there were patients who could not bear the standard rules, and this necessitated an adjustment in therapy rules to their needs. In this context, Shapiro (2000) suggests that the expansion of the time frame in treatment can be important because clinicians often tend to lock into a certain time schema and then are not optimally responsive to a patient's problems.

Hence the therapist's therapeutic decision was strictly based on the client's unspoken needs as they revealed themselves in the first encounter. Intuitively, (Bohart, 1999) I felt this was a crucial matter, as the client 'was living as dead.' With the aim of 'holding', her immediately, optimally and maximally I offered her

double sessions, which later expanded to 3-4 hours at each encounter. My decision accords with the view of Epstein (1994:17) who observed that *'ideally, the therapist will be able to fine-tune the frame into an empathic, dynamic structure that is sensitive to the patient's changing needs'* , while 'holding' is Winnicott's concept and relates to the sense of continuity of the state of being over a period of time (Ogden 2004).

In her second oral history Iris recalled this issue:

> *The timeframe of the meetings, which I had actually completely forgotten about, which sounds a bit stupid, but the fact that we were able to sit and continue talking and working together for more than an hour and usually two hours and sometimes three almost, I think it's also an important factor.*

She explained her difficulty with a conventional therapeutic hour:

> *When I was working with the psychologist I would just get to the point where actually I wanted to say or reveal something or where I was getting ready to know something about what was happening with me when, you know, she'd look at her watch or look at the clock on the wall and say 'Well, our time is about up so … whatever you have to say, spit it out and get out of here!' So I always had the feeling that she really didn't want to know what I had to say, she didn't really care that I couldn't say it in an hour, and I couldn't emotionally bring myself to get close to it in less than that time.*

Although according to most traditional psychotherapy approaches TAE seems a breach of the treatment's setting and boundaries (Elmhirst, 1978; Shapiro, 2000; Roth, 2007), I understood that I had the responsibility to halt the client's further deterioration and felt this was more important than the notion of boundaries. Nor did I feel that there was anything unprofessional or disorderly in prolonging encounters. On the contrary, as the treatment progressed the benefit of TAE became clear. It was a critical aid to recovery; for the longer Iris could spend finding and expressing herself the more she felt she was achieving her needs. With respect to her personality structure, her non-despairing part needed time to

articulate and work through her unfinished traumatic grief. Iris left every one of the sessions feeling that her needs had been satisfied.

TAE was an example of attuning the treatment to the client's needs. The extended encounters became a 'container' that supplemented my researcher/therapist role as a 'container'; a concept that appears in Bion's (1897-1979) psychoanalytical theory, relating to the processing of thoughts derived from lived emotional experience (Bion cited in Ogden 2004). This occurs when *'the infant learns to think, provided that a maternal receptacle or container is available to modify its anxiety, thereby transforming toxic states of mind into manageable thoughts, feelings and moderating unbearable dread of dying'* (Jacobus, 2005:174-175).

Another perception of containment is as a shelter in which the container supplies the sense of a safe secure haven. In therapy, the therapist is the container who has the containment capability, providing safe boundaries and shape to what is contained inside. The container can cause transformation in the shape of experience via the containment process, because when an individual's negative feelings are projected into a good container, they are transformed, and can then be re-internalised in a form that the psyche can bear (Timna, 2007). In this sense I assert that in addition to my own role as a container, the TAE also constituted a container which served Iris' needs. Thus, the TAE container enabled Iris to focus on and delve deeply into a particular activity and process, which became each time a therapeutic mini-journey. Iris's quick acceptance of and adjustment to longer encounters revealed her latent needs. Firstly, she needed desperately to retell her afflicted story again and again. As she said in the second encounter:

During our first session I felt it was the first time that anyone really listened to my story without interrupting or advising me what I should do. Until now I have had no one to talk to about the way I feel. Nobody wants to hear my story because it's so painful.

This assertion became the motto for the whole therapy; it was obvious that the retelling of her story was her way of working out her traumatic grief (Bar-Yitzhak 1999; Jacobs, 1999). She also needed to share the stressful experience of the subsequent fertility treatments. All these discursive, repetitious retellings and the need to be listened to for as long as it took could not have been accommodated within 50-minute sessions. As noted, TAE also provided sufficient time to integrate two types of therapy – therapeutic conversations which lasted about one-and-a-half hours, and dramatherapy which lasted another one-and-a-half hours.

In this way I was able to turn the encounters into a 'subjective realm of reality' for Iris' benefit and ease. This 'realm' is part of the Hopi Indians' (of southwest America) *'recognition in two realms of reality manifested (objective) and manifesting (subjective). The subjective reality is the future and the mental; it lies in the realm of expectancy and of desire'* (Tuan, 2001:120). In this sense it has similar characteristics to the IEZ. Thus, Iris could unconsciously tune herself in to positive and optimistic wishes instead of being all the time in the manifested objective realm.

Iris reflected on the long encounters in her second oral history: *'I found it much easier for me to go deeper'.* Extending the length of the session suited her tempo and temperament and the way she felt like handling the activities of each encounter. The dramatherapy activities, which were so effective in bringing about changes in her state, demanded a lot of time. Creating a scene or artefacts, telling a story or playing roles are developmental processes which take a long time to enter into and to work through their range of opportunities. Thus, the expanded frame of time also became the stage on which to perform all the roles represented by her diverse symptoms and changed states. The TAE was also a 'container' in the sense of a stage which absorbed and contained every occurrence performed by her. Every time Iris came to therapy meetings she knew the time that stretched out ahead of her; it provided an additional TAE trait of being a *'facilitating environment'* that *'keeps the essential quality of a good-enough holding mother'* (Winnicott, 1971:26).

TAE *'accelerated the removal of blockages and isolation, breaking down ritualistic behaviour patterns and provided a positive holistic experience in an interpersonal situation'* (Cohen, 1980: 67:69–81, cited in Shapiro, 2000). It can be seen as one of the explanations for the rapid positive transformations in Iris's state as early as the first phase of the therapy. An additional significant aspect in the interaction between TAE and C.PT was the fact that Iris was completely satisfied and felt comfortable and relaxed with the flexible long encounter; she accepted it as a natural therapeutic time frame.

Summary

This chapter has discussed theoretical propositions, fieldwork evidence and the client's reflections in order to answer the second research question: *how did the interaction between TAE and C.PT contribute to the client's recovery?* The answer is that this interaction operated in harmony and the reciprocal curative influence for the client's sake was evidenced by the positive transformation and the successful outcomes. It explained the notion of TAE as a 'subjective realm of reality' (Tuan, 2001) and as a 'container', which contained the client's needs and afflicted situation while she lived as dead and then was replenished with vitality which assisted her rebirth; enhancing understanding of the researched phenomenon and the process by which the recovery was achieved. The next chapter discusses the interaction between TAE and IEZ and the way that they both contributed to Iris's recovery and addresses the third research question.

Chapter 21: Answering Research Question 3

Introduction

This chapter interprets the connections between the TAE and IEZ and the contribution of this relationship to the successful outcomes. It discusses aspects of the TAE and IEZ presented in the former chapters, intending to answer the third research question: *How did the interaction between TAE and IEZ contribute to the client's recovery?*

TAE and IEZ interaction

Although the theories that relate to the IEZ do not refer to time, its presence can be inferred in them. The concept of the IEZ encompasses imagination and the mental state of 'flow' which can be experienced at varying levels of intensity. Nakamura and Csikszentmihalyi, (2001) discussed eight dimensions that comprise flow: 1) a clear goal, 2) direct and immediate feedback, 3) challenges match skills, 4) concentration and focus, 5) a sense of personal control, 6) loss of self-consciousness, 7) distortion of time and 8) activity becomes autotelic. All this requires a time space in which it can occur. TAE and the IEZ combined positively in the present research because TAE provided the time that the imaginative processes needed. Levine (1997:41) says that '*healing has to be understood as the restoration of the person's imaginative capacity*'. This hint at the role played by the TAE: since restoration in any field of endeavour is usually a long-term process. So too with Iris, much time was required to restore a wounded imagination shattered for three years.

In addition to the TAE features mentioned before, it should be noted that TAE embraces another kind of time: 'quality time'. This notion is a compound of holding, drifting, release, peace of mind, quietude, opening new possibilities and a sense of endlessness.

'Quality time' enables a person to forget everyday reality, while absorbed in dramatic activity and to ascend to the IEZ that represents a different reality. Specifically, in this case, Iris always enjoyed the 3-4 hours encounters; and was

surprised each time that noon arrived, as she did not notice the passage of time. This experience is reminiscent of the distortion of time that occurs in the flow experience. The view offered here resembles the description that Lahad (2007) provides for the concept of 'Fantastic Reality', a state in which there is no control over the three concrete elements of time, place and role. Furthermore, the 'quality time' element of TAE interacted with the IEZ since it provided 'potential space' and 'transitional space', where subjective experience could take place (Winnicott, 1971:47).

Csikszentmihalyi's (1999) flow and the Zone as a distinct and unusual psychological state (Ferraro, 1999) also constitute aspects of the IEZ's transforming quality, with its altered sense of time, loss of self-consciousness, sense of potential control and autotelic experience. 'Quality time' helps account for the dual impact of TAE and IEZ, which enabled the client to attain a CZ.

The interaction of TAE and IEZ created a hothouse that triggered recovery. The combination of these two elements created a calm, warm, welcoming environment that in a short time warmed the frozen body and relieved other symptoms. Frankel (1981:155) has defined the process as giving *'permission to the imagination'* to enter into a rich internal life and spiritual freedom. This explains the client's wish to stay in the IEZ as much as was possible: her emotional and somatic systems experienced an altered existence remote from her afflicted reality. The interaction of TAE and IEZ creates a large container, which imbues those who enter it with a sense of discovery and generates the excitement and enjoyment of finding new abilities in oneself. It also offers the potential of interacting with the dramatherapy activity itself (Chen, Wigand and Nilan, 1999) as Iris herself described many times.

Iris's acceptance of TAE awoke the feeling that time had been adapted especially to her needs, and so enhanced her sense of strength, self-confidence and trust. She felt that she was understandable, contained and safe.

While these elements are fundamental to any therapeutic process, they are crucially important to a successful outcome for people with chronic PTSD. The interaction of TAE and IEZ created a place where, physically and mentally, latent knowledge was accessed by imaginative language and unconscious processes. This interaction provoked emotional and bodily reactions which can be regarded as the connecting path between the IEZ (located in the limbic system) and the CZ (located in the amygdala).

The TAE and IEZ acted as two walls or shields, the TAE the external protector and the IEZ the internal defence. Together they formed a safe protected haven, in which the therapeutic processes could eradicate the three years of horrible symptoms.

Summary

This chapter has discussed several theoretical propositions, to answer the third research question: *How did the interaction between TAE and IEZ contribute to recovery?* The answer is that this interaction created a special atmosphere in which the TAE and the IEZ produced synergy because TAE provided the time that the imaginative processes needed; while its component 'quality time' helps account for the dual impact of TAE and IEZ, which enabled the client to attain a CZ and recovery. The combination of the two elements supplied a calm, warm, containing environment that in a short time warmed Iris's frozen body helping her to restore her imaginative capacity and, in that process, to relieve other symptoms. This chapter forms the foundation for the next chapter that discusses the interaction between the three components, C.PT, IEZ and TAE, and how they contributed to creating a Curative Zone (CZ) and assisted recovery from PTSD and so answered the final research question.

Chapter 22: Answering Research Question 4

Introduction

This chapter interprets the connections between the three core variables - the focus of this research in relation to the successful outcomes, and employs this relationship as the basis for the construction of the study's conceptual framework. It answers the fourth research question: How did the interaction between C.PT, TAE and IEZ contribute to creating a Curative Zone and recovery from PTSD in this case study?

The Interaction between C.PT, TAE and IEZ

This section discusses the interaction between C.PT, TAE and the IEZ — an overlap area represented as D in Figure 17.1 (Representative Schema for Analysis of the Findings, p. 254). In the previous chapters of this Part the analysis specified the importance of each area of interaction in Figure 17.1 (AB, AC, BC,) for symptom relief and recovery. The conclusions of that analysis are now brought together to show how the interaction of all three components explains the recovery from PTSD. Figure 22.1 below redisplays the conceptual framework underpinning the answer to the fourth research question, namely, that within a frame of dramatherapy, the C.PT, TAE and IEZ variables together created a CZ:

Figure 22.1: The Conceptual Framework for the Research

A Dramatherapy Model of PTSD Recovery
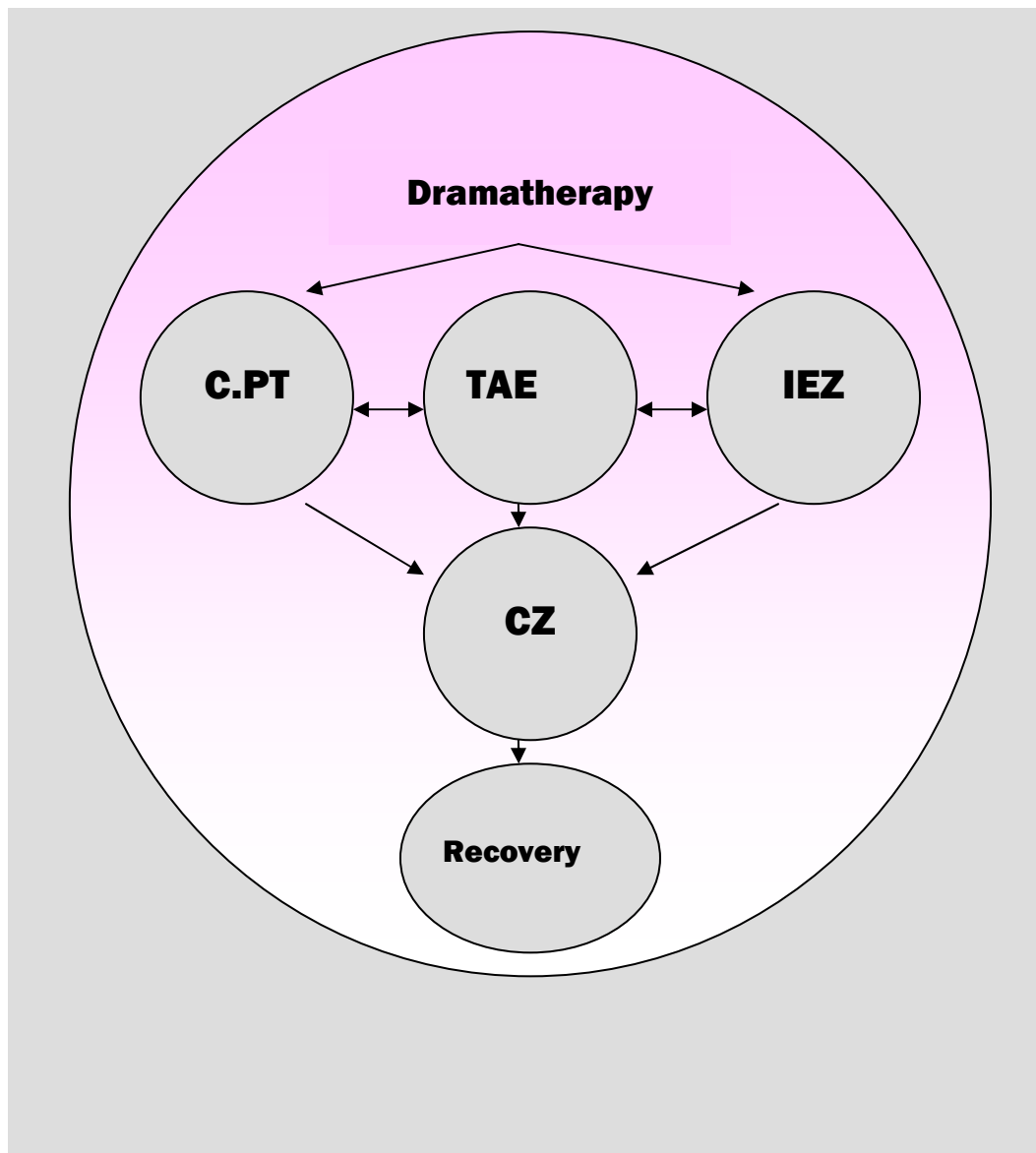
A special constellation emerged within the dramatherapy frame, during the therapeutic encounters, and created an interplay between the three variables, C.PT, IEZ and TAE. Their curative characteristics interacted and integrated to construct a new latent entity, a Curative Zone (CZ), that it is asserted is located in the amygdala.

The heading 'dramatherapy' provided the frame within which the nonverbal dramatic-artistic language, the activities and modes designed to bring out and activate the C.PT's own strengths, and the range of dramatherapy activities were deployed. The dramatherapy frame also embraced much of the nonverbal IEZ, the realm of the imagination, the Zone, memory, visual imagery, expression, and perception of most aspects of the emotions, all of which are connected to and concentrated in the amygdala, which it is postulated is the Curative Zone for PTSD (Winnicott, 1971; LeDoux, 1993; Levine, 1999; Joseph, 2001; Le Doux, 2003; Csikzentmihalyi, Abuhamdeh and Nakamura, 2005; Van der Kolk, 2006; Le Doux, 2008). All these components of the dramatherapy frame interacted with the TAE and QTS (Quality Time Space) to create a safe 'container'.

The interaction of the IEZ and TAE (BC) provided the 'space' where, physically and emotionally, the client experienced her latent knowledge, by means of imaginative language and unconscious processes activated in the limbic system. The interaction between C.PT and IEZ (AB) and IEZ and TAE (BC) occurred simultaneously, activated by the dramatherapy activities and stimulated the client's somatic and emotional system. The recovery began in the IEZ, which I argue is located in the limbic system and extends into the amygdala, where a CZ came into being.

Another curative factor was that the non-literal, non-verbal dramatherapy mode, even when functioning minimally, activated the body and its sensory systems, thus releasing traumatic body memories and locked-up energies. All the processes described in this section are widely considered to be crucial and desirable procedures for the treatment of people with PTSD (Levine, 1999; Spinazzola et al., 2005:343; Van der Kolk, 2006; LeDoux, 2003).

Joseph's (2001) neurological research has confirmed the essential role of the limbic system and amygdala in the context of the research's studied components and points out a locus for the CZ.

He states:

> *Spiritual, mystical, trancelike states, dreaming, astral projection, all these behaviours and beliefs are related to activation of the limbic system, amygdala, hippocampus and temporal lobe. In these states the limbic system displays stimulated hyperactivity (105-106). The limbic system, hippocampus and the right hemisphere in general are directly involved in the production of memory and visual imagery and the expression and perception of most aspects of the emotions, including love, sadness, depression, fear, aggression, rage, pleasure, happiness and religious feelings* (111- 112).

Morgane, Galler and Mokler (2005) specify the limbic system as responsible for emotional, motivational and behavioural aspects, including the acquisition, storage, expression and extinction of fear memories, learning and storing information about emotional events. These and recent (Shin and Liberzon 2010) neurobiological findings strengthen the premises of this study and enhance our understanding of the adduced phenomena.

Based on these findings, I can say, therefore, that the cure in Iris's therapy was engendered by a combination of a range of emotions and states experienced and expressed in many ways; combined with somatic processes that exerted long-term influence on recovery. The review of the relevant literature has shown that holistic body-mind co-functioning is solidly established in neurology, which in turn helps to explain how the curative processes occurred when the three extra-therapeutic components interacted and created the CZ. Additionally, the concept of the holistic body-mind reciprocal influence supports the theoretical conceptualisation of the IEZ; which I postulate is located in the limbic system while the CZ in the amygdala.

My interpretation of the critical part played by the client (the C.PT component) and her contribution to recovery accentuates the role of the following factors in her recovery from PTSD:

- Qualitative parameters (emotional expression, body language and imaginative language);

- Critical incidents and insights always appeared when the client was in the IEZ, not in therapeutic conversation;

- The fixed parameters of personality structure: coping resources, virtues, strengths, self-determination, intrinsic motivation;

- The dramatherapy activities.

- The client's free choice to be active in the IEZ;

- The client's feeling that she could rule the roost, choose the dramatherapeutic modes and thus direct the therapy;

- The importance of the therapist's empathy and ability to enable the client to feel warmth, acceptance, safety and being understood;

- The client actively performing and playing many roles;

- The client being a collaborative participant and co-researcher.

These C.PT-located features all operated in free-flow within the curative features of the IEZ and TAE to enable Iris to gain control over the chronic PTSD. Simultaneously, the neurological regions involved in PTSD resumed their normal activity. It was this interactive, interconnected, multidimensional process that created the CZ.

Summary

This chapter has analysed the interaction between C.PT, TAE and the IEZ — an overlap area represented as D in Figure 18.1: Representative Schema for Analysis of the Findings. It showed that the interplay between neurological activation, giving the C.PT extended 'quality time' and support by TAE to work at length in the IEZ by means of dramatherapeutic activities created the CZ; which explains this instance of recovery from chronic PTSD. Moreover, the united forces of the three variables were activated together within the dramatherapy frame. They acted powerfully in combination with emotional, psychic and somatic systems to release - in sensory language, not words - the PTSD memories engraved in the

limbic system and the amygdala, where they became extinct. This multiplicity of curative factors eliminated the symptoms (Joseph, 2001; LeDoux, 2008; Joseph, Shiromani, Keane, and LeDoux, 2009).

Part V discussed the research findings in relation to relevant theoretical propositions from the literature and answered the four research questions, thus forming the foundation for Part VI which presents the conclusions that emerged from the analysis and interpretation of the data and the findings.

PART VI: CONCLUSIONS AND EPILOGUE

Preface

Chapter 23 presents my three levels of conclusions. It also describes the limitations of this study and its possible contributions to current knowledge concerning the treatment of PTSD. It indicates specific innovations and new concepts concerning recovery from PTSD that developed as a result of the research.

Chapter 23 concludes my thesis with an epilogue that describes my intellectual journey.

Chapter 23: Conclusions

Introduction

This chapter presents the conclusions from my study. It distinguishes between factual, interpretive and conceptual conclusions and it provides a critique of the research. It also offers propositions that others can adopt in their own situations. The way in which this study can make a contribution to knowledge is explained and delimited with some indication of areas in which further research might be undertaken.

Factual Conclusions

Evidence showed that successful outcomes were attained by the integration and interaction of human and non-human elements. These were determined by the client's free will and her choice to take an active role and to determine the therapy's destination, while staying within the IEZ, during the long adjusted encounters. This situation assisted her to regain power and control. The critical incidents always occurred during the client's stay in the IEZ and not in the verbal channel; therefore the nonverbal activities within the dramatherapy mode contributed to her recuperation from the chronic PTSD.

The longer the client remained in the IEZ using symbols, and experiencing the visual thinking of her imaginative power and creativity, the closer she moved to her cure through the use of nonverbal imaginary communication. The client's long stay during the TAE in the IEZ stimulated deeper themes and emotions, and her previously paralysed positive traits, gradually percolated into consciousness in a new structure, causing changes in the negative state. This allowed more positive strengths to emerge that simultaneously cured old, primary traumas in the CZ.

Achieving successful outcomes in this particular PTSD treatment depended on the therapy's adaptation to the client's real needs, positive traits, virtues and competence. This occurred while she actively operated during the TAE in the IEZ; simultaneously creative and flexible open-minded attitude towards the necessity of using dramatic artistic activities. During this process she avoided fixation on

verbal methods and traditional time setting. She confirmed these outcomes herself.

Enabling this to happen was the therapist's empathic style and relationship, warmth and acceptance, that allowed the client to feel safe, contained and listened to (Cain 2007), enabled her strengths and virtues to emerge and so contributed to her recovery. Although Iris was modest by nature, she implied that my positive and supportive relationship with her throughout the therapy had been a determining factor in her recovery.

Interpretative Conclusions

Based upon the factual evidence, the following five interpretative conclusions can be advanced which illustrate the applicability of the factual conclusions in practice and theory. Firstly, the theoretical, clinical and neurological evidence revealed connective interactions between PTSD, the IEZ, the TAE and the C.PT's cardinal role. This seemed to indicate a direct linkage between these interactions and the client's recovery from the syndrome.

Secondly, dramatherapeutic processes and the nonverbal activities, employed by the C.PT in IEZ during TAE catalysed the right hemisphere, limbic system and amygdala activation, creating imaginative power, latent knowledge and unconscious processes. The subsequent transfer of the virtues, strengths and competence from the unconscious to consciousness in order to struggle with the symptoms was crucial and effective in curing the pathological somatic and the emotional constellation.

Thirdly, in treating PTSD, greater utilisation of TAE, IEZ and nonverbal language, using dramatic sensory plays, enacting different roles via body movements, provided the client with more opportunities to reach the CZ and recovery.

Fourthly, the therapeutic setting was based on TAE features that were adapted to the C.PT in terms of needs, tempo, temperament and character of the client. Thus, TAE was an essential component in achieving the successful outcomes of the PTSD treatment.

Fifthly, in that setting, the interaction of the dramatherapeutic mode with C.PT, TAE and IEZ had multiple curing characteristics. These created an integrated powerful curative environment, impacting on the somatic and emotional neurological system and eradicating the PTSD chronic symptoms, a process that resulted in the client's 'rebirth'.

Thus, my evidence shows how interconnections between different forms of treatment, dramatherapeutic techniques, interpersonal processes and explicit curative approaches brought about the restoration of the client's personal image, health and well-being (Christakis and Fowler, 2010: 105-121, 130-134).

The study disclosed the crucial factor of the human being (client) as an extra-therapeutic factor that played a significant critical role in the successful outcomes. It explains how she contributed to her own recovery and therefore adds to Duncan and Miller's (2000) view on the client's ability to *'display on stage the missing main actor'.* In these respects, my study has developed theories that in their respective ways contribute to knowledge.

Conceptual Conclusions

The conceptual framework for my research (See Figure 23.1) combined four variables that were considered to be critical theoretical and practical influences on recovery. They are therefore reflected in the following conceptual conclusions that emerged from my investigation.

The PTSD recovery was a holistic body-mind phenomenon, the recovery from this state occurred in a special structure of mutual collaborative relations between the extra-therapeutic concepts of the C.PT with the IEZ and TAE, in a dramatherapy frame which created the CZ. This is the synergetic process that explains the complicated chronic PTSD recovery.

The expanded theoretical foundation formed from the C.PT, IEZ, TAE and CZ, and the case study evidences with multiple sources from the extant literature: integrated humanistic theories, dramatherapy, sport psychology and neuroscience created my original theoretical model. This explains the chronic PTSD recovery in which successful outcomes are achieved when there is synergy between the

participant human with TAE and IEZ concepts, neurological systems, and the curative characteristic of dramatherapeutic non-verbal imaginative language.

The research findings contribute to the theory and practice of dramatherapy as a discipline. They describe how the curing processes really occurred; while revealing how chronic PTSD recovery was achieved. Additionally, they manifest the importance and effectiveness of dramatherapy as a PTSD treatment and for other feminine traumas. The interpretations relied on original dramatherapeutic language, terms and concepts which this field currently lacks. This then was the gap in knowledge which this research is hopefully able to fill.

The dramatherapeutic model developed by this research can be potentially applied as an appropriate treatment for PTSD. This is because PTSD symptoms are similar for all C.PT'S irrespective of the cause of trauma. PTSD clients have great difficulties putting their traumatic experience into words as well as using imagination. However, this flexible model can be adjusted to each individual's personality, coping resources, strengths and virtues and its non-verbal strategies are particularly suitable for these cases. Moreover, recent neuroscience research highlights and recommends the use of somatic nonverbal, creative and imaginative mode in treating these clients in order to achieve greater effectiveness in therapy. The present research findings and the therapeutic results clearly indicate the value of this model as an applicable, valid, efficient and felicitous treatment for PTSD.

Additionally, the research findings relate to and support Lahad's model of Fantastic Reality that was not previously tested in research. These findings aggrandize, amplify and deepen Lahad's model, providing further foundations for the IEZ innovative concept from multidimensional theoretical perspectives including neuroscience. These innovative notions of IEZ and CZ were expanded beyond the theoretical foundation provided by Lahad. Furthermore, the participant's long reflections on her experience within the IEZ provided additional evidence to indicate the veracity and applicability of Lahad's model. The in-depth explanation, relating specifically to the way in which staying in and exploiting the

features of this zone can be beneficial in impossible situations such as chronic PTSD can contribute to an understanding of the healing process.

Potential Limitations of the Research

My research set out to develop theory and therefore its methodological approach was inductive. In my research the universe is identical to the sample and the statistic, and so it regarded the client as a 'universe of one' (Schön 1983:108). Thus, it is the responsibility of readers rather than me to decide on the generalisability of my conclusions. Others may judge whether to test these conclusions in their own settings and conditions. In this sense I sought to minimise the limitations of my research by providing rich and full information concerning the research.

I was conscious of the potential limitation associated with personal bias that originated from my highly emotional involvement with the client. I have constantly sought to apply integrity, self-awareness, and caution and to re-examine the internal processes referring to how the client coped with her situation.

There is a potential limitation in that I found only minimal extant theoretical perspectives to support my findings that the extra-therapeutic variables of TAE, IEZ and the C.PT played crucial roles in contributing to the client's recovery. Similarly there was a dearth of sources regarding the way in which the curative processes occurred in general and more importantly in complicated chronic cases with PTSD in particular.

Before undertaking this research I was aware that the intended sample size posed a potential methodological limitation for my study. However, that awareness was reflected in how I designed, conducted and evaluated the study. For these reasons I consider that the potential of those limitations has not reduced the significance of the conclusions of my research.

Further Research

Despite the limitations of the present study it does establish a basis and a direction for further research and insights into the treatment of chronic PTSD resulting from infertility or stillbirth. It may also indicate the need to investigate similar aspects of the treatment for PTSD resulting from other traumatic

experiences. The conclusions that emerged from my evidence provide new issues for investigation for those who are interested in testing humanistic-existentialist tailored dramatherapeutic PTSD treatment in their respective situations. In particular this study highlighted the potential influence of three novel extra-therapeutic variables: C.PT, IEZ and TAE on the outcomes of such therapy.

The concept of the IEZ is wider than Lahad's (2007) concept of Fantastic Reality yet it endorses his views on this issue. It encompasses this concept and remains as yet minimally studied. Thus, it may therefore become a new issue for investigation in the field of the theoretical foundations of dramatherapy.

Tailored dramatherapy has been shown to be an effective treatment in PTSD. It was validated in this research as a therapeutic model for the successful treatment of complex PTSD and, perhaps, deserves further study to substantiate my claims.

Propositions derived from this Research

The absence of published studies relating directly to the research topic and the focus on the three extra-therapeutic variables, forced me to develop a theoretical grounding in related theories. The search for adequate theories led me away from dramatherapy into new areas of reading and professional practice. However, it is my belief that I have managed to construct a solid, coherent basis in theory for the authentic points of view presented here.

Meaningful occurrences happened during the search for answers to the research questions though at first, nothing was obvious or clear. Difficulties emerged due to the nature of the latent knowledge and the unconscious processes relating to the client and the therapy. This occurred alongside a dearth of sufficient direct theoretical perspectives that might help to explain the explored phenomenon. Dealing with these difficulties created a fertile ground for new insights, which sometimes illuminated new ways of coping and sometimes themselves constituted the solution.

The propositions from the research are:

1   that a 180-240 minutes therapeutic session might be more appropriate than a 45 minute period for therapists when dealing with a C.PT;

2   that integrating abstract concepts with different aspects of the human being (client) and neuroscience explanations of recovery from severe PTSD can explain the recovery process in which imagination, creativity and somatic experience are all highly significant components of the PTSD treatment;

3   that a client's reflections which highlight the curing processes can provide detailed, vivid and understandable explanations that contrast with explanations on the level of theoretical perspectives;

4   that the mysterious world of the psyche of a client with PTSD can be opened up through extra-therapeutic means of IEZ, TAE and the curative characteristics of the dramatherapeutic non-verbal imaginative language.

These four propositions lend support to the study's conceptual framework. Collectively, they suggest that dramatherapy is a reliable method of treatment for PTSD symptom relief in complex and chronic situations, and that, within the dramatherapy framework, the interaction between the C.PT, IEZ and TAE components create a synergy: a CZ and so enable recovery from PTSD.

Thus, in the context of PTSD a linkage is suggested to anchor dramatherapy and its associated psychological theories in neuroscience, by connecting psychological, dramatherapeutic, and psychic processes to physiological processes in the brain's right hemisphere, limbic system and amygdala.

This study was a long-term collaboration with one respondent who was both the research population and co-researcher. The collaboration began as a professional therapeutic relationship and turned into a friendship and partnership over an extended period, firstly during my M.A. and latterly through this doctoral study. It was the result of a warm mutual rapport and shared experience.

The choice of research methods was determined, applied and viewed according to the context and to maintain the personal spirit of this study. To the best of my knowledge, such an equal partnership in a case study research between the researcher and the research subject is an innovation in dramatherapy practice.

Chapter 24: Epilogue – My Intellectual Journey

In the prologue to this thesis I wrote *'it is my hope that this piece of research will help me to achieve a fuller understanding of the missing links needed to complete my own unfinished business and satisfy my professional and academic curiosity* and to *'live in peace with myself'* and achieve my own cure. I have devoted nine years to my quest to fulfil these hopes.

During this journey I experienced many ascents, regressions and peaks which have influenced my whole entity intellectually, mentally, emotionally, physically and spiritually. In this sense I went through processes parallel to those that Iris experienced in her curative journey. I did not expect nor was I ready for the fact that being involved as a practitioner and a researcher in a clinical case study, would lead me to experience the typical feelings engendered by a psychotherapeutic processes that do not usually appear in an academic research. I adapted myself to these difficult processes and accepted them as natural to my personality and as a critical part in my scholarly growth.

One of the most complicated enlightening intellectual processes was the choice of the research's concepts, that I viewed as my own original creation, which enabled me to reveal my ability to be an original thinker and later on evoked my critical thinking as well as my imagination and creativity. I noticed that the best ideas always emerged when I stayed within the Imaginary Existence Zone (IEZ), not forcing myself to find answers, just letting my mind and consciousness calm down and explore. I enjoyed this quality of imaginative and creative thinking that emerged spontaneously and enhanced ideas, making them crystal clear, and felt that my whole being was illuminated by insightful visions. Later, my more scholarly and intellectual awareness explored and assessed these ideas in relation to other extant theoretical perspectives and literature, until they were accurately established in theories and their ground-breaking qualities were verified.

The intellectual journey involved to reach the last focus of the research topic extended over five years, complying with some of the naturalistic inquiry characteristics depicted by Lincoln and Guba (1985)

> *The focus of the inquiry can and probably will change … the naturalist expects such changes and anticipates that the emergent design will be coloured by them … these changes signal movement to a more sophisticated and insightful level of inquiry* (p. 229)

Another phase along my journey was the need to cope with the interpretation process, which demanded enormous mental effort in order to explain unconscious and latent psyche processes, and how they acted in Iris's recovery from a state of PTSD. Moreover, the paucity of direct adequate theoretical and practical literature, which referred to the research's topic, conceptual framework and the innovative extra-therapeutic concepts, became an obstacle that I needed to deal with in the best possible way. Daring to confront this difficulty, was like searching for a needle in a haystack, as I had to depend on oblique hints, linking up implicit extant literature to the studied context, and creating new connections among the copious data, variables and components. I comprehended that by doing so I was challenging traditional knowledge and axioms in psychotherapy.

The breakthrough and transformation from my professional dramatherapist's roles, and adjustment to my researcher roles, created a new integrated self, an independent, scholar and critical thinker. At the end of my journey and reaching its destination, I feel satisfied and happy that my primary hope has been fulfilled, with consequential benefits both to my client and myself, and that I remain able to believe in the path that I chose for my quest and in the research results. The journey is over but not done.

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APPENDICES

APPENDIX 1

Appendix 1 explains the study's innovative aspects and the rationale for the use of qualitative methodology in order to enable the client's voice to be heard. The qualitative tools used: in-depth interviews and case study method produced outcomes that enabled reflection and interpretation which would not have been possible using quantitative methodology. Hence, this lengthy ~~ethnographic~~ collaborative case study was deemed relevant to fill gaps that were identified in extant knowledge regarding the treatment of PTSD with dramatherapy, focusing on what are regarded as rare and exceptional components to explain therapy outcomes.

The Study's Innovative Aspects

PTSD research around the world (Foa, et al., 1991; Friedland and Dawson, 2001; Silove et al., 2002; Shalev and Freedman. 2005; Farhood, Dimmassi and Lehtinen 2006; Hensley and Enrique 2008; Franciskovic et al., 2009) has focused mainly on war veterans, victims of natural disasters, terrorism, car accidents, rape and soldiers who have experienced combat. Specific to Israel is the wide range of research on Holocaust survivors. In this sense PTSD is a common universal phenomenon, and the syndrome symptoms are similar for all survivors (Yovell, 2001).

This study, however, explores an aspect of this general topic that is relevant to all people but especially to women. Though located in a particular culture, language and mentality, its relevance extends beyond the local context since it deals with the tragedy of stillbirth and sterility, a worldwide phenomenon from time immemorial. Women's painful stories relating to their inability to conceive were told in the Bible (Samuel A:1) and the afflicted reactions that may follow stillbirth even until the mother's death are recounted in an ancient Aboriginal tale (Gersie, 1992:147-148).

Knowledge and evidence explaining how curative processes really occurred within dramatherapy, is in relatively short supply, especially in relation to cases of PTSD therapy that resulted in successful outcomes of full recovery (Winn, 1994). This study makes a contribution to knowledge by creating a new attitude and developing an original way of explaining successful outcomes of therapy for people with chronic PTSD, challenging existing theoretical perspectives. The treatment described in this research was unconventional because it followed the most recent recommendations and assumptions of neuroscience and psychobiology (Van der Kolk, 2002; Spinazzola et al., 2005).

The study's innovation is expressed chiefly in two areas, (a) therapeutic strategy and technique applied in chronic PTSD and (b) research methods which employed the client as a full co-researcher, both at the time of the therapy and later in researching and writing the thesis; as well as analysing and interpreting her roles as the hero of the drama who contributed to her own recovery, constituting what Bohart and Tallman (1999) termed a 'self-healer'

More specifically:

1. The study challenges existing axioms relating to the traditional time of 45-minute per psychotherapeutic session; which was the recommended convention since Freud began his work in the fields of psychoanalysis and psychotherapy.

2. It expands thinking and knowledge concerning the sparsely documented concept of Fantastic Reality (Lahad 2007) and the Curative Zone.

3. It takes a holistic approach, attempting to form a synthesis from abstract concepts, a specific therapist and client and a given period of therapy to construct an explanation for the client's successful recovery from severe PTSD.

4. The thesis is grounded in the authentic first-hand research data — encounters transcriptions, depictions of the client's non-verbal physical artefacts, and two reflective in-depth oral histories of the therapy period written by the client.

5. It establishes dramatherapy mutual relevance to neuroscience by providing a theoretical basis connecting recent findings in neuroscience to PTSD and nonverbal language. It shows that dramatherapy can be an effective treatment for people with PTSD since it uses active-creative methods based on unstructured flow and can be constantly adjusted to the client's needs.

Moreover, Sparks (2000:13) asserts that *'how people transform life from despair to hope, from pain to joy will always amaze and astound. We may understand this by setting client and therapist stories side by side'*. In this sense, subjective research is legitimate and necessary not only for academic purposes but for the benefit of clients. Former or potential clients can gain insights and benefit from articles, books, or documentary films that describe real therapeutic stories.

The primary source of all psychotherapy is the well-known collection of case studies treated and reported by Freud (Breuer and Freud, 1883-1895: 21-184) which opened new horizons for humanity and were the foundation for his theory of psychoanalysis. Remarkable books such as *Love's executioner* (Yalom, 1991), *The man who mistook his*

wife for a hat (Sacks, 1986); and *K–PAX* (Brewer, 1996) have given us access to the mysterious inner world of the human psyche and have demystified psychological/ neurological health.

However, the significance of 'the case' in psychotherapy relies on the special circumstances, client-therapist relationship and the client's specific personality, character and behaviour. This vast diversity enables us to explore new dimensions, and reach new insights we had not gained before and thus enhances understanding of psychological phenomena. As is shown in Part II of this thesis, there is a scarcity of documented evidence concerning dramatherapy that can be used to build further theory; a case study can be used to present small units of evidence that describe and help to explain a therapeutic situation (McLeod, 2000; 2002; 2003; McLeod and Elliott, 2008).

Although Yin (1994: xiii) one of the biggest supporters of case study notes that this method is criticised by others:

> *The case study has long been stereotyped as a weak sibling among social science research techniques. Investigators who did case studies were regarded as having deviated from their academic discipline.*

Nevertheless, McLeod (2003:99) contradicts this criticism and highlights the importance of applying case study method, arguing that:

> *The case study method has the potential to contribute knowledge and understanding that is highly relevant to counselling practice. In comparison with large scale statistical studies, the detailed analysis of individual cases yields information that is immediately applicable to the counselling relationship. Case study methods are also well suited to describing and making sense of processes and change.*

At this point, I agree with McLeod since case study opens up possibilities without losing the uniqueness and particularity of the case, which cannot be achieved with other methods.

In medicine and related fields, when a rare phenomenon is revealed or the purpose is to study the extreme and not the common or the regular, it is sometimes presented as a case study.

> *[The term]'Case' has dual reference to person and situation, thus it can be a person presented as an example of a situation, or as a unique entity existing in his or her own right* (Higgins 1993:15).

Case connotes a spatially delimited phenomenon (a unit) observed at a single point in time or over some period of time. It comprises the type of phenomenon that an inference attempt to explain (Gerring 2006:19).

However, I believe that the core of a case study in therapy is the human being and not the phenomenon nor the disease. Drawing again from the field of medicine, the highly-regarded neurologist Sacks (1986: ix-x) reminds us that:

The natural history of [a] *disease tells us nothing about the individual and his history; it conveys nothing of the person, and the experience of the person, as he faces and struggles to survive his disease. There is no 'subject' in a narrow case history … to restore the human subject at the centre - the suffering, afflicted, fighting human subject - we must deepen a case history to a narrative or tale.*

If this is obvious in medicine, then it should be all the more so in psychotherapy and dramatherapy, as suggested also by McLeod (2002; McLeod and Elliott 2008), where human beings are the pivotal and main actors of any enquiry. When it is the individual and that individual's personal story that constitutes the focus of research interest, not necessarily representing a wider phenomenon, then the case study should be considered as the preferable choice. This approach is in line with the wide naturalistic perspective that according to Schön (1983:48) should be adopted by the 'reflective practitioner' as a method for the collection of professional knowledge, constituting an alternative to the positivist paradigm. He further suggests: *'let us search, instead for an epistemology of practice implicit in the artistic, intuitive processes which some practitioners do bring to situations of uncertainty, instability, uniqueness and value conflict'* (49). This is compatible with the use of case study in psychotherapy research highly recommended by McLeod (2001).

It appears that there are limited references in extant literature referring to the critical components that are the focus of this research: the C.PT the IEZ and the TAE (McLeod, 2002); and to the best of my knowledge there is no literature relating to a client's reflective memories regarding her journey through dramatherapy. This indicates a gap in knowledge which this research seeks to bridge. This case study tells the story of a personal path to recovery and the special client-therapist alliance that facilitated its success. It differs from the conventional approach to such client needs and it elucidates other components considered critical to the recovery process.

The issue of the client-therapist relationship has received minimal attention in dramatherapy literature, but has been intensively researched within the context of psychotherapy. Nevertheless, the present research chose to focus on the extra-therapeutic variables that were appropriate for the original nature of the collected information, instead of researching evident previously explored factors that were not necessarily suitable for the studied case (Kahn, 1991). These variables were examined within a wider scholarly perspective in relation to the outcome of therapy that indicated their rarity and exceptional nature in therapy outcome. It is believed that this examination enhances the contribution to knowledge in the dramatherapy field.

Shortage of Single-subject Case Studies

Contemporary research in the therapeutic field reflects a situation where *'not enough good quality case studies are being published'* (McLeod and Elliott 2008:43). Researchers may hesitate to face the challenges of a single-subject case study, which demand deep personal involvement, closeness, cooperation, and self-exposure between client and self, going far beyond the standard therapeutic relationship. Such an undertaking also requires professional interest in the central role that the client may play in achieving successful outcomes and acknowledgement of the client's ability to choose and lead the healing process (Bar-Yitzhak, 1999). This may undermine a therapists' sense of omnipotence, beliefs, and explicit theories.

An explanation for the dearth of such studies were given by McLeod (2001:16) the first, more general explanation claims that the '*problem with qualitative therapy research, the absence of published qualitative studies despite vigorous championing, can be understood as resulting from a reluctance to embrace the possibilities of this approach, for fear of where it might lead.*'

Due to my serious desire to understand these successful case outcomes, including the complexity and special characteristics of the case and my readiness for self-exposure, I deliberately chose the single case study method in this research despite its limitations. This method raises potential concerns concerning bias, and prevents any possibility of generalisation, exhibiting low reliability due to the fact that this unique case study cannot be replicated. Nonetheless, in naturalistic terms its dependability and trustworthiness are established by the authenticity and idiosyncrasy of real-life evidence supported by the client's two oral histories. Thus, the fortitude of this study is based on its high validity or credibility in naturalistic terms. It seeks to demonstrate that the explanation of the particular events, issues and the set of authentic data, which this research provides can

actually be sustained by the data. Moreover, the case study was addressed by *'prolonged engagement in the field: persistent observation, triangulation, supervisor debriefing, and participant validation'* (Lincoln and Guba, 1985:219,301).

The study's methodology follows the principle that: *'A population can consist of one person …. in any one of us a multitude of collections (populations) are available for testing. Single-case research is the most direct development from a single person case study'* Higgins (1993:89) and also complies with the concept that *'sampling is about choosing who or what is to be studied'* (Knight 2002:119); a determination which reinforced my choice to study Iris as a single case study.

Although I was well aware of these limitations I preferred what Knight (2002:125) referred to as *'this slice of life'* explaining that a single case study was: *'a justifiable, honest and systematic attempt to understand the people and incidents they could sample, also might mean that we need to rethink some assumptions such as case studies, n=1 designs'*. Knight goes on to provide additional justifications regarding this methodology:

> These *'methods,* [are] *more sensitive to the individual and personal-meaning beliefs, feelings etc. Small samples, even n=1 are often acceptable. Full participation in the research situation and absorption of informants' perspectives and beliefs are acceptable, even desirable* (Knight 2002:205-208).

Furthermore, in public psychotherapy services, the shortage of single case studies can be justified by economic, time management, ethical and bureaucratic considerations. Researchers in this setting probably prefer to research a larger sample in which the notion of 'safety in numbers' may be used to justify a deductive approach to investigation and research; while the probability of receiving a study grant is higher than in an inductive case study. Hilliard (1993) discussed the problematic nature of a single case study for researchers in the field of psychotherapy, indicating that the threat to internal validity in such studies led researchers to abandon this design.

Whereas Higgins (1993:98) considers that:

> *The advantage of single-case research is its closeness to clinical practice. The primary purpose of the research is to measure the treatment benefit for the individual along lines that can be tailored-made for this particular person.*

In private practice, the difficulties involved in obtaining support, both academic and financial, constitute a crucial obstacle to undertaking research. Additionally, in private and public sectors, finding the right clients and obtaining their consent to participate in research that continues several years after the termination of therapy is almost impossible. However, single subject research can be planned, designed, conducted and analysed in a clinical setting (Richards, Taylor, Ramasamy and Richards, 1999).

Similar reasons may explain the lack of further research into Lahad's (2000; 2003) theoretical concept of Fantastic Reality as a healing space in impossible situations. Perhaps his far-reaching notion is too complex and abstract to be researched, and it clearly deviates from the dominant conventional psychotherapy paradigm for treating PTSD by verbal means. Moreover, studying his concept in a traumatised population would require an adequate sample that would consent to be treated by dramatherapy, and reflections on their experience for a period of several years, a seemingly unrealistic task. This experience was not planned as a research. It began in dramatherapy treatment and then became the subject of an MA dissertation and only later developed to become the groundwork for a PhD thesis. Thus, reality dictated that I had a single C.PT treated by nonverbal dramatherapeutic modes, willing to collaborate over many years with my research, who contributed her reflections, which enabled further study of Lahad's concept.

Support for the use of qualitative case study of psychotherapy is provided by Gordon (2000:15) in his criticism of quantitative studies:

> Our understanding is limited by our attempts to isolate and manipulate experimental variables, rather than be concerned with talking with people and exploring how they make sense of their experience. Such inquiry is seen as relevant to psychotherapy practitioners in that the clients' understanding of psychotherapy will influence how they interact and become involved in the therapeutic task.

He also argues that:

> The appropriate methods needed to investigate the systems people use to construct and interpret their experience as meaningful, are reflective of the processes of psychotherapy itself and ideally should involve in depth interviews (Gordon, 2000:15).

This case study employs these recommendations relying on the understanding that this is a way to present, explain and so understand Iris's experience over time.

Hence, the fact that there is only a limited body of qualitative research in psychotherapy in general is particularly puzzling, especially in the light of over fifty years of quantitative research on its effectiveness (McLeod, 2002). In comparison, considering that dramatherapy is a relatively new profession, first established in the U.K. in the early 1960's (Meldrum 1994) and in Israel during the early 1990s, the minimal qualitative research published at doctorate level is perhaps understandable.

Despite the growing legitimisation of the naturalistic or socio-cultural paradigm, the positivist approach still dominates in academic psychology since it was defined as a study of behaviour (Rettig 2006).

In psychotherapy this tendency to stick within the 'scientific' and objectivist boundaries of research is also still governing, and seems to be rooted in the early criticism of the profession as being non-scientific. Most researchers have put considerable reliance on the prescribed theoretical orientations as the safe ground to ensure compliance with academic demands and so win scholarly recognition.

> Referring to reflective practitioners, who base their research on the positivist epistemology of practice, Schön (1983: 42) criticises

> *… Their definition of rigorous professional knowledge* [which] *excludes phenomena they have learned to see as central to their practice. Artistic ways of coping with these phenomena do not qualify for them as rigorous professional knowledge.*

This may explain why few researchers in this field have studied the client as a relevant factor using qualitative methods of investigation (Maione and Chenail, 1999) nor have they related to the complexity of researching the 'human factor' in psychotherapy, except for their consideration of measurable behaviour. Thus, there is little development of theory from inductive research in comparison with an abundance of deductive theory testing studies.

Additionally, there is still an on-going debate regarding the issue of research of implicit versus explicit aspects of psychotherapy, despite more openness and the recommendation by Najavits (1997) to use implicit theory and so disclose the therapist's private beliefs about therapy. Najavits (1997) suggests that when studying the process of psychotherapy and its outcomes, the combination of explicit and implicit theory accounts for more variance than explicit theory alone. However, the notion of using implicit theory

is not yet firmly established in psychotherapy literature. This research employed both types of theory, applying implicit theory to the notion of tacit knowledge as well (Polanyi 1997). This was based on the understanding that implicit knowledge precedes explicit knowledge and forms the foundation for the IEZ where the latent knowledge is experienced by the C.PT. My implicit theory concerning our therapy is detailed in Part V: Findings and Discussion.

Summary

This Appendix discussed some meaningful aspects of this study. The innovative characteristics of the research were explained in light of the limited knowledge and evidence available to explain how curing processes really occur within dramatherapy, especially for people with PTSD. Additionally, the issue of minimal single case studies in psychotherapy was debated, detailing possible explanations for this puzzling situation. The need for such enquiry was highlighted; including recommendations by different authors for the use of case study methodology in psychotherapy. However, the fact remains that few studies in dramatherapy have been based on single case study. None of them dealt with this research topic, nor investigated the three focused variables which I surmised had contributed to chronic PTSD recovery hence a gap in knowledge was identified in the field. This research undertook the task of filling this gap through its innovations and challenging traditional axioms and included the client's reflections and participation in the therapy and in the research over an extended period of time.

APPENDIX 2

Who Am I?

Who am I? Describes and explains my personal, professional, artistic and researcher roles in relation to the research. In this case study I assumed two parallel involved roles; I was a dramatherapist and additionally I was also a researcher. In order to provide a wide picture of myself I chose to disclose my private life openly and provided sufficient information to enable readers to trace the influence of my personal details on my research. This information is divided into four sections:

1. The beginning: my early history.

2. Examining myself in relation to the research: mental and cognitive processes related to my personality which may have affected the research.

3. My artistic self and the research: the revelation of my artistic self through the research and the influence of my artistic self on the study.

4. The researcher role: my ambivalence, struggles and difficulties as I adjusted to the researcher role.

The Beginning

I was born in 1948 to my late parents, Hinda and David. I have one brother, who is older than I. My mother came to Israel as a young student from Poland. My father was born in Israel.

I was raised in the small town of Rechovot, not far from Tel Aviv. My brother left home at the age of sixteen to study in a military academy. As I was just four years old at the time, it can be said that I grew up essentially as an only child. At about the same time, my paternal grandmother returned to Israel after living several years in South Africa. She lived with us; I loved her very much and she was a significant figure in my life. She was a caring, warm and sensitive person. Her death, when I was eleven years old, shocked me. Unfortunately, my mother's entire family was exterminated in the Holocaust, so I only knew them from stories and photographs.

I do not remember receiving much affection and warmth, physical or emotional, from my parents. I had almost no relationship with my father; I felt closer to my mother and was influenced by her character. However, when I think about our relationship today, I feel it

was superficial. Physically I was a thin, sickly girl who hated to eat – a wonderful way to get attention and care. I used my 'weaknesses' to my benefit, causing everybody to worry about me.

So far, so good – we were considered a nice, normal family. I was a very good daughter who respected her parents. I was quiet, polite and well mannered, had good friends and was loved by them. I was an average pupil who did not enjoy studying and always thought I was not wise or intelligent enough for academic study. I was known for my sense of humour and acting talent.

Examining Myself in relation to the Research

As an adult, I understand that some very fundamental emotional needs were absent in my infancy. I reached the conclusion that I was probably a very sensitive infant, and my parents couldn't or didn't know how to respond to my internal emotional world. It was as if we spoke different languages or like a conversation of the deaf, and rather ironically I became hearing impaired in my twenties. Until experiencing the traumas, having three children and changing occupations, I considered myself 'in good order' and was not occupied with existential questions about myself.

In the last thirty years I have begun an inner journey to find out what was wrong with me. I have become increasingly aware that my 'sad' moods actually reflected depression. Purposely, while writing these lines I looked at my childhood pictures, in all of them I see a gloomy, sad, unhappy baby and child. Why did I look so miserable in all the photos? Suddenly I was shocked! The fog cleared, and bright afflicted critical insight revealed the truth that I had in fact been depressed for much of my life!

This was a realisation that hadn't emerged in my psychotherapy treatments or in supervision only in the course of this chapter. I felt I had received a gift which actually calmed me, despite my intensified sense of shame, guilt feelings, self–doubts and ethical dilemmas that were incumbent on my existence as a social worker and dramatherapist. Was I fit to treat other people while I myself was suffering chronic depression? Winnicott (1995) highlights the significance of my internal unspoken debates and struggles, perversely arguing in favour of depression: *'I would like to claim that there is a value to depression … Psychoanalysts and psychiatric social workers can undertake responsibility for difficult cases and practice psychotherapy while they themselves suffer from depression'* (59).

Winnicott's attractive idea consoled me, although if I had the choice I would have preferred to live a life free of depression. In any event, taking medication enabled me to treat others. As a client treated by several psychologists over the last decades, I have no doubt that only medications were effective in helping me out of the 'dark hole' of depression and not the psychotherapy itself. Although there may be other causes for my depression (it was once suggested that my mother's serious loss and consequent depression during the Holocaust might be influential - according to Winnicott (1995:92), *'the child's depression can be the mother's depression in reflection. The child uses the mother's depression as an escape from his or her own'* - but I dismissed this possibility because I can only recall my mother's dynamism and positive mood), more than ever I am convinced that depression is a brain disorder and genetic. Beck and Alford (2009) assert that depression has a biological, genetic, organic and psychogenic basis.

Yovell's (2001) contemporary perspective on this issue has helped me to feel less shame:

> *One of the depression's severe problems is that it might return. A genetic tendency existing in depression … if a person suffered in the past three severe depressive episodes or more than that the recommendation is that he will continue taking antidepressant medication for long years*' (253).

Since beginning my work on the PhD I have taken antidepressants. Despite this treatment, my situation often worsened and badly affected my progress and the quality of my work. I became stuck for months and could not effectively use my intellectual abilities or my creativity. In my worst moments, I even contemplated abandoning the thesis, thinking that I might thus reduce my suffering. Changing the medications several times helped me overcome these obstacles and continue with my writing. It was clear to me that my intense involvement with the overwhelmingly painful content of the research for many years increased my own pain and suffering, which prevented me from coping efficiently with the intellectual mission.

Other relationships of my earlier life prior to the research relate to academic matters. It was only when I began studying dramatherapy in 1992 and later while conducting my MA research 1997 that I began to enjoy true academic learning. At last, while I was working on this research's methodology, I understood my dislike for study. During that period to my delight, I noticed feelings of enjoyment, although I had many struggles in understanding the subject matters - it was really strange. These insights were enlightening – 1. My intelligence is dominated by the right hemisphere of the brain and

not the left hemisphere, and 2. I understood that I had been working in the imaginary existence zone and under the flow experience all this time.

I was then able to grasp a more complete picture - the research's philosophy, dramatherapy, IEZ, the traumatic memories and my fundamental integral beliefs - originated in the human brain's right hemisphere. This picture located my inherent perceptions, spiritual and intellectual intrinsic entity. I experienced a sharp sense of integration between being an involved dramatherapist, reflexive in action and a scientific researcher, combining these various areas. I felt that I had been through a remedial therapeutic process. It was a corrective experience redressing my childhood difficulties, enabling me to make peace with myself, as I lived for months within the curing zone of imaginary existence inadvertently accumulating indirect benefit from my own research assertion. It was surprising to experience such a process through the writing of an academic research.

These processes and insights in the academic research context met with two interrelated obstacles – the first difficulty was my natural desire to use a narrative writing style that did not correspond to scholarly academic demands. It took six years till I was able to change my natural style to a more accurate academic style. The second difficulty was that my thinking mode was intuitively based on imagination and associations and much less on organised structured and logical thinking. While my natural mode helped me to reveal creative ideas and the research concepts, its limitations caused confusion, lack of focus, disorganisation and lack of coherence. I believe that the extension of the research so that it filled nine long years was the result of these disadvantages.

My Artistic Self and the Research

Often artists have an especially acute sense of their own woundedness. They are sensitive to the pain of the world and of the soul and use their work as an attempt to heal this pain. The conflicts of everyday life and the demons of the psyche are transformed by works of art into a beautiful appearance, the shining of truth (Levine, 1997:3).

In August 2003, I began writing this chapter about myself. In retrospect it was most opportune that after two years of constant involvement with the subject, I found this quotation and decided to use it in this chapter. Suddenly I realised that I had been ignoring my artistic self, the basic, primary source that I had owned all my life. Most astonishing for me is the fact that despite having acted since childhood and having been

a member of the local Golan community theatre for the last twelve years I still do not call myself an actress.

The first few days, as I wrote these lines, I suffered strong physical and emotional pain; I found it difficult to fall asleep, so that I decided to break away from the research for several months, unfortunately this did not stop my vexing thoughts. To the best of my judgment, this was a traumatic event, my somatic reactions included alert bells ringing loudly, I was frozen and so I allowed myself to escape from writing the conclusion, as Levine (1999) described in *Waking the Tiger*.

The word artist caused me some anxiety. This concept penetrated through the walls of my unconsciousness and touched at the very core of my repressed thought. Suddenly, very vivid memories from my early childhood flickered rapidly into my consciousness as if were watching a film depicting my life and I was totally thunderstruck. This remarkable process evoked a further 'journey through the time tunnel' which helped me uncover an essential and existential part of myself, further illuminating the role of the researcher and therapist that I played in Iris's therapy process as well as curing my earlier traumas.

Never before had I related my having an 'acute sense of my own woundedness' (Levine, 1997:3), or vulnerability, to being an artist, I had considered it to be my acquired or born trait. Was this a denial mechanism? I remember my mother's reaction when, at age 18, I wanted to study theatre: *'In Poland being an actress is neither a profession nor livelihood; it is more like being a prostitute. You should study a real profession, like teaching'*. My mother never encouraged my natural dramatic and theatrical talent. Nevertheless, many years later, I compensated my inclination, by becoming a dramatherapist and I even dared to express myself by drawing...

What possible connection can there be between these reflections and my research? It was only as I neared the completion of my thesis that I revealed that these traits and behaviours had direct influence on my interpretation of the research. The sparsely of existent direct theoretical perspectives on the topic coerced me to find a way to cope with this problem, which I found by employing my artistic-creative character and linking up to my sensitivity for my own suffering and the suffering of others, especially Iris's. In this sense the research was my work of art in academic form and it led me in completely new directions that I had not and could not envisage; following this new understanding, I decided to write the next conclusions stemming from my insights under my description of the researcher role presented below.

Staying and working amid the imaginary existence zone produced three effective contributions 1) It extended my imaginative creative capabilities, abilities and qualities by adding unexpected latent knowledge to my doctoral thesis. 2) It opened new expanded channels which enabled me to be touched by and exposed to deeper themes, emotions and unconscious material which had been hidden or covered for a long time and which now influenced my interpretation. 3) The remedial process occurred unintentionally under non-therapeutic circumstances and affected primary childhood wounds enabling me to fulfil my hope of achieving a cure for the soul.

Although I tried to avoid writing this chapter, since after all this is not a heuristic research, the process I experienced in doing so was both exciting and ecstatic. It was as if I was looking at myself through a magnifying glass, with open eyes, having nowhere to escape or hide.

This expanded process of self-analysis revealed my personal characteristics, personality, roles and behaviour, which had a direct, integral connection to the research. It was one of the most difficult processes that I had to cope with during the writing-up of the thesis. Including such a chapter is not usual, even in clinical single-case studies where the researchers were also the therapists (Ragan 2000)

However, despite my resistance to viewing myself as an inseparable part of the research, only by doing so could I evaluate the extra important benefit of this component to the different levels of the research. It enabled me to explore hidden in–depth multidimensional processes and notions, enhancing my understanding of the components that contributed to Iris's PTSD recovery. Obviously I was wrong and my supervisor Professor Trafford was right as both he and Kroath (2002:164) emphasised the logic that:

> In practitioner research, the reader could be expected to have some understanding or appreciation of who you or I are. They might find it interesting – or even helpful – to know what attracted us to the topic, or to what extent we were personally involved with various aspects of the research field.

Evidently, in addition to the benefit reaped for the research, this process constituted a personal facilitator allowing me to reach a deeper understanding of 'who am I'.

The Role of the Researcher

Under the guidance of my supervisor, I have studied the role of the researcher. Initially it was really very hard for me to believe, accept and mostly to think of myself as a researcher; it always awakened the association of exact science or quantitative research

that reminded me of my weakness. I maintained my natural way of thinking and acted as I did in the practitioner's role, for at least the first three years of my research. I felt ambivalent and sensed many contradictions between these main roles (Landy, 1993). It was as if I was struggling to preserve the case study's authenticity and was afraid it might be lost if I admitted the researcher role.

Expanding my reading on methodology, in order to write this part of the thesis exposed me to other kinds of researcher than those I had in mind, namely: the naturalistic researcher with whom it was easier to identify because of the similarity to my profession.

Ultimately I internalised and adjusted to the researcher role, but the long-term therapist-researcher-client collaboration had intensified my attachment and emotional involvement with Iris and it now became almost unbearable to deal with this difficulty. One of the most unexpected reactions occurred while assuming the researcher role in the course of my second interview with Iris (4th July, 2002) four years after the therapy termination. I sensed pressure in my belly I was overwhelmed by a difficulty in breathing and became completely frozen – as Iris had been 5 years before, in her most profound posttraumatic state, yet Iris remained very relaxed, comfortable, and at ease. I tried to understand these reactions but did not find a satisfactory answer; I did realise the impossibility of clear differentiation between my roles.

In the context of my profession, dramatherapy, a noteworthy explanation by Jennings (1992:21) clarified this issue: '*A character is more than a role – a character has a totality, a wholeness that contains many roles*'. I needed to recall this basic notion more than once, in order to maintain my unity as a single person with several roles and retain my sanity as a holistic unit. It helped me greatly in the course of the research, despite my continuous disturbing symptoms, that I learned to take for granted as part of my character in the hope that they would vanish at the end of the research.

Beside these facts I should point out that this personal integrative process assisted me in assuming the researcher's role. Generally speaking, it was a coping process through which I developed an independent scholarly ability under the enlightening guidance of Professor Trafford. The significant basis of my transformation was formed when I assimilated his special way of asking me questions, enhancing my limited right hemisphere answers with a wide range of new perspectives. The need to think in an 'other' way than my intuitive thinking using the left hemisphere more frequently caused cognitive dissonance and breach of my homeostasis.

As a result of this polarised oscillation I adopted a strategy to bridge between the functioning of the hemispheres which I called my 'mind resiliency'. I began each step in the right hemisphere, directed by its creative ideas and emotionality, and then studied the literature to re-examine their meanings with the perception of the left hemisphere. This processing aroused new dilemmas. Reframing the synthesised material in a new and different order helped me to criticise the expanded options. At last I could overcome the hindrance of being a perfectionist with a sceptical view of myself; I began to believe that I was sufficiently capable to be able to ask good enough questions and to find definitive answers.

This long yet hectic struggle resulted in the definition of satisfactory research questions and a conceptual framework. I thought and felt that I had at last found the correct route to achieve the case study's purpose. I was unprepared for yet another new surprise in my researcher role, which reshuffled all my known cards.

Although I am not a scientist, I was able to identify with Winnicott's (1995) view because it partly reflects my experience.

> *In the scientist's eyes phrasing the questions is almost the whole interest. When answers are found they lead to additional questions. Perfect knowledge is the scientist's nightmare. The scientist admits the lack of knowledge unafraid to wait and stay in the lack of knowledge; because he believes not in one thing or another but in general belief* (p.12).

Identifying strongly with this feeling, it was only my strong belief in this case study that enabled me to bear the brunt of the nightmares, which had been my constant companions from the start. Mostly, these nightmares gushed from my personality, or from the very sensitive complicated character of this study and sometimes the unexpected surprises presented by reality aroused them. They expressed the obstacles I had to face as I attempted to conduct an extended collaborative research. I had allotted one part of the original four conceptual framework sections for the client's written reflections based on reading the whole transcription five years after therapy termination. This plan was based on Iris' consent, and she also volunteered to transcribe some of the encounters' audio tapes. On 12th June 2003, I received an email explaining Iris's unbearable emotional difficulties while transcribing, and her withdrawal from the written reflections. I was totally shocked by its content and felt guilt for causing her unnecessary suffering. For a long time I could not return to the researcher role, and could only continue to blame myself as a friend and as a dramatherapist. Even though five years

had passed since the therapy my primary obligation was to Iris's wellbeing and she had the right to withdraw.

As I emphasised when explaining my ethical considerations to Iris: *'The right to withdraw may be at issue in the event that some painful subject or life event causes one or the other participant to feel the need to diminish their "exposure"'.*(*Ethics Guidelines for Research*, Anglia Polytechnic University, 2001).

In these circumstances, it was rational to think about giving up the overall project. Together with Iris, I needed to process our emotional reactions, the consequences of our relationship and clarify her attitude towards further participation in the research. We shared many hours processing the painful experience we had experienced and despite this crisis our mutual feelings, closeness and connection strengthened. After ensuring that Iris was safe and willing to continue her collaboration in the research, with the exception of her written reflections, I was able to again assume the researcher role. I went through two processes: firstly, bereavement and detachment from my former plan: Iris's written reflections, which I had thought would be the most original evidence which had ever been received from a client in a collaborative research; secondly, I needed to cope intellectually and creatively by searching for a substitute in the framework of the thesis.

Mentally encouraged to continue and assisted academically by my supervisor, I was motivated to renew my questioning having already studied the case for two years. The problem was not lack of evidence, on the contrary the absence of Iris's reflections in fact eventually relieved me, and the problem was to resolve the alteration of the plan without damaging the research. The solution I found was simply to reduce the four parts I had decided on in the beginning, into three and condense the components which contributed to her recovery to these areas. It was a necessary compromise that I made in my role as the researcher that enabled me to move on with the research.

Two examples of doctoral theses are presented, below, in which research has been undertaken through single-case study methodologies. These scholarly works provide formal legitimating for small-scale case study methodology.

Learning to teach mathematics for understanding in the company of mentors was based on a Ph.D. thesis by Neli Woolf (2003). She investigated a case of a student-teacher learning to teach mathematics for understanding with the help of mentors. Her single-case study offers a detailed description of the substance of a novice teacher's learning and the learning opportunities that changed her thinking and practice. Arguing that the focus was on the specific case and not the whole population, this study aimed to learn about the private case in a holistic way through its uniqueness and complexity. This study was conducted under ideal conditions with a highly collaborative respondent who was an ambitious intelligent learner and it demonstrates what can be learnt from a single-respondent case.

Traumatic brain injury: A case study of the school reintegration process, by Karen Williams (2004) is a Ph.D. thesis that presented an exploratory case study. It illustrates the reintegration process from acute care and rehabilitative care to the traditional school setting following a Traumatic Brain Injury (TBI). Williams explains her personal interest in Larry's case as the foundation of her doctoral research. She was employed in 1994 as Assistant Principal in a large elementary school. On the day that she began, one of the teachers was absent because a few days earlier she had been injured in an automobile accident.

> *Two weeks later she returned to work and assured me she was recovering. However, her 16 year old son, an unrestrained back-seat passenger in the car, had sustained a Traumatic Brain Injury (TBI). She explained that her son had received acute care at one hospital and had been transferred to another for rehabilitative care. He was recovering slowly. Although I had not seen her son in several years, I remembered him as a bright and energetic elementary school student. He had been found eligible for the Gifted and Talented programme and had enjoyed playing on the interschool basketball team. This report of a brain injury to such a bright and enthusiastic student was devastating to me. I began*

to read and study the topic of traumatic brain injury. I wanted to investigate ways in which I could assist the family through such a difficult period in their lives. I felt the family and the student needed my support as well as the support of the professionals in the school division. I was concerned that this student might return to school and few teachers or administrators possessed sufficient experience to assist this young man who had sustained a Traumatic Brain Injury. Later that school year, this same teacher was diagnosed with non Hodgkin's lymphoma. She died the following summer. It now became my mission to do all in my power to see that her son reached his full potential.

Other justification of N=1 cases relies on experience in the educational field. Researchers, especially those who focused on narrative research, preferred to study a single subject because they were specifically interested in the individual and, investigated the integration of an individual's multiple dimensions. This was elucidated by Lavie and Karim (2004) in their study of a single person. They suggested that research should consider a person as a multi-dimensional entity – focusing on that person as the stage for the encounter of a variety of personal meanings and a multiplicity of social/cultural meanings. They discuss this issue through a reflective discussion at a point in the life of Michal, one of the authors, while exposing an integration of the multi-dimensional findings. They ask how it is possible that the following data all co-exist in one person: a female student, living in a student dorm, woman, wife, mother, undergoing a crisis at age 40. This approach enabled them to surface the complexity of the subjective experience and the multiple voices of one person (Lavie and Karim, 2004:197).

In an Israeli investigation, Karnieli (2004) focused on the unique story and professional perceptions of Dvora, a young ultra-orthodox Jewish woman aged 29 who was the principal of a girls' ultra-orthodox high school. This study offered a glimpse into her life, and perceptions as the adult responsible for girls' education and development in the ultra-orthodox society which is regarded as exceptional in Israeli society. This single-study research design allowed Dvora to voice her views, building a bridge between the secular feminine and the ultra-orthodox religious worlds; thus contributing to mutual understanding and co-existence.

Broerem, Georgsson, Rydmarki and Stibrant Sunnerhagen (2002) published work entitled *Virtual reality in stroke rehabilitation with the assistance of haptics and telemedicine*. Their study was of a single–subject, a male, aged 59 years who had suffered brain stroke three months earlier. It was his first occurrence of a stroke, the cause was an infraction

and the diagnosis was determined by a clinical neurologist after examination and confirmed by CT-scan. He had a paresis - a partial form of paralysis - in the upper left extremity and normal spatial competence and body awareness. There were no limitations in understanding the information given. The findings in this study implicate that virtual training of the effected upper extremity can promote motor rehabilitation. The results verify the efficacy of the treatment and justify further clinical trials. It was also concluded that a larger trial is required to determine difference in improvement in motor abilities of the upper extremities in stroke survivors.

This oral history in-depth interview took place at Iris' home one week after termination of the therapy. The three-hour conversation was recorded. I originally intended to gather new evidence through an oral history to include it in my MA. The decision to do it at this time was made by both parties because the client was due to visit her family, she had not seen for 5 years, at her homeland outside Israel and it was unclear when she would return to Israel. It was also important to preserve her reflections close to the therapy while they were still fresh. This seemed to be meaningful additional information different then existed in the therapy. We were no longer in a client-dramatherapist relationship since we had become co-researchers, partners in a new phase, now at the research level.

The way the interview was conducted emerged from my misunderstanding of the meaning of an oral history, and insufficient knowledge in research methodology and methods. Lack of experience, being unconsciously frightened by the conversation caused unconscious emotional reactions, trying to maintain some 'objectivity' and play the researcher's role instead of playing the dramatherapist's natural role, may point out the weaknesses of this strategy. I felt Iris talked willingly and seriously but she looked as though she was avoiding express her feelings, without the personal involvement that had naturally characterised her during the therapy. The scene pictured in my mind remained and was fresh in our memories as both of us behaved as if we were interviewer and interviewee, reviving hard guilt feelings I was not aware of in real time. It reminded me of the emphasis attributed by Lincoln and Guba (1985) to the importance in naturalistic inquiry of the context in which the informants said their words, and invoked my unpleasant hidden memories, helping me to reveal a more genuine explanation of what had happened during Iris's therapy and save my personal integrity.

In retrospect, giving a subject to the client and ask her to respond to it seemed to be a very artificial distanced situation. At her suggestion we were sitting in her dining room. It was also the first time in our relationship that a table had separated us and the whole atmosphere was completely contradictory to our intimate warm and close feelings that had characterised the therapy period. I never foreseen this aspect of the interview and although I was eager to obtain new thick evidence, I had not thought to ask Iris for her

feelings and thoughts about the three-hour event. After many years under a constant transformational process while I was involved with the PhD I have no doubt that my reactions affected this situation. Unfortunately it only became a conscious process in July 2004, while writing this chapter.

Despite its weakness, this interview can still be regarded as unique, the respondent's real-life rich and thick evidence. The real significance of this data was understood only after I became aware of its rare value while completing the PhD research. An anecdote, which can support this view of the interview is the reaction of Prof Lahad, my dramatherapy guide, concerning this interview and several things that Iris had said. His reaction was: *'she should write a dramatherapy book'.*

First oral history: 21st May 1998

(Author's note this protocol of the interview is unedited in its authentic original form and wording)

R: Hi and good morning, how are you?

I: I'm ok

R: we will do the interview like this – I will give you a word, two or three and you will openly and whatever you want to speak about it.

I: okay what comes in my mind to say?

R: yes exactly. Psychotherapy treatment, psychology treatments….

I: psychotherapy – one on one conversation – one person who is supposed to be objective supposedly helping the other person find some kind of truth. My impression is that it is cold and in my mind I see this little basement room where I used to meet with that psychologist where it was very cold and one fluorescent light, I felt more like I am being interrogated by the KGB – laughing…

R: Dramatherapy

I: It's dramatic, it's active feel and felt more like I was working and talking with a friend or associate. I remember sitting on the floor and being very comfortable on the carpet, and being able to be open and if there is something that I didn't want to talk about … Didn't feel corded to talk about it, but that somehow it would come out anyway, but through part of the work so, the differences in my memory of dramatherapy is like a different…life different of…comfort level, and I was looking forward to it ,I can't say that I was looked forward to psychotherapy or meeting with the psychologist. I felt that I

needed help from the psychologist but I never looked forward to….and when I left there I didn't feel very good, and I always felt better living dramatherapy

R: PTSD

I: well, I know what is ,because I have/had it and felt it….degree but it is after something terrible happens in your life really terrible….I think that 90% of the time is unimaginable ….see only in movies it happens to you at the time….perspective with, and you probably the most vulnerable and can't do anything about it, and probably one of the…the biggest parts of PTSD is the helplessness in this situation and for me personally because I'm generally I doer I whole my life if something was bothered me I did something about it, and if it was the government bothered me I wrote a letter, if the boss bothered me I did better work, I always was capable in doing something and when our baby was born, stillborn, I couldn't do anything ,I couldn't do anything for her, I couldn't do anything for me I couldn't do anything for my husband and I think that feel that sense of helplessness is one of the keys of PTSD because that the things that continues is that fear of not being able to do anything …or that fear of being helpless

[She spoke in very quick energetic and fluent voice]

R: Stillbirth

I: (long pause) stillborn is the tragedy that almost nobody can understand unless they have gone through the same experience and…. It is probably one of the worst surprises of life because it happens at a time when everyone's expectations are very high. And because it is also a physical tragedy…you know… people you know sees a pregnant woman and knows she is pregnant and when she is not pregnant anymore they automatically assume that she had a baby and that it is healthy and that it is a girl or a boy. And it is one of nature's anomalies that a baby that is supposed to be born to live, dies – it's not natural – it not only crushes the spirit of the parents and especially the mother, but also other people who find out about it usually don't …it's almost like something from the Middle Ages like a witch or curse – they almost jump back like they don't want to get the Black Death…you know? So …and forever we will be the only – the mother will be the only person who really remembers and probably the only one who will want to.

[Her voice weakened choked very low]

R: I'm sorry… Infertility

I: infertility would have to be the most frustrating medical condition to have. I would never have imagined that 20 years ago – at that time I was a career woman and it didn't bother me the idea of not having children, and I even thought that with so many children in the world why did we need to have more children – especially when there are already so many who don't eat and don't have parents, but after our baby died and I realized through the process of being pregnant that ... I understood finally why people like and want to have babies and not just children and the following period of infertility was so incredibly frustrating because again it is something you can't do anything about. It's not in your hands. You can go to every doctor. You can go to the best doctor, you can have the best treatments and there is a very small percentage of success. Okay there are some cases if you are in the childbearing age, and if you are both healthy there is a fairly high success rate of IVF but once you are over the age of 35 obviously you already had problems so the % rate of success rate is very low. The emotional highs – the expectations – the hopes followed by the crushing despair, is really unbearable. On the one hand it is a really private personal matter and on the other hand once you go to the doctor it is very public and you have all these strangers poking around in your body asking very personal questions – and for me personally it was even worse because we did have a baby but we weren't able to have another one at that time and I don't know if we ever will, so of course everyone always wanted to know 'What happened to the baby?' So it also always took me back to the tragedy of my daughter stillbirth. But infertility itself is just tremendously frustrating and you have so many well-meaning friends who just can't help themselves getting into your life –and suggest stupid things and give you their secret tips on how to have sex and you wouldn't believe the idiotic things people have said. Like that doctor so-and-so is a wizard and he worked with everybody or they give you experiences like 'My sister didn't have any children for 50 years and now she has 10' you know…great ... fine… but leave me alone… I did not ask for advice. It is the most private issue, it is a huge invasion of privacy by the medical profession and the people around you and again it is something that you can do almost nothing about. You can try changing your diet, taking hormonal shots, go to a homeopath, get hypnosis, you can go to a chiropractor, you can have a massage, people tell you to go on a vacation, you should do meditation, you know you end up filling your whole life up with it and also because a woman's life is directly connected to her menstrual cycle …people say 'Don't think about it, try not to think about it..' but you go to the doctor and he says 'What day of your cycle is it?' So you have to know exactly what day of your cycle it is…you can't get away from it, so it is just frustrating and disappointing and between the couple the

situation can be really…?   And again society – especially in Israel – begins to judge a person's worth by how many children they have and whether or not they have them. For the man I guess the man starts to feel not very potentates or virile and I can tell you my feelings as a woman when women started to compare how many children they had and what ages they were I feel like NOTHING – I don't even want to be around them at all. Is that answer to long?

R: Fine no…maybe if you can add to the infertility in addition to what you said what you plans are in the future on this issue

I: First my method of …Clomdine is a fertility drug which didn't work very well for me – and it made me ovulate early and my doctor didn't notice and I kept saying to him 'Hey, I think This is happening' and he said No and I looked in medical books and yes – it said it was one of the side effects. By this time several cycles had gone by. Then we tried Pergonal except there was no Pergonal in the country, and then we got on a IVF programme and there still was no Pergonal so the medical profession suggested Metrodine which I after I used it they told me it was no good for a person in my situation and why did I use it at which point I said well YOU recommended it. And for me that was really a traumatic procedure – I felt like I was pushed into it –and I had all kinds of strange doctors examining me and one guy said to me 'Do you have 2 ovaries because I only find one?' at which point I wanted to jump off the table and run away – so you deal with people who see you as a medical lab experiment and the whole issue is related to timing – all very related to exactly what day you have that treatment and we tried different treatments after that with a hormone that is supposed to suppress my body activity and it did the exact opposite of that – so almost all the treatments we tried have done the exact opposite of what they do at the time and for me I am really depressed about it. I don't feel that it is worth continuing with IVF, and everything I have read in the literature says that for a woman over the age of 42 which I am that IVF is not the answer. Which surprises me because all these doctors keep telling me that it probably is and ….at the expense of my future? I am willing to continue with some Pergonal treatments and one of the reasons why I came to you was so that I could continue going through these treatments without becoming hysterical every time I am near a doctor. But on the other hand I also have to think about the medical complications such as Osteoporosis which is one of the side effects of hormonal treatments and to be realistic that maybe it won't happen. I think there is still a possibility for me to get pregnant and I don't think it is in my hands. And I think I won't worry about it…if I get pregnant great

and if I don't… I am not going to sit up all night and worry. So I am willing to continue trying some treatments. Personally I am interested in adopting, my husband is not, so I am not sure what will happen with that.

R: drugs that are given in cases of PTSD

I: I never had any drugs given to me – except at the hospital they gave me something in labour to make me feel better like Percadine – makes you feel that everything is just perfect and you get a bit hallucinatory on it but you don't lose total consciousness and after I think they gave me a shot of something to put me out and the only other thing I had was something to stop the milk from coming in which I don't' think is a very good drug to take because it depresses you. I didn't take any kind of antidepressants after – personally I don't take any kind of drug – if I get a headache I go and lie down, have a massage or a hot bath and I don't think it is good to take drugs of any kind unless you are completely incapable of functioning. But I think it is better to try and heal whatever it is and I am not interested in any antidepressant drugs.

R: even though it was for about 3 years that you suffered from a lot of symptoms that knocked you down, you didn't think about taking some anti-depressant to make it easier to move through that period

I: no when I went to the psychologist in Haifa who always wanted my husband to come even though I told her he didn't want to come and that I wanted help – uh and when I described the symptoms that would happen to me in a medical setting she said to me 'Well why don't you just take some Valium?' and I said 'Because I don't want to have to rely on taking Valium! I'm coming here to see you to try and solve this problem. If I want to take Valium I can go to the health food store and take Valerian but that's not the solution' SO…I just find it a 'cheap' solution because it is not a solution – it is a band -aid and that's how it should be used in my opinion. If someone is really in stress, like if they see a bus blow up, and people are horrified after, they should be given something to knock them out until they can physically return and cope with the situation. But…it shouldn't be used on a long term basis – except for people who are manic depressive or something and they have a biochemical problem that needs drugs.

R: in all of the literature that I have read it is part of the treatment of PTSD

I: it may be but I was never told I should take a drug it was never prescribed it was offered to me but when I said that I wanted to work on me and my perceptions more than to take drugs then they would usually say then you'll do it…

R: the first psychologist offered it too?

I: I don't really remember. I think in one of our first sessions when I was having bad dreams she said 'If you feel you need some kind of prescription let me know' but I told her I didn't want to – that was why I was there. And just in what I have read also about taking drugs, any drugs, even alcohol, when people take it as a part of relieving problems it depressed your sleep cycle, so what happens is that it depresses your dream cycle, which is usually what helps people solve problems is screwed up.

R: I don't know how to define it – I wrote immigration – or being a new immigrant in Israel

I: At first it was just fun because I was in a different place and I also told myself when I left home I consciously told myself that if I was to live here successfully I should cut my ties and not make comparisons. And I had travelled a bit before and I knew that it was probably a practical thing to do not a good thing to say 'Oh in my native land you never stand in lines like this…' so you have to accept a new country the way it is – but once I really started living here – like five or six months after then it started to hit me just how helpless I had become in terms of doing many simple things - I couldn't read mail from the government, I couldn't read forms from the government, I couldn't read things that are filling out and signing and once at Ministry of immigration absorption, they gave me a form and I signed it and then I said 'What did I just sign?' and they said 'You just signed a form that says you have never been a drug addict, mental ill, had troubles with the police…' so I laughed and looked at her and said 'I guess I hadn't'…and I thought why have people sign a form like that, like why bother – you don't realize how many simple things are affected in your life until you go to a new country, especially a country where the language is so different. I think if I had gone to France or England I would also have had some problems but here for instance, even when I could read Hebrew I couldn't even find Insurance agents and I couldn't find it because it is not under Insurance it is under the agent's name – things like that where some of the simplest things are impossible to do – you just can't find it. So those things really make you feel helpless and they take away some of your desire to try things because quite often you'll go to the wrong office and they'll send you to the wrong office…or getting directions and going to the wrong place…you know you lose your self-confidence because you can't imagine how you could have made such a big mistake. And even now when I have a conversation on the phone I will tell my husband something after that this person said 'This, this and this' and he'll ask me 'Are you sure?' , like he always asks me 'Are you sure now?' and before

I always used to be 100% sure when I was in my native land and in fact he never used to ask me that. Now he's become accustomed to asking me that because many times I made big mistakes. And it takes away your own self confidence when your partner/husband is always asking 'Are you sure? And then you think 'Maybe I'm not.' Immigrating to Israel there are other things which are directly related to our tragedy to our baby and our infertility and that is that it is a very family oriented society. In America no one would ever DREAM of asking anything about your marital status or whether or not you have children or why – people are very sensitive to that …they never assume that people should or should not have children – and here it is exactly the opposite. Where everyone assumes that you MUST be married and you MUST have children and if not there must be something wrong and we can HELP you! (laughs) so – it is so unfamiliar to me that I have really been taken by surprise many, many times when a stranger on the bus I'll be sitting beside him and he'll say 'Where are you from?' America 'Are you married?' 'Yes I am' 'How long have you been married?' I used to say 6 years (you see and it is like the Spanish Inquisition – they find out all the facts first and being polite I answer honestly with all the facts… …and 'Oh how many children do you have?' and I'd say 'None' and they'd say 'OH what's WRONG with you?' And so now I do a trick that I learned from my husband…which is to lie. 'They say how long have you been married? I say 'A month'. And I have tried different approaches including being honest and saying 'We had a baby and she died' and they say 'Well have another one.' Or they'll say so what's wrong – maybe you should go and get checked…or I know this doctor…I mean they really jump right into your personal life, people you've never even met!

R: In America it never happens? People never ask?

I: In America people would say 'My name is such and such…' and they would notice if you were wearing a ring and they would VERY politely say 'Do you have a partner or husband?' and the person will say 'Yes I am married, or living together…or gay..' you know every kind of answer is accepted, they won't ask if you have children or in some circumstances if you've been talking for some time they might say 'Oh, do you have children?' and if you say 'No' they say 'Oh' – end of conversation. They move onto another subject – no one pries in to your private life

R: And you are saying that here in Israel because it is something very different they will continue until they get the whole answer even though they don't feel that you are willing to talk about it –

I: EVEN IF YOU TELL THEM TO STOP and you say 'This is none of your business and I don't want to talk with you about it anymore' they will say 'Why? I can help you. I know my sister-in-law she couldn't have children and now she has 10' and 'Maybe there is something wrong with your husband' and 'I can take him to my doctor friends…I have a special rabbi he can go to ….you can have your Kabbalist name fixed, …I know an Arab who converted to Judaism and he's a holy man and he can fix you…It's unbelievable! It's one thing if you are sitting with a good friend and someone you know, you confide in them and they say, 'If you like, can I suggest something?' …that would be the typical scenario in the place I came from. But here everyone jump into the story so I have no defences…I came with no idea of how to deal with this. Like in America if someone asks and I did tell them that our baby died they would say Oh sorry,' and they would leave it, but here NO…how and why and what… and you just want to kill them!

R: How would you say it…you suffered more in comparison to other immigrants?

I: We don't have children …so we don't fit in. And there are lots of immigrants from other countries, intermarried couples with someone from outside of Israel and Israeli but most of them have children – so I not only have to get over the fact of the language, the fact that I am from a different culture with a very different culture…it would be different if I came from Morocco there are lots of people here from Morocco…and we are also as a couple we are older – and we don't have children…so we don't fit in like regular people…even in this community there are 70 families and there is one couple on our block who have no children and we just happened to be friends – I wonder why – but they are young in their 20s so that is acceptable but we are in our 40s.

R: You spoke about the Hebrew and how it affected you.

I: yes – when I first came here I spoke very, very little Hebrew. I studied a bit before coming here and I could spell but I couldn't read, I couldn't write and I could not speak. And the first year I was here – because I was pregnant, we lived in a little community in a very small little house and we have very little money and I didn't go out so I didn't expose myself (to the language) and when I worked in the office when I was 6 months pregnant till the end of my pregnancy our main language was English and most of the people I worked with were South Africans and all of the marketing staff spoke English all the time at work, so I knew very very little Hebrew and when I got to the hospital suddenly everybody at the hospital ONLY speaks Hebrew, I mean I can remember clear as a bell the doctor looking at me after he did the ultrasound and he said 'Lo tov' (not good) what does that really mean? So the ultrasound technician before that, when she

was doing the ultrasound, she started crying. So I mean, that was how I understood how 'lo tov' it was. And from that time forward in the hospital, almost everything around me was in Hebrew. The midwife could speak French so sometimes we communicated in French. My husband was there and translated [the Hebrew] for me but you know really it was a linguistic nightmare because I didn't know what was going on - I mean I knew something…I knew that our baby had died but what was going on with me or going around me ..I was also kind of stoned on that Percadine or whatever they gave me but you know…I didn't know WHAT THE FUCK was going on! (very exasperated) and so …and even the next morning there were these two women in the room with me and they asked me 'Did you have a baby?' and 'What was it?' and they were asking me in Hebrew and I could hardly understand what they were saying to me and I could hardly understand what I needed to say to answer. So they did have an Australian nurse working on that ward that would come and talk to me and everything else was in Hebrew and it was very unreal, sort like I had dropped into this other world. And I had been living in this very Anglo-Saxon world, kind of like a tourist at the Hyatt hotel in India… you know – you're in India, but you're in the Hyatt Hotel, so you're not REALLY in India because you can have a coke and a burger and you can have everything in America and suddenly someone kicks you out the door and boom! You're in India. And you don't know what people are saying or what they mean or why they are saying it…from then on everything was like that for me…then anytime that I was in any kind of stressful situation, whatever I could understand of Hebrew I couldn't understand anymore. I mean the first IVF treatment that we went for – and this had also happened many times before with ultrasound treatments but it was less apparent because it was a shorter treatment – so if you ask someone what they mean – they explain you once or twice and then you get it…and then you are out of there – but there I was in the operating room with them all around me and they are saying 'Take off your shoes' or 'put on this gown'…telling me all these different things and I completely lost it and I started going into shock. I was lying on the table and squirming around. And they are all going 'It's all going to be okay, it's not going to hurt, and it's going to be wonderful…' and the anaesthesiologist leaned over and said in English 'It's okay, you don't have to worry,' and I said to him 'I'm sorry, I'm so upset, but I had a bad experience once in hospital and I am remembering that right now..' and he said 'Its okay... it can't be that bad it won't happen again...' and he said 'What happened?' and I said 'My baby died' and he just like pumped me full of aesthetic. (Kind of laughs but in pain) and I could see in his face like 'Aw shit!' you know, that was when I really realized that it wasn't just a passing thing. And my husband

would always get mad at me and say 'You speak Hebrew, why can't you talk with them!' and he couldn't understand why it would…I didn't understand why it would just 'click' off either…and I understand now. And so in all these medical situations I would just walk into the room and I would start feeling tense and breathing as if I was scared and people would start asking things and I would get about as far as my identity card number and they would be asking me other things and you could have been talking to me in Chinese – they were usually simple things, not something that I hadn't answered in my life, I just couldn't think anymore – I just couldn't do it.

R: sounds like an unending circle of those situations that when they came together they knocked you down…the Hebrew, the trauma, the stillbirth…

I: yeah it is all like the unreality of it – to have a stillbirth is unreal enough and I also know that from what my Mother told me. My Mom was also at the end of her pregnancy went into hospital and was in labour for like 20 hours and they knocked her out and when she woke up her baby was dead. I mean I at least went through the process, I knew, I saw my baby, I knew what happened, knew it for a fact, and that never happened to my Mom. I think she still is not sure…you know?

Like my Dad is the only one who saw my sister but in this situation because of the Hebrew …that sense of uncertainty…what do they really mean? How can they be saying that our baby is dead? They can't be serious, I must not be understanding this, it can't be true…and then the on-going situation in the hospital where other people are asking you questions or doing check-up and nothing makes sense – not the language, not what they are doing, not your answers – just that whole feeling of unreality. So the language factor in that instance was very important and it repeated itself in other situations like with clients…Whenever I got that sense of uncertainty …of tremendous uncertainty – what do they really mean here? What are they really asking me now? They are explaining something and I don't' understand and it would just take me right back…to that same feeling of…almost like high anxiety when you are standing on the edge of a cliff – and you are not sure what will happen – are you going to fall, are you going to fall back?

R: and the treatment with the first psychologist, were in Hebrew or in English?

I: in English her first language is Hebrew -the meetings were in English. The second one I specifically looked for someone who spoke English as a first language …but I found her to not be interested in MY case – she was interested in family therapy. She did tell me that at the beginning, but I told her look, I am looking for an Anglo-Saxon, I think I am

suffering from the loss of our baby still and I need your help to get over it somehow. So she said I usually treat families so I said 'I don't think that my husband will want to come but I do – I need help...you know whether or not he comes I need help.' But then most of my time with her was spent with her saying 'Well, where is your husband?'

R: for how long did you meet her?

I: I went to her over a period of about 2 months but I didn't get to the meetings on time or I would get there completely late, usually, because my husband would volunteer to take me. The meetings when I made it by myself I was always there on time. It was just a waste of money and time – it wasn't making me feel better because I didn't feel she was interested in helping me. I felt she was interested in helping my husband or my husband and me but not me alone. But I understand that her interest is in helping the whole, but I think in a free society if one partner asks the other 'would you be willing to come to this treatment' and they say 'No' whatever their reasons are, you have to respect it.

R: what would you expect from her as a professional?

I: either to say 'I can't treat you unless your husband comes' or to say 'This is the only kind of treatment I can give you without your husband but those things didn't happen. She also tried many manipulative things (or I thought they were manipulative) 'You mean if you tell your husband 'look, don't you think it is in your interest for me to get well, and for that won't you come to at least one meeting with this psychologist?' Like to me that is a very manipulative approach, I would never say that to someone. I would say 'Look this person recommends joint treatment and I am asking you would you be willing to come?' and if they say 'NO'…well you can ask questions – like to you have a good reason … but if they say no they say no…but even in a medical hospital they respect your right to make decisions, even if it is life threatening…like if you are a Jehovah's' witness and you don't want a blood transfusion you don't get on, you know? So why in a situation of mental health why would it be more valuable to manipulate, coerce someone to come to treatment they don't want to get.

R: and what was the part of the Hebrew in our dramatherapy?

I: well I think in our sessions – I'm just trying to remember how it was at the beginning. First of all, I already knew that Hebrew was not your first language. Secondly, I think because we were…dramatherapy isn't language based – it is activity based…maybe it is language based but it wasn't for me as a client …you know we were doing things and out

of the things we did then we talked about that thing – so it was not so much of an issue.. I think there were a few times when I kind of lost my way with the language but I didn't find it a barrier – and I think that also your level of understanding in English is very high so when I needed to speak in English you understood what I meant, or that was my theory and when we continued with the treatments I never felt like 'Wow, she's really missing my point' I never felt that way. So language wasn't a barrier…and it was surprising because we were dealing with issues where I normally couldn't speak at all or with great difficulty but I think that because of doing things outside the person…like if I look at a situation in a hospital or clinic where I am confronted with a doctor who is saying Why are you on this treatment?' because quite often I would be dealing with different doctors who wouldn't know my history – so then they would say in Hebrew 'Lama bat le tipol hazeh'? (Why did you come to this treatment) so I would say 'Because my doctor sent me' and they would say 'why you do not have children?' Just like that! And BOOM I would start going 'uh…huhh…' and they would say 'What is the problem?' and I think I told you once we had to go to hospital and I had to have this ultrasound at a certain time and there was this one doctor who was really rude to me, but this was after many treatments and this one time that he was rude to me I just jumped up on my feet and took a step toward her like 'Listen! You talk to me like I am a person and you talk to me like I am a patient or I am going to punch you in the face!' And I said it really strong and forcefully like a good Israeli, showing that I had really acclimatized and was no longer an immigrant. But you know she saw that I was right and I was serious but in other situations I was treated unjustly and badly and that also made me completely shut down I just couldn't' deal with it…it made me go back in time.

R: dramatherapy activity

I: Spectrogram … is letting your inner self tell you what you think about things, especially your life. And I think it is quite amazing how it works because you would think once you have done it once or twice you could think 'Ah ha, now I can fix the game, I can make them think I am this way when I am really that way' but your subconscious is smarter than you are and the first one I did in the dramatherapy session really shocked me to the core – shocked me that my world was so small and I was insignificant and it wasn't until I put all these things on the page THEN I saw what I put on the page – I didn't think 'Oh this little blue button will be me' I just picked these things and put them there. The dog looked like my dog I put it there. But the other things I put there I didn't consciously say

'Oh this big giant rock is my baby's death'…and I really felt the whole day and the day after, really shaken …

When I did the second spectrogram I came up with the idea of how I would like my world look, which was very intriguing form in my imagination. Automatically your mind starts thinking 'Oh how do I get that' so I think it is a very good exercise or treatment because the person almost automatically starts making the journey from A to B - from how they are now to how they want their future to be. You almost don't have to tell your mind to do much more because it understands much better than the intellectual part.

R: associations with the word roles?

I: roles are allowing external things or objects to represent internal feelings and by letting them be outside and by giving them different definitions um, you get to see more or less how your own ego or brain is working to deal with your problems or pain which would not be clear otherwise. Like for instance in the time that those two characters were supposed to be protecting me but they were shooting from behind, for me suddenly I realized that yes, part of me should be looking ahead and protecting me instead of looking back and protecting me from what already happened. – and that's why when I go forward am unprotected, I keep getting hurt, not because I don't have something protecting me but it is protecting me in the wrong direction. It's a very concrete example of how the roles can help people figure out the problems, because for me it was suddenly and immediately obvious. Now many people have said 'Hey get over it' 'stop looking back' stop living in the past, but that's quite different from realizing that your present and your future is being hindered and stopped because of HOW you are living in the past, and it is interesting to see the choices of creatures and people that go into the role-making you really don't know why you are choosing them but there is a reason and your subconscious knows what it is, and it is interesting how it all gets drawn out even though you think 'Ah, people will never know that or I will never know that about myself' or it is a deep dark secret you can't even talk about it and there it is with all these plastic creatures right in front of you – that's about all I can say .

R: sometimes you work with your body and afterwards we work with projection and role what do you have to say about working with your body.

I: Working with the body is also like working with the spectrogram because at first. You don't think that your body will talk about things that are bothering you – you kind of think 'well I am in charge of my body so I can do whatever I want' but as you start doing the

performance or whatever physical explanation or whatever, your subconscious just takes over and tells the story that you need to tell…and I am thinking specifically of the time that I was telling you how I felt really empty like a derelict and you said 'What's a derelict and show me what you mean?' and for me it was really powerful for me to actually do that physically and realize as I WAS DOING it like 'what am I doing this to my life?' …why am I doing this to myself because when I think of all the poor people who actually do live like that their life is nothing, they are not going to go anywhere and I am not an alcoholic on the street, I am not in that situation, but I might as well be in the way that my life is going right now. So physically enacting it and sliding down that wall and felling this sense of nothingness and emptiness …and uh… inside me hearing the rest of me saying 'but wait – this isn't really you! You might feel this way but it isn't really you!' and it shouldn't be you and part of me also saying 'That's why you are here, so let's fix it' and many of the times when we did the dances I think that I would never I couldn't have planned it cause I didn't know the music so it would just come with the music and it was always a surprise to me too –Dance… I thought 'Oh, I will just do some nice movements' and then I started crying in the middle of it. And I really didn't expect that but it was obviously what needed to come out. You know and for me it was much more powerful than having a psychologist sit there and say 'So how do you feel now? Do you feel like crying?' So what if I feel like crying? You can make them cry if you ask them because that doesn't help them resolve their internal feelings, but if they start crying naturally because of what they are doing – they are doing their own resolution.

R: Another example that jumps to mind in working with the body if you can see the connection between bodywork and the role that came out for example the derelict, if you remember other examples where the role emerge from the body, from the movement.

I: I think the time …I don't' remember the initial session was about…I remember there was a time I was climbing out of a pit or cave or something, pushing myself up to the light – I really felt like I was doing that and it felt good to realize that I could get out… and I think I told you before and it is also in my book, my massage friend told me muscle has memory' .so I think the bodywork is an important part of dealing with it because especially painful memories because it is part of your body – so if you only deal with the head you are not getting to that muscular part. I also remember doing one session where I was an Indian running through the woods and someone was running to try and chase and kill me but I managed to hide and stay free – and when you think about all the bad dreams I had, they were always about someone trying to kill me and I always woke

up at the moment they were going to shoot me or something – so I think that was a powerful tools to stop having those dreams because I don't have them anymore.

R: …working the roles that emerged from the Indian and the Indian music – you are giving me lots of new things today, thank you…and I see how important it is to do this interview because I wasn't very sure if I should do it because of my fear of bias – really. I don't know in which way I will put it – as a material in the thesis – I don't know how, but it is very important not less than the other things. I remember one of the most important tools was when you played the two roles – you remember? And all the time when a role was evoked and you gave it a name and I asked to you pick the opposite role of it and when you played the two parts at the same time – do you remember this?

I: I remember the role with the derelict and the person helping him…

R: you remember the guard at the gate?

I: uh right, yeah yeah…And he said how boring his character is

R: also one of the two roles – the black and the white roles, like role and reality.

I: um roles and reality – well I think with respect to the roles that come out of the sandbox, with respect to reality, one of the great things is that they are not real, because then you can be as aggressive or gentle or crazy or fantastic as you want and it doesn't really on anybody making real guidelines – you know it is like if someone says 'I want to be a millionaire tomorrow' people would say 'Oh be practical, be realistic' In the sandbox you can do it – 'you can say, here's someone on the beach, they dig a hole they find a million dollars and now they don't want to get up' but in reality people are always making these little squares for themselves and others and saying 'No this is the framework of reality FOREVER for you' and that is the other thing – it is inflexible in most peoples' minds and in most situations. If you have a job, people point at you as if you will have the job for the rest of your life which may or may not be true. But it doesn't mean that you a job for the rest of your life, but like working in the sandbox a character can one day be a guard, the next day a janitor, the next day a King the next day a Robin Hood and within that second they can transform themselves anyway they want – and just giving you mind that imaginative openness is a really powerful tool – because it is also an element in my work which I had been able to apply in my life, but after what happened, I think after that crushing reality of her death where suddenly creativity didn't help and clever talk didn't help and brilliant ideas didn't help – nothing helped – then I really closed the framework. But usually when you are in a creative meeting when people are

brainstorming you come up with ridiculous ideas –everything is permitted and because everything is permitted, one of those crazy ideas comes up and people say 'YES we'll do this and we'll plug it into this part of reality and voila…' but most people don't have the tool available in their life but even if they do, like myself, if they get stuck they are not able to use it…and the sandbox is able to open up that possibility again and it is like – I think I told you about that minister in the States who wrote the book 'the power of possibility thinking' ..maybe it was someone else I told…anyway they wanted…he's evangelical guy well-known speaker... anyway they wanted to build a new church and it would cost 17 million dollars and they wanted to build it all of glass, so it would really be beautiful and fantastic and they had no money whatsoever and he came into this group of people at the time and said 'Instead of thinking about what we don't have, let's think about what we might have, what we could have, what is possible…could everybody give 10 dollars?' and they all said 'Sure' so he said, great, then let's just find 17 million people with a dollar and that's what they did – they went out and found people how would buy a brick or a window or whatever and they did it. So it is a well-known technique that people don't use and that is the sandbox thing too that it opens the possibility…and that's part of its power – and also that it is fun – it is not threatening – it takes you back into your childhood it takes you back into some of the funniest things you have done which was also a situation where it was harmless and you felt very protected , so there you are able to really uh … throw out a possible life – throw it out, look at it… change it …you realize you can change things. So…you realize that part of reality and a good part of it is in your hands.

R: ... let me put it another way… it was … you were outside reality. Can you make any connection between what has happened in your real life?

I: I think basically what I just said – you leave the sessions feeling that there is some power in your hands. And that you can change things in your life and that's really the direct connection to external reality. Ummm that's it.

R: persona cards

I: persona cards are so abstract compared to the other three dimensional items or even the bodywork like at first I couldn't understand how this could possibly be useful. I mean it was kind of interesting to pick these different faces but it wasn't clear to me what my collection of faces could ever do – why it was important how it could ever have meaning, but until you pointed out the selection of colours and the way that the expression on people's faces and until you asked me to describe that person or tell about that person

then you see all these hidden perspectives in side you that were very unclear. I think the cards were probably stronger tool than you think (than I think) but I am not sure how I can verify that – just because I always see the picture of that woman in black, the advertising woman? And the exotic woman – they are still very strong images in my mind. And I remember also when I picked the alien, and again even though I had already gone through the spectrogram and I had already picked the button and that was me so small and tiny and nothing…and we had gone through quite a few sessions before we got to the cards and then I picked the alien – and it was also blue but also very alien and obviously a representation of what I thought – which was a surprise because I was already thinking that I was 'one of the gang' and how I fit in, and it also make me think about a more fundamental perception of myself that maybe I always have felt about myself, maybe I always have felt like an alien – partly because of the creative work that I do and partly because of the way I am creatively – I don't find a lot of people who can relate to what I do. I mean I thought of this alien card when I got the new annual report that I did – I came from the mail, I had the package in my hand and I opened it and saw how beautiful they were and I thought, 'there is not one person in this town I can show this to who will really understand what it means or what it means to me.' And I thought that's okay. Whereas, before that, would make me feel really isolated. I saw some other people after and I said 'Hi' and I didn't try to show it to them or explain it to them, I waited until I could find people who I knew would understand it and uh I came home and phoned the people I worked with on it and left them messages saying 'What a great job' 'I enjoyed working on it' 'thanks for sending it' so I connected with the right people because I think them mistake I made before was connecting with the wrong people. Like for instance is someone asked about our baby … what do I need to tell some stranger about it for? I'm just going to get hurt – but because I was so alone, maybe looking for a connection, sometimes I would tell people but then I would always get hurt because their reaction would always be horrible or stupid. So realizing that I had this alien experience I started finding only common aliens to tell it to and therefore feeling less like an alien. Understanding finally that there are something's that I can't share with everybody because they won't understand – so not to try and not to worry about it – I think some of the car choices were very surprising like the exotic Indian woman. I am still not sure how I relate to it but it is a very strong image. And I still also think about the time I drew here in a picture standing in the garden so there is also a strong image – directly connected – so I think it is more powerful than you know but it is probably impossible to measure the power.

R: …. if you have anything to say about clay

I: I liked working with the clay. I liked making that bird. After I made that bird I almost had an obsession. I kept finding black pieces of stone and I wanted to take a hammer and break them and make them like that bird, the bird I shaped with my hand, and I never did get the nerve up to actually break it – it would be just find if I would break it – I think it is good to make this 3-dimensional thing with your hands outside your body, outside your mind... again it opens the options. You uh…realize that reality is in your hands and also your dreams are in your hands…visions … at first I made a power station and then I turned it into a bird – and that was interesting to make a power station and to realize that my energy level was at some kind of all time low – I was always seeking some kind of energy base or power base.

R: I think we will finish with sandbox

I think just a few minutes of my time I will play in the sandbox and then we will get on with the real therapy (they laugh) you know I had been to a traditional therapist before and … so that was always in my mind that first we will do this exercise and THEN we will have the session but having gone through it now I know that IS the session…it is a very disarming approach – usually people are afraid of getting hurt again, they are afraid of being hurt in their weakened state – so 'come and play in the sandbox' oh sandbox – so you lower your defence and you really open up - it is not threatening , it is fun and it even feels ridiculous , so you are more open to everything

R: and can you say it worked for you because you are so creative and close to the field?

I: no. I think it may have been more fun for you, I might have done things differently than many people – you mentioned that my stories were much more convoluted, but I think anybody would do similar things.

R: so can I say a client should not to be with a degree of creativity to gain from the therapy?

I: you don't have to be creative to work with 3-D objects – you just put them – and how you put them tells something about you. And if you want to paint a picture of the Sea of Galilee exactly as it looks today…you have to be skilled – none of the paintings I did were particularly skilled, they were expressions. And from those expressions you could see something of what was going on in my mind. Now maybe in some instances I could draw figures more in proportion because I have more experience in drawing, but it is also a function of a person's state of mind – if someone draws someone who is really out of

proportion against a person in proportion, that is not a matter of skill, it says something about how they see that person. Sometimes it might have been detrimental I remember once or twice when…I can't really remember the words…because I work with word all the time it was hard to work with them because it was 'too common for me'…I personally never draw anything – maybe a sketch but I'm not an artist – so I think it is good that you chose alternative media because it forced me to express myself in a different way. Which in turn probably… (too low)

R: what are the most effective or impact or meaningful that caused the change?

I: the first spectrogram….I can read you what I wrote about it. I don't know what date this is exactly. 'I have dramatherapy with Rocheli, yesterday we talked a bit and then began to work with drawings. I drew the memory chest box that the girls sent me. And as I started to draw what was in it, I started to cry. She asked if it was in my room and if it was good or not that I saw it all the time. And it is not. I will put it away – with love – but away. Then I drew a picture of how I was and a picture later of how it could be later – I think that was a spectrogram…

R: I know what you are speaking of – it is a drawing with the blue…and then you were crying and drew another picture with the box and the things in it.

I: That part I remember but now when I draw a picture of how it was and how it will be later …this is a spectrogram how much I want to bury the past and how hard it is to do it. How much I want to go to the grave…why I don't exactly know... I feel that I must, at least once. Rocheli gave me a good idea and one which I guess I half-heartedly had for months and I tried and didn't succeed - or from fear, guilt, shame, would someone laugh? To make a symbolic grave at our house then she can be with us and I can be at peace. I felt shaken to the core to realize how small and shallow my life had become. How great the barrier of rage and fear and hate…how forgotten my husband and how invisible myself and how colourless, shapeless empty. I could not draw more in the first picture –I have no power, no desire, empty…what more could I draw. I felt so stupid doing this stupid idiotic drawing and then so shocked to see how much it really was me…or at least how I saw the world. When I left, I still felt shocked, shaken, inside all day…but also kind of optimistic because I know what I have to and want to do. It was also exhausting. I popped right back in time and had many, many flashbacks but this time, many were more objective as if I were a third party and I also had a big dream, a long complicated one that I don't remember anymore, but it was one that I felt and lived. So that is from that time – I thought it was about the spectrogram…

R: whatever you think about dramatherapist

I: the task of the dramatherapist? Like you in particular?

R: if you can talk about it separately…

I: I think just like the person who works in the sandbox gets to look down from above, the dramatherapist gets to see everything from the outside …because no matter what the person is working on the dramatherapist gets to see how they are breathing, facial expression, how they move – they get a much broader pictures of everything and from that they are able to help the person get through different issues and they can see if people stop when they are about to move something – and they can see if it is heavy or if they are afraid – I guess that is part of your training – I HOPE that is part of your training – so the role of the dramatherapist is to get the big picture of what is happening with the client because part of the whole process of getting through any kind of emotional problems begins with awareness – and if a person doesn't realize that they are not drawing or that they always draw with black…….once I had a whole wardrobe full of blue clothes –everything – I never realized until …I was kind of proud of it at the time and then I realized…and I went out the next day and started buying other clothes – so what is the point the point is that the dramatherapist is an external WITNESS to what is happening – the SEE THE EVENT and then they can guide the person. Many times the DT will say 'Why are you stopping?'' and the person will say 'I don't know' and you can see the expression on their face so you can say 'Are you afraid maybe? Or 'What feelings do you have now?' and those prompts help the person get in touch with their real feelings and the fact that someone SEES the person's process of emotions help the person release them because they don't feel that they are being judged and they are not afraid of being judged – as I said before when I started cutting off connections to people it was because I was afraid that they would judge me and it was very difficult for me to make a personal connection – because part of making a personal connection is sharing personal experiences but there was one I NEVER wanted to share with anyone and any time I did I was always rejected or disappointed …so with you I was not afraid, partly because of how you are as a person but also because in the context of our meeting, you never asked me to expose my heart and soul – you allowed me to do it if I felt comfortable …

R: what you are saying is as if it not the task of the psychologist and psychiatrist to see, to feel to be outside the patient –

I: that's true but their method of working is more related to words and just the physical reactions of the person ... Like when you ask someone making a spectrogram it is more revealing than just sitting talking across a table and if you are using prepared Rorschach blots … you getting a much different uh … response from the person than if you see them make their own Rorschach blot – because with those blots you are asking them to compare their response to the norm –whereas when a person is creating their own painting or spectrogram it is coming from them. And also the method of psychotherapy is much more confrontational... like if a person says 'I feel blocked in my life' you know they kind of questions are often really annoying like 'You feel it necessarily to punish yourself by blocking your forward process?' You know, no one wants to consciously block their forward progress…that's why a person comes to a psychologist for help – it sounds like they are being victimized again – though I didn't have that experience…'I feel blocked'. ….'Yeah? Well, try this on!' which I often felt in psychotherapy. It made me angry.

R: self-confidence

I: open ended question?

R: yes I am continuing with the subjects that I wrote

I: self-confidence is based on an inner strength, many things such having a clear vision of one's strengths, weaknesses and potential of realistic objectives in life. … So I think it is like the Greek saying 'Know thyself' that's what I think self-confidence is about and from there I think true self-confidence comes. I think self-confidence is also based on life experience. I think if people have positive or successful life experiences that generally they are more self-confident and if people have negative ones or if they come from a negative family background they have less self-confidence because they don't have a very good feeling about their value as a person. And I supposed the real message should not be related to what a person can or can't do but it should be about the person's intrinsic self-value, but the times when you need it the most it is the hardest to remember that. Because you never need self-confidence in a simple situation but in a difficult situation you do…

R: and especially for you… can you see differences in your self-confidence before the trauma, during, after and now…

I: Yes. Before the trauma and before I came to Israel I was a very self-confident person and I always felt that if people had a problem and couldn't solve or wanted to get ahead

in life they should just get up and do something about it. Which I still think about that –
it is still important to be self-motivated to find ways to resolve problems and make the
most of their potential – but now I realize that there are some circumstances when you
just can't find that inner strength any more, and that's what happened when our
daughter died. It was so far beyond my expectations and I was in such a new situation
that any previous framework that I had for getting out of problems was almost entirely
collapsed or broken, and all the kind of things you can say to somebody about other
kinds of failures or problems in life 'You'll get over it', 'You'll learn from this experience' ...
maybe there is some value in it…they really don't count in that situation. Because you
will never get over it you might be able to cope with it, but you will never get over it.
Maybe there is some value in the situation …well MAYBE but what a terrible price! And
all those clichés that work at some other times – okay you went for a job interview and
didn't get it , well you can think about the interview after, how you were dressed, are
there things you can improve…like there is nothing you can do – so that really shakes
your self-confidence and I think for a person who has generally been pretty successful in
life, and that's how I consider myself, (not in terms of being a millionaire or famous) but
successful in achieving the things I started to do – I think it is really hard to be put in that
situation because I don't have previous experience in that kind of 'failure' or inability…I
am used to solving problems, giving a hand, making decisions that lead to a positive
outcome and none of those tools worked anymore at all. Then you add to the fact that I
had very few resources in terms of friends, family support, language etc. all the other
things that would make it easier….

So during the tragedy, at the moment when we understood what the situation was, I was
fairly strong, and surprisingly calm - I kept telling myself 'Well there is nothing I can do
right now, I just have to get through this…' and I just wanted to get through the delivery
because I knew that this would be physically and emotionally difficult and also at that
time when they tell you that the baby is dead, you understand that they are telling you
medical facts, but you don't really believe them. And we were also at a religious hospital
and my husband said at one point 'Even here they don't believe in miracles' you know
both of us still had the faint hope that it wasn't true, even though we both knew that it
was. So after she died, at first I guess I was pretty numb and I didn't realize what the
consequences would be for my self-confidence, but immediately and drastically
everything about my perception of life changes – and I only see it now in retrospect. I
suddenly became very attached to being at home with familiar things. And I was really
nervous all the time that we were driving which is probably a normal thing to be in Israel

but I was even more nervous and I had to go to new job interviews and meet people but I just couldn't and I just didn't have the usually spark – and people would ask me one question that I didn't understand and I would say 'Oh that's it, I will never get this job.' Uh, at times when I could have used my self-confidence to play a game when I didn't understand, I couldn't do it anymore. I remember I went to this one job interview at a high tech company, I met with these 2 people from the department – we had a good meeting and they liked me and wanted me to work there and then they gave me a really creative assignment and I did it and I could see them saying 'Wow we've got a really creative person here' and they gave me one more assignment …and I couldn't understand it. Suddenly my whole mind went blank. Now I have run into that situation before because I have had to write about oil wells and oil companies, things I have no day to day connection with – so you know I have always been able to say – give me the material, I will look at it and get back to you. But in this situation my mind went dead and blank and I looked at them and I said 'I don't know'…and they said 'Well pretend, what would you do?' and I said 'I don't know' and they could see that my energy level just went….and that was it, I never heard from them again and I could see at the end of the interview that it was OVER. That happened a lot.

R: And what about now

I: now...well I know after the treatments my self -confidence has really come back – it is really related to being assertive because if you don't have self-confidence you can't speak up for yourself and in the past few years uh… I became more and more quite. I never used to be a real pushy person about my opinions but I used to like to set my own boundaries and I wasn't able to ask for what I needed and I really suffered the past few years just from not being able to be assertive and that's related to my self- confidence...I still have trouble with it but I am able to protect myself – like I told you about not answering all the personal questions strangers try to get into – I realize I can set that boundary and that's okay. It's my right to protect myself. That is related to self-confidence. And in work it is my right to say 'up to here and that's it…I am willing to take a risk and do things on spec – I have done a lot of that all my life but now I weight my risks and my rights better…so and I think a lot of it is remembering that little spectrogram with that little flat blue button as the symbol of me and I think I have come a long way.

R: okay…uh… options…

I: options? Related to creativity related to being able to imagine a variety of solutions being able to look at a broad spectrogram...and to be open minded and to not be too narrow minded in one's visions because then you can see all the options and I think it is also related to self-confidence because they require risks taking and responsibility because if you have one choice...like if you are a very fundamentalist religious person , one of the great things about your religion is that is sets a boundary very clearly and then outside of those boundaries you don't have to make any choices … Hari Krishna ... whatever religion it is – your life is simpler because you have fewer choices and options. So you have to be able to be self-confident in order to have options because otherwise you won't be willing to take the risk or the responsibility for the choice and with the responsibility for the choice of the various options you need the courage to go forward – so they are all connected.

R: can you say some things about this word – especially for you?

I: options:

R: in the content of our work

I: yeah, when I came to see you my options were limited or I had limited them the shock or tragedy the fear of having to take a risk was very great – meeting a new person or starting new work , and I am also usually a very responsible person and take my commitments seriously and it really bothers me when I don't fulfil them or I promise to do something I can't for me it was a big problem getting into work situations where technically I knew I could do it, but emotionally I could not. And my range of choices was getting smaller and smaller because I was very attached to the house and dog – I could stay here it's so beautiful…I forget what the word was?

R: options

I: so with the process of our work I started opening up more and trying new things like shortly after we started working together I decided that I wanted to do some video – and in all the time that I worked here in Israel ….voice too low…something about not going into video…

Now having overcome them I suddenly have a whole network of resources…but before that I didn't even have the urge to start, and also that was when I convince this guy that we could do this video and it was kind of an innovative idea of mine to use existing material from his clients and it is true that it is not the best quality but I told him you don't' NEED the best quality what you need is a way to show people how your product

works and you can either show them still photos of a thing laying there, or you can take pieces of video of your client's products that use your motors and they can see 'Wow look this tank is using his motor and that missile is using the motor' and the quality won't be the critical factor and I got him to agree to do the show and I think it works well, I didn't make money on it personal but I learned a lot, got good connections and I don't regret doing it.

R: you said that there was something that widened your options; it was several things or the processing

I: the first thing that widened my options was looking at the first spectrogram and I realize how small my world had become and it was a real big shock to me – a real big shock – but also when I did the second spectrogram I came up with the idea of how I would like my world to look, that was very intriguing form and my imagination – it was something that made me think like Yeah what do I want my future to be, what do I want in it. And automatically your mind starts thinking 'Oh how do I get that' so I think it is a very good exercise or treatment because the person almost automatically starts making the journey from A to B - from how they are now to how they want their future to be. You almost don't have to tell your mind to do much more because it understands much better than the intellectual part…that was one…I think also working in the sand tray was very useful because the roles help demonstrate what tools you have within you and how you are using them – whether you are using them for your benefit or your detriment. Because sometimes you find all these stupid characters that you've put in the sand tray and you are thinking what an idiot this leading figure is to have all these goofy characters around and they don't know what they are doing or they are not organizing, but then you start to realize that 'that's me' and I have all these skills and abilities but I have them all lined up in the wrong order! So you realize you have these strengths that you just aren't using properly so it is also very enlightening – awareness I think awareness is one of the key elements that helps give you all those options back.

R: Self-esteem

I: self- esteem is different than self-confidence. Self-esteem is the person's own …self sense of their worth unrelated to what they do or how they do it whether they have money, title, business card…it is a really core issue but I think Self-esteem can also be detrimentally affected by these kind of tragedies or traumas and I think self-esteem is related to how one grows up as a child. Which is usually related to mom dad and home and has that kind of child-like aura of protection around it, and all those kind of

things...and when you are in trauma or tragedy of some kind which no one can help you and nothing can save the situation – it shakes that trust which the self-esteem or sense of self has in the entire world, probably in all these kinds of unusual traumas...I think that is one of the main issues – it is not just that your general framework or your regular framework of life is shaken or broken, it's that there is a really a core issue of trust in life that is broken, shaken, torn…and that's really the inner self, the most basic perception of ..and in this particular instance the issue of motherhood is related to a woman's sense of self , sense of herself as a woman, mother, human being…those things I never ever thought about when I was in my career and I always thought it was kind of stupid when people talked about the biological clock and motherhood issues and how it is related to your sense of self but now living in this more traditional world in Israel and having gone through all these infertility issues and all these conversations with people – now for instance I understand Biblical stories much better. When you read about Hanna praying for children or Sarah, you realize that in that world, a woman had NO OTHER VALUE than to have children – she didn't have another option at all and if she was married to someone and didn't have children she was NOTHING. But those same feelings are alive and well in society today and also in the people who suffer from infertility or tragedies like ours and because reproduction is such a 'natural' thing – everything in life reproduces we have puppies here we have five cats last year, you know life is full of reproduction, so when life doesn't reproduce itself naturally it is also a big shock to the core issue because it doesn't make sense that something was created to not reproduce, just like it doesn't make sense that something was created to die.

APPENDIX 5: DESCRIPTION OF THE SECOND ORAL HISTORY

4TH JUNE, 2002

This oral history had subsisted one year after embarking the PhD research in 2001. At this time although the conceptual framework was not clear to me, it was obvious I would like to hear Iris' voice and reflections. The belief was that, four years after termination therapy and the first oral history, and two years of being a mother miraculously (2000) caused some changes in Iris' memories. After all her unexpected happiest femininity fulfilment wishful, enabled this research to be born. The conversation was tape recorded continuous about one hour.

My search for years after answers what was so special in Iris' case recovery had convinced me that the only person who can help me to find them is Iris. An echoing silent voice incubated in my mind since finishing the MA was the high 40% extratherapeutic factor that belongs to the client in successful outcomes in psychotherapy (Duncan Hubble and Miller, 1997). The idea was to collect the client's perspective in different times and forms in longitudinal period based on the notion this kind of knowledge is very rare in psychotherapy and not exists at all in dramatherapy.

It was stated few times that uppermost, I was interested in this particular human being – Iris (Mittroff and Kilerman 1978). Her willing to participate in my PhD research by being interviewed during its period enabled to focus and put on the stage the hero of the dramatherapy to reflect upon it, turned to be a unique contribution. This knowledge comes directly from the respondent real life experience it was not leaned upon academic theory, psychotherapy methods and techniques and above all not on professional practitioner analysis.

It became clear insight in April 2003 which led to establishing the research conceptual framework on the client's contribution to recovery based on the therapy period and on her later oral history memories. We met at Iris' home in the morning on 4/7/2002 to her convenience and recorded our short conversation about an hour only. Had being more experienced with this research's methodology and methods especially with oral history influenced the decision to conduct it differently than the first one. As well as sensed vividly the unpleasant memories of it, being technical non- personal not intimate conversation although it was very long and detailed.

This oral history became one person's unlimited fluent reflection storytelling of her experience without my interruption. Iris offered we would do it in her child's room we were sitting on his bed close to each other. Iris was talking to the microphone as she is performing on the stage a new role. She was very much alive happy in serenity mood her body was relaxed and loosed, completely opposite to the first oral history and even to the therapy period. I never saw Iris in a situation like this. It was reminded me the clay eagle she made in our fifth encounter '… when a bird flies into the sky it flaps its wings several times, and then he has no need to work harder. When I was pregnant, and also when I used to write, everything came to me easily, nothing was difficult to me'. She became free like her own symbolic eagle but now the eagle was flying it became alive while when created it she said 'it is not flying yet'

Then the whole scene turned to be surrealistic absurdly event. I had sensed overwhelming and anxiety symptom for a week since we arranged our meeting, which sharpened and increased during the conversation. My extreme physical and emotional reactions caused me almost dumbness and frozenness, breathing difficulties and stomach-aches. After an hour, I could not suffer anymore my pains, and asked Iris if we can continue in another time due to my unexpected responses, she agreed. So 'easily', our roles had changed.

Second Oral History: 4th July, 2002 - Four Years after Therapy Termination

R: How are you? I am very glad to meet you after a long time to do our special interview called an oral history, for using it in the PhD research. This is your main part after four years we have finished our successful treatment and here is the stage for you to tell what happened since we finished the therapy and how you see it from the perspective of four years that passed and shed light from your points of view on the whole healing process.

I: *Okay, is there a particular point you would like to start from?*

R: No. This is yours, these are your memories and you can start wherever you want or feel like.

I: Okay, it's kind of a big …it's a big open task….Can I think about it for a minute?

R: Yes of course you can take all the time you want. I will wait.

I: It's ….just a second. I guess because we are looking at the client-therapist relationship and some of the factors there, and I think I'll start there and I think one of the first things for me that was very important was that you had a very great sense of empathy toward what had happened to me with the death of our first baby and partly because of

your personal similar experience, and I think that these are situations that are very difficult for other people to understand. They might understand it mentally, but they don't understand it in their heart. Aside from that I think that individually you are a very empathetic person.

Some professionals are in the healing fields are very professional, but they are not very empathic as human beings. I know one of the things that I found very important when we started working together was that we were in a very comfortable room and there was no desk between us….before that I had gone to a psychologist, like a couple of years before that , and we met in a basement in a Maccabi (health service) this kind of dead end room if you like , and it was at the bottom of a stairs and there was nowhere else to go there…..there was this room and I'd walk into the room and there was a desk…..and there was the psychologist and although she was quite nice and everything, it always made me feel like there was something physical between us, you know, I could never cross that barrier and that she also really didn't want to get too close to me….whereas in the room we worked in your house, the space was open and there was nothing separating us except some space. You always gave me the choice of where to sit and how to sit and somehow that's important because is felt more personal. It felt more friendly more- it established more of a sense of trust I think. One thing that we have talked about in the past couple of months also was the timeframe at the meetings which I actually completely forgotten about- which sounds a bit stupid but the fact that we were able to sit and continue talking and working together for more than an hour and usually two hours and sometimes three almost, I think it's also an important factor because again when I was working with the psychologist I would just get to the point where actually I wanted to say or reveal something or where I myself was getting ready to know something about what was happening with me when , you know , she'd look at her watch or look at the clock on the wall and say 'Well our time is about up so ……whatever you have to say ,spit it out and get out of here!' So I always had the feeling that she really didn't want to know what I had to say, she didn't really care that I couldn't say it in an hour and I couldn't emotionally bring myself to get close to it in less than that time, so, you know, I always left feeling like….kind of like I had been to a restaurant and they have shown me the menu and walked by with food for somebody else and then they said 'But we are closing now so you can't eat', just to the point where you are thinking 'Oh, I know what I want , I know what I want to say, I know what I want to do- 'you can't, it's finished.' I suppose it's convenient and profitable to book meetings for an hour for a professional therapists but it's not always enough and I'm sure there are cases that it

would be too much for people – I don't know if you could say that the rule would be that it has to be longer, but I found it much easier for me to get deeper.

I think working with different kind of modalities was also very important because I think I told you once, when I started working with the sandbox, I thought it was kind of a stupid thing to do because it seemed very childish-you know-like, well…here I am ,what was I then forty- two or something? And sitting here with a box of toys and a sandbox….but in fact it is quite a powerful tool and I was surprised myself at how effectively it worked although in all the work we did, the most effective, the most powerful things for me were the spectrograms, the three dimensional spectrogram, although the sandbox is also a three-dimensional environment and it was also quite enlightening and powerful. And I remember I always used to end up suddenly yawning in the middle of these sessions and feeling that something was kind of overtaking me or… (Iris last words are lineal to her work with the sandbox -R) and at one point you said to me 'Well that is often a sign that something is working deeper, that something is clicking you're getting some kind of a gestalt, understanding of something that you didn't have before.' The other day I was thinking about the penguin that I chose I think as the first model from the sandbox work. And I was thinking about how, like what an incredible force my subconscious mind had to choose that character, even though on the surface, why would I even choose a penguin? But in fact, at that time, I was in a situation where my life was really quite frozen in place and really I could not fly, I creatively couldn't fly. I could hardly walk and there is no creature more appropriate too chooses than that.

And the fact, I can't remember, if it was on a little golf ball, and that was his world, a little cold, white world.

It's funny, there are many things about the sandbox work that I can t remember, which I think is maybe one reason I have been a bit apprehensive about doing this interview because I keep thinking well I hope she does not think that I am going to remember everything I did there because I don't. But I do very clearly remember the sandbox with the penguin and I remember the story about the (chayalim) that didn't protect me ~the soldiers~ my guardians that didn't protect me because they were looking the wrong direction. I also remember the last treatment that we did, and what I also remember about it that I didn't have the guts to go one step further because there were all those characters marching around the gravesite and marching out into the vast unknown and then I just couldn't continue anymore, it's likely and probably at that time that was as mud emotional strength as I had and it got me to the point where I could continue in life

and be productive and make friends and go to public places and see babies and not freak out and go to medical clinics and not be a basket case. So … ,the treatment at that point in time accomplished what it needed to do , maybe I knew for myself that I didn't have the strength to go that one step further to really fly because I had so many other things to cope with in general, in life here, being a new immigrant, you know, accepting some of the responsibilities. I accepted by going through the healing process. Because I think when you are getting well you are accepting a responsibility to change your life and change is a lot of work. So ... from that time forward, I think I've done okay. I suppose one part of me would say that I could have done a lot more I could have expanded my career more and everything but in fact the surprise pregnancy of my son is kind of , I can't say that it set me back but it confused me because I had sort of come to the decision that we would probably be childless and I'd just have to live with that and that would be okay and then to have that decision completely reversed in a wonderful way, it's also a big change and a big shock. Aim sure that part of the treatment, I personally think that the treatment really was an integral part of me, becoming pregnant, because I stopped worrying about it, because I started valuing myself as a person again, because I had stopped doing that. But as I said it was another huge life changing event and also very late in life so I think the impact on me is probably more than it might be in other situations. With respect to our relationship during the treatment (just trying to get back to the main subject)I think we've talked about it a few times that it was very different for me and very good for me to be in a situation where someone didn't tell me what I should do or take kind of a textbook approach. I went to another kind of psychologist/family counsellor type of person in Haifa before I came to you and she was always very adamant that either my husband should come to the meetings or she couldn't really help me. But she kept encouraging me to come. I always had the feeling that if I wasn't going to do things her way then there would be no solution and maybe she was right in that context but it didn't help me I always left there feeling bad. And the same kind of thing happened with the other psychologist where, especially the time that she intervened in our conversations and said well you should go straight to IVF treatment. It's like you know who are you to tell me what to do in that way. That's not the solution to my grief. That's your solution for me talking about not having a baby but it's not my solution for getting well.

Whereas, when we were talking you were always offering me options of what kinds of things to do and where to go or asking me about how I felt and how it affected me.

I think giving me that lead gave me a sense of personal power , not power over you , but it gave me a sense of being capable of something in a way it suddenly forced me to be capable of something, I had to take a step because you gave me the option . I don't know if that's an integral part of therapy or not but I think it works very well.

You also never judged anything that I did or said, you always were very accepting of it and you asked me what I thought of it , trying to elicit from me , trying to show me my own mirror .I think that that kind of technique is very good also.

R. Do you have any comments?

I. Yeah it's okay.

I have no comments until now, it's wonderful I hope that I will be able to transcribe the tapes because you are talking very fast and I hope that I can understand your English and if you can reap other memories that belong to the whole what happened its very good it's a kind of recalling our memories and or /freely discussing them its natural.

Okay, with respect to recalling other memories again, I have to go back to the spectrograms and the ...   well also the artwork but the spectrograms, I can still see in my mind the difference between the two spectrograms the first one that I did and the last one and how rich and colourful the last one was, and how many of those things did come true. I did travel to my homeland just like I said that I ,you know in the first weak little one there was some little thin bracelet there, saying this is my connection to my past and to this land or something like that and I didn't really even think I'd ever get back to My homeland and its funny because I remember once I worked with a woman in an office situation when I first came to Israel and she told me she was going back to the States and that she hadn't been there for twenty one years, She was originally from Florida. And I was thinking how can it be that someone doesn't go back home for twenty one years and having been here for five years I understood how it happens, financially, its difficult, things happen to you in life , you can't get over them, you can't get yourself together and you just end up not going back, and within a few months of completing the treatment I went back to my homeland and many of the things that I had been missing in the first spectrogram or I had talked about as being smaller or insignificant in my life by the time we got to the end of the treatment and I built the new spectrogram with the hopes and visions for the future many of those things came to life(What are you now talking about) this was one idea that crossed my mind travelling here this morning that it's a fulfilment it got true like a prophet and I remember also the spectrogram and all the

things you put there in the second one how they became reality and it's amazing that you are mentioning it here now, it's the same thoughts, it was the same in the sessions sometimes.

Yes its like, you know, in self-fulfilment seminars or self-awareness seminars and stuff like that, you always talk about you will see it when you believe it: or when people talk about bad things happening they talk about self-fulfilling prophecy. But in fact in this case it was a kind of self-fulfilling prophecy but to the good and I emotionally felt it. That's the thing with the spectrograms, and I think it's also a thing with the sandbox that it's a very physical response, a gut response, a real gut response to these external elements that are often very abstract and simple.

(Not clear) Do you think it's inevitable what happened to you??

Okay with the first spectrogram as I recall the elements that I chose were very small, the biggest element was my dog, I think.

The biggest element was my grief but besides that was my dog and then my husband was this little dot with a musical note on it and I was this little flat blue button and the most important thing was really sort of where I lived and that I had a view and that was it and that was my whole life, but, even though I was liking that everybody and even though I needed, I know that I needed come kind of help to got me past and through and over and out .I couldn't , I myself didn't see how small my life was until I made the spectrogram and I looked at it and I physically felt a shock , because I saw what my life was and I saw this thin big connection to my past and to my homeland and how everything seemed very far away and very small and empty. And then, when I did the final spectrogram the colours were so rich and it was also like a shock and I chose these things I didn't choose them to make it into a shocking experience, I chose them because they drew my eye and I didn't know what they represented really until I put them on the paper and you asked me to tell you what it represented to me and only then could I say, oh , this is what I hope for in the future and this is this and this is that and really the gut feeling is so powerful they are like a physical change emotionally in your guts, I mean it's a .. It sounds stupid to describe it that way but, and it's such a simple tool, it's very... its non-confrontational and nobody is saying well, are you going to be a successful writer in the next year? Are you going to be a capable parent in the future? Will you be a mother? Will you fly around the world? No one is setting a specific goal and asking you to meet it but your dreams and your hopes appear in an abstract form and suddenly you are able to see them and realize, and think well that is very important to me and why shouldn't that

be part of my life, you know I have a right to achieve that I have a right to get it I have a right to enjoy it, its.. It can be normal for me to have that instead of being in a situation where you accept that it's abnormal to have it, abnormal to have friends. To say okay, well, because of what happened to me I'm going to cut myself off from the world and make my own safe little world and make it as small as possible because then nobody can hurt me and I won't hurt anybody, but instead to open up your world and you do it on this little piece of paper with all these little 3-d objects and suddenly your world is bigger, and fuller and richer.

It can really be a self-fulfilling prophecy tool for the good. I think it's a very powerful tool. I think also with the sandbox it has a similar kind of impact because it's 3-dimensional.

But probably the good thing with the sandbox is that it's like running a play where you're completely in control you are directing it yourself, you are telling the actors what to say and yet they are also telling you what you are thinking about yourself and your world and again things come out that are very enlightening that you didn't realize were bugging you so much. I mean, I was talking about a film project that didn't work years ago. And why that came up when I'm here in Israel who knows. But it's obviously something that I never dealt with and something that still affects me or affected me then and in that way the sandbox is really useful because you can really literally shape your world. You can dig in it, you can throw the characters around and you can have them shoot each other and jump off cliffs whatever you need to do, it's a way of getting it out of your system literally, physically, and before your eyes and within your control without having to experience whatever trauma it is or was or without having to actually confront that person or whatever situation it is that is bothering you, you can do it as if. So I think it's a really powerful tool.

And the facts that you let me kind of choose the characters and set up the story and said: well, would you like to tell a story about that? (You know) - either you can tell a story about a character or you can, tell the whole story and then work it through in stages, by saying well now would you like to act out the story?. So, gradually letting me enter the world of the drama /or of the imagination without setting particular objectives, like you didn't say tell a story about this., you said, what do you want to tell about the story?., What do you want to tell about the characters?., So, it was quite open-ended.

This is the difference between the period we were in the sandbox and compared to the first two spectrograms that you used to tell a story, each time working with the sandbox objects and it occurred to me that it was maybe the first connection to talent again, not

writing but telling these stories. You can see them as a part of the whole process and addition or out way you saw the story part after the working.

I think that's probably true and in connection with that I must say that in the past couple of years I think that I have completely lost that ability again. Because, again, of the birth of my son, that you know, completely twisted my world around 180 degrees both in hope and in fear. I think that at that time it's quite true that that was the first connection back to my roots of writing and such like, and I haven't really made use of that healing since then which is unfortunate although it's on my list of things to do (laughter). One of the reasons why I came to you at that time was that I couldn't write creatively anymore, I couldn't even write for business. The past couple of years I've been writing nothing but business so it's been good for me in terms of maintaining the financial situation of the family... But it hasn't been very good for me creatively, but on the other hand, my son himself is a creative demand. So, I don't think that I've been able to put to best use the healing that I went through in the process with you but in fact I keep thinking about that last session with all those characters and thinking that maybe I should just free them all. Because, oh yeah, one other thing I wanted to mention it was interesting that I chose the penguin in the sandbox but about a year ago I had my new letterhead done and it was with this symbol ! of a bird flying which is also a symbol that I made in the clay in the treatments with you and that loge feels really like me and even my mom, who usually doesn't notice things like that but she, I sent her something on that letterhead and she wrote me back and said, well it's just so beautiful and I love it, and it's so you...

This morning while I drank my coffee, your card was on the table and I thought about the symbol of the bird and you are now talking about it.

Well, it was a real liberation really, you know I always used to be very free and able to write and things flowed very easily and then, before the treatment with you it was impossible.

And after, it started to flow again and it felt good and I felt much freer about everything and I did in fact start to fly , I did go to My homeland a few times and I did have much more success in business (cause when I came to you I was at the point where even going to meetings I usually kind of failed in the meeting just by being there. because I was at the point that I had so little self-confidence that I just couldn't even deal with being in the meeting and people could sense it they knew that something wasn't right here let alone the fact that I found it very hard if not impossible to do the assignments or to do them on time.) So I've really gotten over all of that, the work aspect is quite easy

for me now and I am seeking new creative challenges and I just don't have the time or energy because of our child, who makes me run around the block with him every night on his bicycle.

But which is fun but there is a limit!!!!

Maybe this was how the PhD is the start of a creative phase because the idea of writing a book came from you, not from me.

I never thought about writing a book. I hardly could think of in those days writing M.A. and how you can I'm thinking your idea of writing together a book was echoing in my head all these years and you know I never thought about doing the PhD, never and all the time since we came back to our subject and the decision to go to England and their permission to go on with the project I think that your creativity even though you are still complaining that you are not doing with it anything first of all. I gained from you from working with you a lot of creativity inside and I think maybe I don't know this mutual joint journey will be another opening phase for you that you publish your first book or the stories, because the stories that were fold in the sessions, are going to be published. I hope that not only in the thesis, but afterwards in a book. How you see it.

Well, you are a partner in this so you are quite permitted to talk as much as you want!

It's funny that it has turned out to be a book because ... I simply look at things from the viewpoint in many times form the viewpoint of advertising or marketing, where I think well you know if this information is so hard to find in the marketplace or in the first instance of your M.A. where I felt that there is so little knowledge in the professional world and my encounters with professional people , medical people and everything were so terrible, most of the time, except for that one general practitioner, he was the only guy among all these professionals who saw that the trouble with me at that time was my grief and everything, and gave me a very practical kind of assignment like to go home and write down everything that I remembered and then come back in a week and tell him about it, and it was my inability to go back and tell him about it ,that stopped me but just the fact that he gave me that direction and I did it really helped me. Other than him, my experience was so terrible with most people, also friends, also friends and family, but more important with medical professionals, that I was so glad that you wanted to do something to try and change the world to try and enlighten them a little bit to try and inform them so that other people wouldn't have to suffer so much so there would be more understanding out there. So I looked at it kind of like this is definitely a necessary

thing that is missing in the marketplace, in the medical marketplace and I was very happy to be part of it and again as I've told you of my other experiences with many of the psychologists and such like that I felt were counterproductive or non-productive with your PhD I also think there is a real value your methods of working that can really help people, and help the people who come for help and also the practitioners.

I'm sure practitioners want to help people. But I think sometimes people in a sort of authoritative position say , well, here is my model I am always going to work with this and people should get well because I'm going to tell them here it is , this is recipe x and it is going to taste good to you.

And I think you look at it the other way and you say: you know what? What would you like to eat?

You offer people an opportunity to find their own level of ability and interest and from there you work with their abilities to help them. And so I think that this idea of the client-therapist relationship is important because your method is significantly different, and maybe in all drama therapies it's the same (I don't know) you are the only drama therapist I know. But maybe it's a common element in most drama therapy but also maybe it's an element that people even drama therapists don't really think about as much as they could or use it as much to their advantage as they could so that's why I am happy to participate, And again in respect to a book or something again I guess it's part of my personal philosophy that if there is some positive knowledge out there why should it only be for professionals? Why should it only be, if it's a doctorate and its going to be in a university, then the number of people who can access the information is quite small compared to a more publicized book where many people can benefit from even just as there are so many self-help books today where the average consumer can read something and learn, oh, that's what neuro-linguistic programming is about. They are not a professional, they are not going to practice it but they understand suddenly more about how language works, or they understand more about human interaction just because they can read a book. I think you have a lot to offer so why keep it to yourself? Why keep it to the academic world?

I see other aspects remember other aspects that were significant to you in respect to our relationship or what is called a client-therapist relationship. But I think you mentioned a really a personal experience if you remember other things that were meaningful to you?

I think your willingness to be patient and let me experience emotions, I think your willingness to be patient and let me experience emotions was very important maybe because of my background I sometimes felt very shy or embarrassed if I was about to cry or if I had certain feelings welling up, And I always had the feeling that you were willing to let those feelings happen and you totally accepted me. I never had the feeling that, well, let her cry for 5 minutes and then we will move on with the program. It... I don't know maybe it's a personal thing, maybe it can't be copied by someone but the sense of acceptance by you was very high for me, a sense of not being judged on anything. As I mentioned before the fact that you were willing to offer me options as to what I would like to work with and most of the time you let me choose but there were a few times when you did kind of directed me by saying, well look you can't do that ,. Whether you said it indirectly or directly, you kind of do that every day so let's not write when you could draw and let's not draw when you could dance and let's not dance when you could work in the sandbox. So shifting the modalities of the work I think that was kind or your role and seeing that I didn't just do repetitive work on the same issue that I didn't do the same thing or I didn't work with the same tools all the time. I think that was very important because each one of the different tools that you gave me to work with actually shed another kind of light on the subject about me and my thinking of light on the subject about me and my thinking of the world., and often in a way that I didn't expect myself and it surprised me and I think from those surprises I learned a lot. I learned a lot, I was aware much more.

Even though it wasn't a good way to spread the whole modalities tools, maybe it was too overwhelming, too much, but I remember that you could choose each time first two things. To use a sandbox even if you wanted to but you choose another thing.

Maybe it was too much tools that we used.

Well I'm not sure, I think also again, I kept expecting to have some kind of a traditional session where we would go back to just sitting and talking like you usually do with a psychologist because I think that is so built into our social norm you know, whenever you see a movie about a psychologist or somebody sitting or lying on a couch and talking you know in a way I always kind of expected us to go back to that or to continue with that but I realized that the drama process is about expressing things about doing it and being it and so it was so enlightening for me that I did want to try some of the other things and see you know what happens if I do this instead of that because last week when I drew this picture for the whole week I walked around feeling shell-shocked. Which is true, that

one picture that I drew where I saw how small I was and I also had kind of the same feeling from the spectrogram, seeing that this little pale blue insignificant thing was me and suddenly realizing that's actually how I see myself. No wonder, things aren't working right in my world, because I'm nothing in my one world! And that experience was so powerful I wanted to see what else would happen if I tried something else, .And in most of the experiences there was some kind of gut reaction a very deep and powerful response which by itself made some kind of change me .. I didn't have to write a bunch of affirmations on the wall and I didn't have to try to be somebody different just by being aware of what situation I was in somehow I started making changes in my life. I think also, I just remembered right now about the cards that we worked with, they were quite valuable too because the unconscious is so powerful and it just, it was always amazing to me that, I think, oh well I'll just pick these cards, and then you see them laying there in front of you and you think, why would I why did I pick this. Indian woman, you know, dressed up in a sari and everything and why did   I pick this unhappy looking person? Why did I pick these ugly colours? And then you start thinking to yourself, that's because that is how I am thinking … or, that's what I'm seeking, one or the other. And things like the angel cards, well first of all they were fun, they were influential because it was kind of a whimsical thing to do, whimsical, it's like something not very serious and I think that's part of their strength, that they are, it's just kind of, kef (fun), kind of silly funny thing to do like reading your horoscope in the daily newspaper. How serious are you going to take it I mean really, But at the same time you read it anyway you think and it says, don't cross the street at 5th and 11th so you know you don't go...

But the angel cards were fur, it was also like getting a little blessing because it's a little angel and they are very optimistic and often ironically quite matched to the situation like if you want to explain it in metaphysical terms or whatever who knows why or how it works, but they were quite useful kind of as a tip for the week or some small sentence or thought to keep thinking about..

What can I say?

Do you remember that we talked about many components that I think contributed to this healing therapy, or this healing process? You mentioned the length do you have something to add about the untraditional length of these sessions? And about your part, how do you see, I'm calling it the main part, in contributing to your healing processes if you can relate about it.

Well with respect to the hours or the timeframe I think I already pretty much mentioned that the greatest benefit was not having to choke off the emotions that were already choked off., it seems like kind of a waste of time getting a person into a therapeutic setting, they are already choked up about something and unable to talk about it to get them to start to talk about it and then to choke them off again because of a time limitation, it seems kind of counterproductive.

Because I don't think that the next week when they come they will be more ready to talk more at the beginning knowing that they have this short time. I think it will be the same kind process of trying to get them up to speed or trying to get their trust open enough that they will reveal these emotions and once again they will be cut off,.

That's probably why Freud's method took so many sessions on the couch because if it was always based on certain hours or an hour or a time limitation then you can never get the person to fully reveal what they feel or fully feel what they feel and I found with the longer period of time it allowed the release of the emotion and exploration of it and then some kind of closure as well which is also important. Because then I left feeling more healed rather than feeling more wounded. In the sessions with the psychologist in the Far Saab area it was always worse when I left because I would get to the point of revealing something or feeling certain emotions and then it was time to go, but there was also no time to sort of deal with the emotion or close it. So it's like picking a wound and opening it every week. Then it would just have enough time to sort of heal up and then you come again and now it's an abscess, so maybe that's the way the psychotherapy actually works , that you pick the wound until its really infected and then you squeeze it out in a crucial session but what a painful way to go about it when in this process every week I left feeling much better because I had a chance to get part of the pain and the confusion out of my system get some kind of control on it again, and find in some way whether through your direction or through my own insight a way to get a bit more control in my life or heal a bit more , so every week I felt much more optimistic and much better so I wasn't afraid to come there.

I didn't feel like I'm going to go there and it will really hurt again. It was always interesting it was always comfortable and sometimes even really exciting so...

Professionals in the field will say about it that it's not professional to do such unlimited sessions.

Well I think if you are trying to schedule people in typical office setting, if you had an office in downtown Tel-Aviv and it was costing you x thousands of dollars a year to run the office then you know you have to fill that office up with people x number of hours a day and they have to pay x amount of money and it has to happen, its all based on a financial calculation and so you say, well I need ten patients a day so I'm going to work ten hours , and people will come at each hour and leave.

So I think it's probably based on a more business and financial situation then that it is actually based on the treatment of the patient.

And I'm sure there are cases where people's emotional state is such that they don't need two hours to express themselves. At that point, mine was such that I was that closed it would be very difficult for me to emotionally free myself enough to even found that painful part of me, in less time than we took . Whets the point of being a professional if your client isn't getting well?

That's what I have to say about the hourly thing. You have to look at the objective, if the objective is that the person gets well in some way then maybe the hours have to be modified so the person can get well. It's like saying, well this person is hysterical so let's put them on some kind of drug to calm them down, fine but you're not going to keep then on that for the rest of their life because that's not a solution. That doesn't make them well it only calms the situation so I think if you look at the objective of the healing professions, if you want to heal people then whatever way is going to work to help them get better, that's the method that should be worked with.

And it's not a matter of being professional or not professional.

R. You said that it is accommodating time according to each patient.

I. Yes ,I think probably a professional can do that early on in the treatment of a person, maybe they can see in the first couple of hours long treatments if the person is having trouble getting out what they need to get out of their system, then maybe that's the time to say, let's try longer sessions an hour and a half , or two hours and see and maybe schedule the treatments in such a way that it can happen, I'm sure if people have to take time off from work in the day to go for two hours for treatment it would be difficult but then maybe the treatment has to be done in the evening or on weekends. There is no doubt about it that in terms of time it's a difficult thing to organize both for the professional and for the client. In our case we were lucky that you happened to have those days of the week open, you were working from your house, and you could

schedule yourself accordingly and I work freelance so in most cases I also could schedule myself , but there is no doubt in my mind that the longer time really helped.

And again, as I said because there was really a chance to open up, get it out in the open, look at it, do something with it and close it off in a way that it wasn't shutting it down again, it was a way of completing the processing of the emotion in some way, in a positive way, and again as I said I left feeling well. Many times in the psychological treatments that I had before that I left feeling horrible, I left feeling more wounded, I left feeling more of a failure, So, in terms of the room again because the clinic was in your house on the one hand it's a very personal kind of feeling that establishes probably more trust, it did for me anyway, because the person is inviting you into their home so they are making you part of their life, they are accepting you in a physically, geographically very open way. And again most office settings are very modern style a very, rather cold and everything coming into the room in your house there was nice daylight coming in, no fluorescent lights, you could hear the birds outside, I really liked that. You know, especially the times that were very emotionally difficult and I'd hear the birds chirping outside it kind of gave me a sense of optimism or hope. If your office had been in a city somewhere you would just hear traffic and beeping and stressful sounds in the background (so) ... and fresh air blowing in through the rooms no air conditioner, just thinking of the one or two times that I met with a psychologist in Herzliya in this office that was with a glass wall, and there were people sitting outside waiting to come in so you really felt that you were in some kind of a fishbowl, it's hard enough revealing your emotions to someone without having to be in a room where you think everybody in the hallway, that they come to buy underwear or a Porsche or dinner or whatever they come to buy in the mall and there you are going, and here I am here is my bleeding heart why don't you all come and look at it. It was very difficult.

I remember one time that I was there , some guy was sitting outside and he kept tapping on the glass and I was trying to talk with her and finally I just went over and I just slammed the glass really hard with my hand and the guy nearly fell off his chair. I think she was quite surprised about how angry I was about it but, I didn't understand why she didn't take some action and I didn't understand why this room, why she close this room for the treatment because it was definitely not suitable.

So, I felt very safe, protected in your room, accepted, again the fact that there was no table between us, no division.

You Have Run Out of Memory

Reflections on the Treatment, Post-Treatment, Typing and Transcription of Sessions and the Final Open ended Interview with Rachel Bar-Yitzhak, Dramatherapist

By Iris

A couple of months ago, I decided to make a Power Point presentation of the poems I had written in my book 'Stillborn: Still My Baby' along with the illustrations by Paresh Athparia. I scanned all the illustrations and started working with a lovely water/sunlight background on the Power Point – but I was only a few poems into the process when suddenly the computer crashed and in the dialogue box it said:

'You have run out of memory'

This was an accurate message from the universe.

I couldn't 'bear' to remember anymore. I wanted this 'issue' to be in the past. And yet beside me on the desk sat 15 x 90 minute audio tapes awaiting transcription – and I was the only one who could likely understand them enough (due to quality problems) to transcribe them for the PhD.

I find that now I have my son in my life, it is very difficult or almost impossible for me to 'think back' to that time when my first daughter died, and when for so many years I simply limped along.

It makes me feel angry when I am around my son and yet involved in the process of transcription of my sorrows and pains then – is it that I fear what might happen if he too was taken from me? Or that I regret I did not have a chance to see her smiling little face or her announcements of how old she would be on her birthday? Do I feel that going back is like being cursed? I don't know and I don't want to think about it anymore.

I want to be finished with this.

Finally I realized that there was a two-fold problem with the tapes. I could not transcribe them during a normal 'work day' because I felt fearful of a phone call from a client – an invasion of my privacy. Yes I could not do them in the evening – as I was almost always alone with Daniel and I knew from my TV experience that transcription simply takes hours – and there is no short-cut.

Time was ticking on – Rocheli needed the material for her work and there it all sat on my desk.

So I told Rocheli that I needed a babysitter…someone I could trust who my son would also love to play with who could take him away for a few hours so I could sit and plough through the transcriptions – and she agreed.

I started the transcriptions and found myself hurled back in time. I had 'completely' forgotten all the horrors I/we went through and as I went through each session, I relived everything around it.

On the one hand, I was amazed to hear the change in my voice/behaviour/outlook over the course of the treatment, and on the other hand I was depressed to find out that in many instances I have been 'standing still' and many of the issues I dealt with then with one client are the SAME ISSUES I am dealing with …with the SAME client…to this very day.

I had forgotten that I 'got well' and was creative and vibrant and productive in my professional field for a couple of years until I got pregnant with my son and he was born. Since then, I see that it is almost like I regressed in many ways – I noted that my Security Guard has been working overtime in terms of my own work life – forcing me to do work I dislike and shutting the doors of optimism for creativity. My 'Wizard' has/had virtually vanished. Although I am aware that most of my creative energy and physical energy is being spent on my son, I have been dismayed that for the past 3 years I have had the same lack of creative ability as I had when I first turned to Rocheli….but now I understand why.

It crossed my mind that the reason the house is a total mess is partly because of my facing this 'burdensome task' of returning to a painful past…but also because I have no role of the housekeeper or 'balaboosta' in my character library – perhaps I did that on purpose in my youth because I never wanted to be judged on those abilities – the opposite. (Not to mention the lack of time/energy to do anything in the house)

So in doing the transcriptions I did find many useful tips and in many ways it was good to 'redo' the therapy because it has helped me recover from the 'trauma' of having Daniel and becoming a mom.

I know everyone thinks I should be ecstatic all the time about being a Mom and to bless my luck – and I do. But I also know that being a mother is damn hard, boring work (most of the time) with no time off and it is filled with terribly boring repetitive tasks that

make ME feel like I am sitting and spinning my wheels and going nowhere. Maybe some women love cleaning their house, doing laundry and making order out of masses of Lego…good for them. I don't. I HATE IT. Particularly because of the gender things which seems to say in our society that these tasks are only for the woman…and particularly in our relationship wherein if my husband has to pick up Lego (because this been lying on the floor for a week or more) then it is with great sighs and shakes of the head as if to say 'how can my wife be so irresponsible and lazy to not have picked this up before and why is this burden falling upon me?' Well it is falling upon you this ONE time because it fell upon me the other 20 times and I have no more desire to pick up Lego my dear.)

Yes it is traumatic to find out that your life has been completely taken over by someone else who actually needs you <u>all the time</u> – and to find that your once recovered self has once again vanished into a pit of a different kind. Where once my life was consumed by grief, it became consumed by joy, cleaning, and serving….but consumed.

I realized I didn't have much of a 'mother role' in my repertoire either…just what I have learned from my dogs really (no offense to my Mom, I mean I personally still don't see myself as a Mommy who is cleaning, baking and ironing. I just don't see myself in that role at all.)

So in this respect reviewing the tapes was somewhat educational and somewhat cathartic – but also incredibly painful.

It might have been easier if I had been able to do a half an hour at a time – but this is not my typical work method and we also had no time. Therefore I sat and did about 4 hours of transcription per session. At the end of each session I felt tense, angry, confused, lost, spaced out and desperately needed A DRINK. In most cases after Rocheli went home I would drink an entire bottle of red wine myself and then sit on the couch playing sad records and crying – something I rarely have time/energy to do these days.

By accident or coincidence I found a song on the Michael McDonald record 'If that's what it takes' which ideally suited my mood and the scenario. I thought of it a lot when Rocheli told me that a music therapist had come to her lecture, especially because she had also had a stillborn child and was having trouble coping…the fact that the woman also told Rocheli that her work/my experience had helped her gave me a great deal of strength to go on and finish these bloody tapes because I was really dreading every session.

And here are the song's lyrics:

I CAN LET GO NOW

Lyrics: Michael McDonald

Piano: Michael McDonald

It was so right, it was so wrong

Almost at the same time

The pain and ache a heart can take

No one really knows

When the memories cling and keep you there

Till you no longer care

And you can let go now

It's wrong for me to cling to you

Somehow I just needed time

From what was to be – it's not like me

To hold somebody down

Chorus

But I was tossed high by love,

I almost never came down

Only to land here

Where love's no longer found

Where I'm no longer bound

And I can let go now

So I would play this music, drink red wine and pass out on the couch. Forgetting again – and I understood why alcoholics drink to forget some terrible pain. To float into a blissful stupor. It works very well.

Ironically I did do a therapeutic role play between a derelict (street alcoholic) and a helper as part of the dramatherapy treatment because I had described a kind of emptiness which could only be that of a derelict (in my opinion). And I felt that emptiness again after every transcription session except the last. Perhaps because I knew there was more suffering to come – but in the last session Rocheli saved me by saying she would do the last tape.

What a great relief! I was still exhausted, confused and spaced out, but although I would have enjoyed a drink, I didn't NEED one and instead of getting drunk I had a nice long hot bath.

I don't think need to reflect any more on the dramatherapy treatments because the open ended interview is quite specific about what worked for me during the treatments and those things are still true today.

In closing I can say that reviewing all the treatment has had some impact on me because I have decided to self-publish all of my books this summer and hopefully one will be out in the next two weeks. I have no idea where the money will come from for this project but I don't care – I'm sure it will come.

Since making that decision, things have been falling into place – almost magically. Is it my wizard coming back?

On the other hand with all the acts of terror in Israel, I do have a great sense of foreboding and I hope that I will be able to see my son grow up – my greatest fear is that he could be orphaned and left alone. I at least want to be able to give him the best survival tools I can and for that I think I need to be with him at least until he is 18…but who ever knows? Life is so strange and unpredictable – or as Van Gogh said: 'Life is so beautiful and so sad.' (Something like that – the quote may not be 100% accurate)

That is all I have to say and I don't want to say anymore, probe anymore histories, review anymore diaries. I have said it all, written it all and I am done with it. I have run out of memory. And I can let go now.

Iris, June 12th, 2003

APPENDIX 7: CONSENT FORM

CONSENT FORM

June 25, 2008

The client consents to participate in the PhD research of Rachel Bar-Yitzhak on the subject of:

Stillbirth to Rebirth: A Dramatherapy Journey from Post-Trauma to Recovery

Anglia Ruskin University

TO WHOM IT MAY CONCERN:

I [Iris] hereby consent to participate in the above-named research as the subject and as a researcher of Rachel Bar-Yitzhak's PhD thesis for Anglia Ruskin University under the pseudonym of "Iris".

My conditions are:

I do not want to have my nation of origin mentioned in the thesis, nor my other names. I want to read the whole material that belongs to the research, including the university's information, and the final draft before final printing of the thesis, in order to correct any errors or to ensure that my privacy is protected and that some personal details are appropriately presented.

Client Signature: _____ Date: _June 03/08_