The Authenticity of Trauma and Depression in Drama: A Clinician's View of the Possibilities of Art

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Abstract. Trauma and depression often go hand in hand. Depression can develop without traumatic events, but with trauma there are almost always depressive episodes. Going through trauma is dreadful, but the real challenge is to live with the memories. That is where depression, flashbacks and anxiety come into focus. Depression and PTSD (post-traumatic stress disorder) are treated by psychotherapy and antidepressants, but culture can add a lot to the coping and comprehension processes and to dealing with disorders. Specifically, drama can mirror and help to create a narrative, showing different ways to solve difficulties. In addition, theatre can be a place for discussion or to bring up stigmatised topics. It is more and more essential to destigmatise and share information, but also to find and integrate new interventions into psychotherapy to help patients.

In my paper I have three main goals. First, I compare and show how drama can portray particular symptoms of trauma and depression. For this I use plays by renowned English playwright Sarah Kane (*4.48 Psychosis*) and young Estonian playwright Heneliis Notton (*Emesis*), and symptom lists and descriptions from ICD-10 (International Classification of Diseases, 10th Revision). Second, I show psychological processes of reception and how they can offer possibilities to work through traumatic events and comorbid disorders, and to learn about them. Third, I offer examples of how drama can be used in therapy or be part of so-called psychoeducation. As I work as a psychologist, I would like to offer an insight from the perspective of psychotherapy and demonstrate the role of art in healing.

Keywords: trauma; depression; drama; psychological processes; reception; psychoeducation; psychotherapy

Overview of the symptoms of trauma and depression

Drama has often served as a means to interpret and mediate social issues. While literature and theatre engage with real-world concerns, they do so through representation, which inevitably involves selection, transformation,

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and reinterpretation (Auerbach 2003). Similarly, symptoms are representations of an illness, just as art represents the illness. Therefore, we increasingly see mental health topics in drama and on theatre stages. But a question arises: how accurately can art depict real-life symptoms? To explore this, I will employ comparative analysis to examine the portrayal of depression and post-traumatic stress disorder (PTSD) in dramatic narratives, considering both their clinical definitions and their artistic adaptations.

First, I will introduce both depression and trauma, specifically the symptoms of PTSD (post-traumatic stress disorder), based on the ICD-10 (International Classification of Diseases, 10th Revision). Depression is one of the most common mental health disorders today (WHO 2024) and is often described by its main symptoms: a low mood, reduced energy, and decreased activity. Depression has three stages, mild, moderate, and severe, and to diagnose it, the symptoms must be present for at least two weeks. In addition to the main symptoms, there is also a list of symptoms that may or may not be present in every case. These symptoms include: reduced capacity for enjoyment, interest, and concentration; marked tiredness after minimal effort; disturbed sleep; diminished appetite; reduced self-esteem and self-confidence; a sense of hopelessness about the future; feelings of guilt or worthlessness; agitation; weight loss; loss of libido; and suicidal thoughts or actions (Tartu Ülikooli Kliinikum 2024). Thus, each case can present a slightly different profile of the disorder, but the main characteristics remain recognisable.

In psychology, we can distinguish between different types of trauma. These include for example acute trauma, chronic trauma, complex trauma, PTSD, and sometimes adjustment disorder, which is not a trauma but a condition where we lack resources to adapt to life events, because of which our emotional state can be disturbed (Tartu Ülikooli Kliinikum 2024). Acute trauma is often considered a short-lived sympathetic response to a real or perceived threat that typically results in a 'fight or flight' response; chronic trauma occurs if this acute trauma response does not resolve or the perceived threats remain ongoing, whereas complex trauma is repeated trauma exposure that can be severe and prolonged (Feriante and Sharma 2024). PTSD is a disorder in which traumatic events resurface as flashbacks due to memory malfunctions and issues with processing. PTSD symptoms include reliving traumatic episodes through images and dreams, emotional numbness, isolation from others, anhedonia, avoidance of situations and actions that remind one of the trauma, possible episodes of fear, panic, or aggression, insomnia, and potentially depression, anxiety, and suicidal thoughts. To diagnose PTSD, the main symptoms – repeatedly reliving the event(s), emotional numbness, avoidance – must be present for at least a month (Tartu Ülikooli Kliinikum 2024).

Diagnosing trauma and depression (in plays)

Knowing the criteria for diagnosing trauma or depression, it is possible to compare these criteria with the information presented in the plays. In this article, I use *4.48 Psychosis* as an example of the portrayal of depression and *Emesis* as an example of the portrayal of PTSD. To support my analysis, I draw on insights from literary studies to better understand how trauma and depression are represented in these texts.

4.48 Psychosis by Sarah Kane (2000) is a play about a person experiencing severe clinical depression and who has decided to commit suicide. The play is filled with metaphors, dialogues and monologues presented in a fragmented structure; through these fragments, we learn about the protagonist's pain and loneliness. Short episodes hint at past events in this person's life, giving glimpses into his or her experiences (the play does not specify who the main protagonist should be). *4.48 Psychosis* portrays the disturbed mind of someone with depression, where thoughts and interpretations are distorted and chaotic.

Kane conveys most of the information through dialogue. The very few stage directions mainly indicate silence or provide minimal guidance on the main character's actions. However, the written text itself is highly expressive as it defies conventional rules and often appears chaotic. At times, numbers are inserted, or the text is arranged in specific positions on the page. This creates discomfort for the reader. Not only is the content dark, but its form is also unconventional and, at times, incomprehensible. From the perspective of a psychologist, we can view the play as a stream of consciousness. As mentioned, a depressed mindset does not have to be clear or logical, so disturbances are to be expected.

In the following, I identify direct references to symptoms in protagonist's monologue (Kane 2000: 4) and compare them with the clinical criteria.

From this extract (Table 1), we can identify three main symptoms – lowered mood, reduced capacity for enjoyment, and reduced energy – that are essential for diagnosing depression. For severe depression, at least four additional symptoms must also be present, with some being strongly expressed (Tartu Ülikooli Kliinikum 2024). In Table 1, we identify at least five additional symptoms, and the play confirms that they are strongly expressed. The play also indicates that these symptoms have been present for more than two weeks, meeting the time criterion. We see recurring ideas of guilt and worthlessness, often emphasised in severe depression, and the protagonist expresses a desire to commit suicide, which is also characteristic of the depression. The title of the play – *Psychosis* – can be interpreted as a clue to a variant of depression where psychotic symptoms are also present.

Table 1. Comparison of *4.48 Psychosis* and symptoms of clinical depression.

Example from *4.48 Psychosis*	**Symptoms of clinical depression (main symptoms)**	**Symptoms of clinical depression (additional symptoms)**
I am sad	Lowering of mood	
I feel that the future is hopeless and that things cannot improve		Future looks hopeless
I am bored and dissatisfied with everything	Capacity for enjoyment, interest, and concentration reduced	
I am a complete failure as a person		Ideas of guilt or worthlessness
I am guilty, I am being punished		Ideas of guilt or worthlessness
I would like to kill myself		Suicidal thoughts and acts
I used to be able to cry but now I am beyond tears	Lowering of mood	
I have lost interest in other people	Capacity for enjoyment, interest, and concentration reduced	
I can't make decisions	Reduction of energy/ decrease in activity	
I can't eat		Diminished appetite
I can't sleep		Disturbed sleep

To better understand the protagonists in the plays under discussion here, it is first necessary to clarify how the notion of character is approached. Characters can be defined as a text- or media-based figure within a storyworld, typically human or human-like (Jannidis 2012/2013). They can be analysed from semiotic, cognitive, and philosophical perspectives (Eder, Jannidis and Schneider 2010: 8). From a psychological standpoint, the cognitive approach is particularly relevant, as all interpretations must ultimately be processed through the spectator's mind.

To analyse characters, Phelan and Eder propose complementary frameworks that reveal different aspects of character construction. Phelan identifies three spheres: mimetic, thematic, and synthetic. Each sphere offers a unique perspective on the character, revealing different aspects of their existence within a narrative. The mimetic sphere focuses on character traits and behaviours, reflecting psychological or physical attributes. The thematic sphere

deals with what the character represents, such as societal issues or groups. The synthetic sphere concerns the material construction of the character, including how they are structured in the narrative, the medium of presentation, and the creator's artistic choices (Eder, Jannidis and Schneider 2010: 16).

Kane's protagonist presents an unusual case, as there are no clearly defined characters. From the linguistic construction idea, it can express different states of consciousness. From a cognitive perspective, much of the interpretative work falls on spectators and their imagination, as the play lacks a unified, coherent subject. Approaches that view characters as abstract or non-existent also offer interesting insights when considering the possibilities of theatre: even if characters are not explicitly present in the text, they can come to life on the stage.

Analysing the protagonist through Phelan's three spheres – mimetic, thematic, and synthetic – further reveals the complexity of characterisation in *4.48 Psychosis*. Mimetic elements, such as recognisable psychological symptoms, allow spectators to perceive the fragmented voice as a representation of mental illness. Thematically, the play embodies the existential despair and weight of mental health problems, reinforcing its function beyond individual characterisation. Synthetically, the text's unconventional structure – its absence of stage directions, shifting voices, and numerical sequences – foregrounds the constructed nature of the main character, reminding us that this person exists within a literary and theatrical framework rather than as a fully realised individual.

This brings us back to the idea that theatre has the unique ability to create a concrete character with fully realised traits, even when these are only implied in the text. Moreover, it can introduce a meta-layer that shapes the overall theme of the stage production. As seen in *4.48 Psychosis*, the play's ambiguity allows for vastly different stagings. However, within the text, clear symptoms emerge that align with diagnostic criteria, making it possible to construct an authentic portrayal of mental disorders on stage. To achieve this, a character does not need to be a fully developed 'person'; rather, only recognisable and clinically accurate symptoms are required.

The second play, *Emesis* by Heneliis Notton (2022) is a play about a teenage girl named Sabi, who lives alone in her father's house because her father has moved abroad and her mother left the family a long time ago. Her father's friend Rein is supposed to keep an eye on her, but in reality, he is abusing her sexually. The play is fragmented, alternating between flashbacks of the assaults and endless parties in Sabi's house. It shows how PTSD can intrude into everyday life, making it almost impossible to distinguish between past and present, as well as the malfunctioning coping mechanisms used to avoid disturbing reality.

If *4.48 Psychosis* places its reader in a position where the text unfolds as inner dialogue or a stream of consciousness, then *Emesis* offers a completely different perspective. The reader takes on a silent, observant role, gaining insight into Sabi's life, which is a mix of reality and traumatic experiences. Like Sabi, the reader cannot distinguish between memories and present experiences. However, as Sabi gradually becomes aware of her flashbacks, the reader does as well. This close perspective allows the reader to witness both the events and the symptoms of trauma more clearly.

In *Emesis*, the character is clearer than in *4.48 Psychosis*. The reader does not need to fill in as many gaps as in Kane's play, as the author provides more information about the character. However, the reader still needs to shift attention between the level of representation (the character) and the level of presentation (the text, the actor's performance) (Eder, Jannidis and Schneider 2010: 11), as the author does not specify who is speaking. Moreover, there is little explanation of the relationship between scenes, instead readers must piece together the connection based on the information given in the dialogues. Nevertheless, across different spheres, the necessary information is present.

Similarly to *4.48 Psychosis*, on the mimetic sphere, *Emesis* presents many character traits associated with PTSD and, therefore, mental disorders. The most prominent symptom is the repeated reliving of how the assault ended:

> 7/11/16[1]
> *(A bedroom in darkness. A narrow bed stands against the wall. Sabi is wrapped tightly in a blanket. Only her head is visible. Rein stands beside the bed, pulling on his pants. The floor creaks under his weight.)*
> – Do I close the door?
> *(Sabi nods.)*[2] (Notton 2022: 6/11/17)

It is an image that runs through Sabi's mind uncontrollably, recurring many times throughout the play. It is always the same, and it is deeply disturbing. We can say that it corresponds to the primary symptom of PTSD: reliving traumatic episodes through images and dreams. This repetition, along with the absence of character names in dialogues and the lack of clear temporal or connecting markers, is part of the synthetic sphere. Through this, we gain insight into Sabi's experience of trauma: days blur together, disorder prevails and it becomes difficult to distinguish what (or who) is around her.

[1] Scene sequence numbers.

[2] Here and below free translation by the author of this article.

To make a connection with trauma fiction studies, we can view repetition as a typical narrative technique used to reflect the fragmented and disruptive nature of trauma. Repetition mimics the effects of trauma, as it suggests the insistent return of the event and the disruption of narrative chronology or progression (Whitehead 2004: 86). Moreover, the previously mentioned incoherence between scenes illustrates the idea of fragmented narrative structure (ibid. 6). For Sabi, too, reality is fractured and portrayed through a fragmented experience of trauma and the difficulty of integrating it into coherent memory. Interestingly, Whitehead highlights the use of supernatural elements, such as ghosts, to symbolise the lingering presence of unresolved trauma and the inability to escape the past fully. At the beginning of *Emesis*, Sabi tells a story about a burial site for witches beneath her house. She claims that the witches were angered by the construction and cursed anyone who lives there (Notton 2022: 4). This motif remains in the background and is mentioned again at the end, when reconciliation has been achieved, suggesting that the curse is now broken (ibid. 43).

As Laurie Vickroy (2002: 21) notes, trauma narratives allow readers to engage in both critical and empathic modes of understanding, which are also essential in therapeutic processes discussed later. Vickroy (ibid.: xi–xv) describes this state as empathetic unsettlement, where intellectual understanding and emotional engagement occur simultaneously. This dual-layered reading experience enables the reader to grasp the psychological logic behind trauma-related behaviours such as dissociation, memory gaps, or repetition while also emotionally experiencing their impact. In this way, trauma narratives help normalise post-traumatic symptoms and build a bridge between the reader and the trauma victim.

Through such narratives, readers are not only informed about trauma but are also emotionally drawn into the trauma victim's fragmented inner world. In this way, the spectator can gain a deeper understanding of the difficulties associated with trauma, as well as the broader personal and social contexts surrounding it. The reader is guided through the narrative via the disorientation and conflict characteristic of traumatic memory, and for example by sharing Sabi's perspective, is given the opportunity to witness and emotionally process her traumatic experiences (ibid. 3–8). This makes it possible to confront and work through fears or themes that we might otherwise seek to avoid in real life (ibid. 2), a process that is also highly relevant in the context of therapy.

Throughout the play, we also observe emotional numbness, which is both a defining character trait and a symptom of trauma. It is important to understand that after trauma, it is possible for the emotional system to stop functioning correctly, with emotional reactions not corresponding to situations. This can

serve as a kind of protective mechanism, allowing individuals to keep going without fully feeling all the pain or exceeding the available recourses (Foa and Cahill 2001: 12363–12369). Sometimes, however, people attempt to numb themselves, often using strategies like alcohol or other substances to achieve this (Schiraldi 2000: 10–11). In the play, we frequently see Sabi drinking or using something, often to excess, as illustrated by scenes where she is vomiting in the bathroom, for example. We also observe her calmness and apathy, as Sabi shows little concern about who visits her or what happens in her house. Anyone can come, and anything is permitted. For example:

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(*Doorbell rings. Sabi looks out from behind the curtains to see who it is. She opens the door. Kristjan is there.*)
– Hello.
– Ciao.
– I heard… there was supposed to be a party here.
– Supposed to be?
– There's nobody here?
– No. What time is it?
– Five past eight.
– I'm in the middle of watching a film.
– Sorry. I can go to the shop. Do you want anything?
– Chill. There's pasta and beer in the fridge if you want. I'll go upstairs. There's a speaker on the sofa, you can put on some music.
– Oh… okay.
– What's your name?
– Kristjan.
– Okay, Kristjan. Knock if you need anything. I'll be upstairs, first door on the left.
– Um…
– What?
– My friend Sass wanted to know if he could come too.
– Sass?
– Yeah, he's graduating next year, the one with the green hoodie… you know?
– Yeah, fine.
– Cool.
– I'll be upstairs, then. Make yourself at home. But don't smoke inside.
(Notton 2022: 6–7)

Among the main symptoms, we can also find references to avoidance. Avoidance can be both physical, where victims avoid places or items that remind them of the traumatic event, or cognitive, where thoughts and feelings are suppressed and victims do everything possible to avoid thinking about it (Schiraldi

2000: 1–11). For six years, Sabi has not spoken about the assault, and no one is allowed to visit her on Mondays – the day when Rein comes to see her. Additionally, partying and substance abuse can be forms of avoidance, as they allow her to avoid thinking, feeling, or processing what happened. When Sabi's love interest, Leenu, learns what is happening, it becomes impossible for Sabi to ignore reality, as she now has to talk about it and begin making changes.

Psychological processes of reception

To understand the benefits that drama can offer, it is important to explore reception and its psychological processes. Reception occurs in our minds, meaning that human psychology and group processes must be considered. Here, concepts such as beliefs and the process of interpretation, cognitive dissonance, trauma narratives, empathy and emotions are addressed. I also introduce a concept I have developed, the trauma simulator, which is closely related to trauma narratives and reception.

No individual is exempt from group processes. Group processes refer to the psychological and social dynamics that govern interactions, relationships and behaviours within a group. These include the formation of norms, roles, decision-making, conflict resolution, and the effect of group cohesion and diversity on outcomes. People join groups due to shared goals, social identity, proximity, external assignments, the need for mutual support or innate drives for connection and survival. These mechanisms are influenced by personal motives, social dynamics, and situational factors (Stangor 2017).

Individuals often hold subconscious ideas about themselves and the groups they belong to, even if they are unaware of these perceptions (Beck 2011: 32–34). People naturally feel closer to certain individuals, shaping how and with whom they communicate. Trauma victims or individuals with depression may isolate themselves, believing they do not belong to the 'normal' group. However, they may unexpectedly find belonging in new groups, such as those formed by people facing similar struggles such as addiction, trauma or other life challenges.

In this way, people can also find their group through drama. Whether in text or on stage, characters experiencing similar challenges or sharing the same thoughts can represent an in-group, making it easier for individuals to identify with them. Seeing someone go through the same difficulties can open the door to discussion, foster understanding, evoke emotions, and engage other cognitive processes. An in-group provides a sense of safety due to shared experiences, making it more trustworthy when relatable characters demonstrate changes such as adopting functional coping mechanisms or embracing new

perspectives. Considering the different groups presented in drama can enhance its impact, allowing for a deeper connection and greater emotional resonance. For example, in *Emesis*, we meet a young girl who struggles with a troubled relationship with her parents, has endured assault, and leads a dysfunctional life, while simultaneously dreaming of attending university and longing for a connection with her mother. This character can represent an in-group for young people dealing with trauma or strained parental relationships. Moreover, it resonates with those who recognise that their current lifestyle does not align with their aspirations but feel trapped without a clear path forward.

Everything that happens around us and to us is processed through our cognitive systems. We receive information and interpret it, but to do so, we rely on a system built from our prior knowledge and experiences. We use our attitudes to give opinions or cognitive rules to motivate behaviour or to decide the best solution to a situation. We also have beliefs about others, the world and ourselves. Beliefs are strong ideas which may or may not be true. They have developed from the childhood based on our experiences, mainly from early life, although later intense life events can also shape them (Beck 2011: 32–34). We can think of beliefs as a kind of 'bottom line', which means they start to modify our interpretations of everyday experiences, and that readers or audience members therefore have their own unique belief systems. For example, people suffering from depression might believe they are worthless or unlovable, while those with traumatic experiences might feel they are weak or tainted, depending on the nature of the trauma.

In the plays analysed here, we can observe self-reflective beliefs. In *4.48 Psychosis*, the I character states, "I am a complete failure as a person" (Kane 2000: 4), while in *Emesis*, Sabi remarks, "You are just *fcking* pitiful" (Notton 2022: 39) and later adds, "I'm like-like a house spirit. And I really don't exist" (ibid. 39). These beliefs shape the decisions and interpretations of characters who are clearly presented in the plays. Interestingly, neither the characters nor individuals in real life often make such harsh judgments about others. This tendency links to group processes, as we are more likely to identify with those who share similar self-beliefs, as well as to other cognitive processes, which I explore below (Stangor 2017; Böhm, Rusch and Baron 2020: 947–962).

In psychology, we see empathy as a process where we can understand other people's emotions without making them our own, or we feel them in relation to our own thoughts and reactions (Hardee 2003: 51–54; Spiro 1992: 843–846). Drama can create a situation in which we can present the reader with a picture or a story about trauma or depression, along with backstories, possible positive future outcomes, unfortunate circumstances, or examples of how other people can have evil intentions, and how we can sometimes be powerless to change

something. This process can be emotional, but it can also help us develop empathy for the protagonist. It can allow us to see, from a distance, the deadlock or the lack of mechanisms to help ourselves. Additionally, it can reveal that developed beliefs are not always trustworthy. Depressive thoughts are just that – thoughts. They do not represent reality, and it is more tragic that people say such things to themselves than that they are truly unlovable. Similarly, a person cannot be considered weak if someone else has ill intentions toward them and they lack the means to defend themselves. Empathy also has the power to help us immerse ourselves in the story and care about its characters, which makes all of the above possible. From this point, a mental health specialist can help integrate this newfound empathy into a person's personal cognitive structure.

Cognitive dissonance occurs when a person's beliefs, or their thoughts and actions, are contradictory, creating a feeling of discomfort. To ease this feeling, people often try to avoid certain situations or make changes in their beliefs or actions (Wright and Riskind 2021). Drama can create a situation where we experience something similar to cognitive dissonance. Immersed in the story, our beliefs are tested against the beliefs and actions presented in the play. For example, someone who is depressed and believes in their own worthlessness might feel challenged when a character in the play expresses similar negative beliefs. In this situation, we have both the reader and the character with their respective beliefs, as well as the reader's own beliefs and attitudes toward others, including the characters in the play.

This setup creates multiple ways in which dissonance can occur. For example, the reader might have negative thoughts about themselves yet positive views of others and is now confronted with a character who also has a negative self-view. Similarly, if a reader who thinks negatively about him or herself sees a character with similar beliefs but also gains an insight into the character's full story and influencing factors, cognitive dissonance can emerge between the character's beliefs and the reality of the situation. An identification process might be needed for this effect, as a reader who identifies with a character is more likely to have the character's beliefs and influencing factors transfer to their own perspective. With this newfound perspective, it becomes possible to start cognitive restructuring, using the support of a professional.

When considering Sabi's story, it becomes empathically challenging to label her as lazy, reckless, or irresponsible. Instead, we see a young person betrayed by her parents or caregivers, with the responsibility for her struggles resting elsewhere. The narrative allows us to understand how circumstances unfolded, fostering greater empathy toward other seemingly troubled adolescents. For those who might face similar challenges, the story can inspire self-compassion. This dual effect can lead to cognitive dissonance in the audience, challenging

preconceived attitudes about troubled youth, and in adolescents who have struggled to extend compassion to themselves. Sabi seemed to forgive herself, illustrating that change and self-compassion are achievable.

As seen above, understanding the story and the events surrounding trauma or depression, including the factors before and after its impact, is of decisive importance. Psychologically, part of the trauma lies in the lack of a cohesive narrative. During a traumatic event, memory function is often impaired, resulting in a condition where some details are not properly recorded, while others might be amplified or misinterpreted. Because of this, the brain struggles to integrate the event into a coherent life narrative, yet it still attempts to make sense of what happened and its consequences (Ehlers and Clark 2000: 319–345).

Creating this kind of narrative can be challenging because victims often lack the ability to view their lives from a distance, making it difficult to evaluate the accuracy of their interpretations or the potential outcomes. However, being able to see the events from an external perspective – such as a spectator observing a play – provides an opportunity to construct a trauma narrative. Figuratively speaking, drama can act as a 'trauma simulator', where all the details of a traumatic experience are presented, but in a safe environment that allows them to be processed with both the rational and emotional sides engaged.

Because drama traditionally requires a narrative to tell a story or provide a framework for actors to perform on stage, it serves as an excellent candidate for this 'simulator'. Drama can construct a coherent story that incorporates elements of trauma while also presenting other crucial aspects, such as ongoing life, opportunities to move forward, and the varied ways in which people might react. It can depict the time before the trauma, the traumatic event itself, and the period after, creating a logical sequence that is often missing when trauma remains unprocessed.

Even though *Emesis* is fragmented, it still follows a chronological framework where young people are graduating from high school, preparing for university entrance exams, and navigating the passage of time. The audience can observe how flashbacks and trauma disrupt everyday life, while also recognising how new perspectives, such as the prospect of university or the formation of trustworthy friendships, can offer potential solutions. Everything that unfolds in Sabi's story feels understandable and logical within the context of her personal narrative, as the play provides the necessary background to make her struggles and choices coherent and relatable. The narrative allows the audience to see that her actions, even when chaotic or difficult, are driven by her past experiences; as part of this they witness the struggles Sabi endures as she navigates through it all.

This process is similar to exposure therapy, which is commonly used in therapeutic settings, including trauma therapy. Exposure therapy involves confronting elements (for example, places, objects, memories) that evoke intense emotional reactions, with the goal of reducing sensitivity to them over time (Ehlers and Clark 2000: 319–345). While it is often feared that revisiting traumatic memories might harm victims, it is important to understand that memories themselves do not cause harm, they are simply thoughts. The real harm lies in our interpretations and beliefs. Engaging with memories and being exposed to triggers in a controlled way can help reinterpret them, ultimately teaching that the memories themselves are not harmful and that the danger is in the past (ibid.).

This approach can also be effective in addressing depression. Depression and other mental illnesses are still heavily stigmatised, leading to widespread prejudices and misconceptions. Even individuals suffering from depression often internalise these beliefs, viewing themselves as lazy or dismissing their condition as not being a 'real' illness. By utilising this 'simulator', drama can demonstrate how depression develops and highlight the critical distinction between reality and the distorted thoughts characteristic of depression.

Another important aspect of trauma and depression is the integration of emotional and rational processes. Emotions are essential for providing information about our environment, particularly concerning safety. However, they cannot always accurately evaluate information due to the influence of adverse environments and maladaptive learning (Izard 2009: 1–25). Rationality becomes crucial in these cases, enabling the evaluation of emotional signals and facilitating informed decision-making. It helps challenge negative thoughts and emotions by introducing arguments that contradict initial reactions (Beck 2011: 167–185). Thus, the rational side often possesses more accessible knowledge than the emotional side, making it a more reliable resource for problem-solving. However, individuals with PTSD are more sensitive to trauma-related stimuli, which heightens arousal and makes it more difficult to inhibit. This, in turn, complicates the process of unlearning fear responses and diminishes the capacity for rationalisation (Hayes, Van Elzakker and Shin 2012).

Depression, on the other hand, can be expressed as exaggerated negative emotions or an absence of emotion altogether. However, it also lacks rational understanding, allowing the distorted and biased condition to persist (Beck 2011: 1–3). For example, in *4.48 Psychosis*, the main character expresses intensely emotional, self-critical thoughts that are rarely countered by alternative rational perspectives or fact-based evidence that challenges their validity. Within the I character's mind, everything feels resolved, even when these conclusions cause distress or dissatisfaction.

Flashbacks and other trauma-related disturbances frequently occur because trauma memories lack integration with rational or contextual understanding. This phenomenon stems from the nature of trauma itself: during traumatic events, the overwhelming focus on survival or minimising harm disrupts normal cognitive processing. Consequently, trauma is processed defectively, leading to distorted encoding of information in the memory and leaving individuals with fragmented, emotionally charged recollections. As a result, we retain two separate pieces of information about the trauma: one from the moment it occurred and the other shaped by the passage of time (Ehlers and Clark 2000: 319–345).

Trauma therapy often seeks to integrate these fragmented memories by utilising imaginative techniques. These methods allow individuals to reconstruct the traumatic memory and incorporate rational perspectives gained through time and distance. This process helps create a more balanced and coherent narrative of the event, reducing its emotional intensity and enabling better coping mechanisms (ibid.). Drama in the context of therapy offers a unique opportunity to engage with trauma or depression while maintaining enough distance to control the pace, take pauses when needed, and analyse the story or narrative. Analysis requires rational thinking, which helps uncover new angles, insights and contexts. At the same time, drama is often emotionally engaging, making it easier to activate the emotional side and connect it with the analysis, fostering new perspectives.

Drama as a literary text is unique because of its form. Like other genres of fiction, drama requires the readers to interpret intonation, create atmosphere, and imagine the expressions and hidden thoughts behind the words. In other words, the author provides a framework while leaving much for the reader to fill in. For directors or actors, this framework becomes the foundation for bringing the story to life on stage.

Unlike prose, plays rely almost entirely on dialogue (and occasionally monologue) and stage directions to convey the narrative. However, what makes drama especially distinctive is that it can be performed – 'brought to life' –, adding layers of action, body language, gestures, facial expressions, intonation and other prosodic elements. Additionally, the performance includes the input of the director, dramaturg and actors, as well as costumes, makeup, and scenography, elements external to the written text. This brings us back to Phelan's ideas, which although developed as part of character studies, when applied to theatre show how this medium has the unique ability to create a character with fully realised traits. A character, in this case, who can truly take on 'flesh and blood', and therefore appear more real.

In therapy, this concept can be applied by placing the patient in the role of director, allowing him or her to construct a story around the dialogues and add the necessary details. Just as every staging of a play can differ, every therapy-created world can be uniquely tailored to the individual's needs or narrative. This method can serve as an intermediate step for those not yet ready to directly discuss their trauma but who still need a way to process it. This demonstrates that addressing trauma or its details can be unsettling but is not inherently dangerous.

Drama's potential in psychoeducation

Psychoeducation is an inseparable part of any therapy. People need to understand their disorder and its effects, as greater knowledge empowers them to make meaningful changes. Psychoeducation involves discussing how disorders develop, their triggers, and the factors that maintain them (Beck 2011: 70). While this often happens after a disorder has already emerged, it should ideally be a focus earlier, as a preventative measure. Learning about disorders, self-help techniques, and recognising the early warning signs are all crucial. Currently, prevention efforts are typically carried out through outreach programs or advertising, but to emphasise its importance, we can always do more.

Drama holds significant potential for exploring mental health topics and presenting them from various perspectives to readers or theatre audiences. It can depict different aspects of a disorder, including its development and possible paths to recovery. Drama has the ability to craft narratives where readers or viewers can recognise themselves or their loved ones, thereby increasing awareness and encouraging people to seek help. As demonstrated above, drama can accurately portray real-life symptoms, making it possible to create relatable stories, scenes and characters. This relatability allows individuals to identify with the narrative and see reflections of their own experiences.

Moreover, by integrating character studies with cognitive psychology, we can see how much depends on the audience's interpretation and mental processes. The audience not only creates a character in its mind but does so based on their personal cognitive structures and prior knowledge. Eder, Jannidis and Schneider (2010: 13) point out that "we not only make use of our knowledge about persons in understanding characters, but also our knowledge about character types, genres and the protagonists they typically feature, and the rules of specific fictional worlds." In other words, interpreting a character is a process of blending personal beliefs and thought patterns with the knowledge we have about the character and the world they inhabit. A simple phrase like "I want to go away" can be understood in vastly different ways depending on

context, i.e. whether it is spoken by a tired teenager who is shopping with her mother, someone suffering from depression, or a person standing in the place where they were assaulted. Those with personal experiences or core beliefs related to such situations bring an additional layer of understanding to the protagonist's journey.

The concept of 'trauma simulator' can be expanded into 'mental health simulator', as drama and theatre inherently involve playing out and showcasing various scenarios. This can be connected with psychoeducation, enabling individuals to explore different decisions and their potential outcomes. Through this simulation, it becomes possible to observe where poor choices could lead or what could happen if one takes a leap to change behaviour, employ coping strategies, or apply therapy techniques. Drama offers a unique opportunity to practise mental health scenarios in a safe and reflective environment. For example, in *Emesis*, we can identify several coping mechanisms, as discussed earlier. Sabi's misuse of alcohol and narcotics leads to a cycle of another party, more chaos, and a lingering hangover. Her avoidance of talking about the assault does not make it disappear; instead, it perpetuates the cycle, allowing the abuse to continue unchecked. At the same time, by the end of the play, Sabi allows herself to reconcile with her mother, which seems to mark the beginning of her emotional healing and a slight improvement in her well-being.

Due to the nature of drama to tell stories, create mental experiences, provide new information, and potentially evoke cognitive dissonance, it can serve as a powerful catalyst for attitude change. Attitude is defined as a psychological tendency expressed through the evaluation of a particular entity with some degree of favour or disfavour, encompassing an individual's beliefs, emotions, and behavioural intentions toward a person, object or idea (Eagly and Chaiken 1993: 1). Attitude change, on the other hand, refers to the process by which attitudes are influenced and altered, often through persuasive communication, social influence, or personal experience, involving shifts in beliefs, emotions or behavioural intentions (Eagly and Chaiken 1995: 413–432). By taking advantage of the unique opportunities drama offers, such as immersive storytelling and emotional engagement, attitudes toward stigmatised mental disorders, traumas or other topics can be transformed. Drama allows individuals to develop new understandings, perceive less harm, or adapt their attitudes as they reconcile new information with existing belief systems.

Theatre and plays can also serve as a platform to spark public discussions. These discussions do not need to be solely victim-centred but can provide an opportunity to openly address topics like abuse, depression, anxiety, or family issues. A play can encourage people to share their own experiences or highlight areas of concern. It can also initiate conversations about the protagonist's

choices, prompting the audience to think critically and consider better alternatives. This process encourages analysis and the drawing of conclusions, which simultaneously fosters learning and awareness of the topic. In essence, theatre enables psychoeducation without overtly labelling it or applying pressure, creating a more accessible and engaging way to explore mental health and societal issues.

Drama in every day practices in psychology

Therapists rarely explicitly state that they use drama or theatre-based techniques, especially in structured approaches like cognitive behavioural therapy (CBT). However, upon closer examination, we can identify similarities between established therapeutic methods and drama-based approaches. Below, I highlight some examples where drama-like techniques are already present and suggest potential areas for further integration.

In CBT, role-playing is a frequently used technique where patients practice scenarios they find challenging, such as confronting fears or improving communication (Beck 2011: 267–268). This method mirrors theatre exercises, where individuals step into roles to explore behaviours, emotions and outcomes. Role-playing is particularly valuable because it allows therapists and patients to uncover unexpected obstacles, bring hidden fears to the surface, identify missing skills, and address thoughts that might hinder progress. While not a substitute for real-life experiments, role-playing offers a realistic and controlled environment to explore these dynamics, making them an essential tool in therapy sessions.

Role-playing is also an effective way to work with core beliefs and connect with a person's emotional side. Similar to the ideas mentioned earlier, role-playing in therapy sessions aims to challenge irrational or emotionally charged thoughts by introducing rational and compassionate alternatives. Core beliefs often make it easy to accept negative thoughts about ourselves, as we might feel we have 'evidence' to support them. Through role-playing we can uncover what our core beliefs are telling us, and the therapist can guide us toward healthier, more constructive responses. These exercises frequently involve re-enacting situations with a critical parent figure or portraying the patient as a child (Beck 2011: 248–255). In such cases, role-playing help us process memories and explore alternative perspectives on past experiences.

In addition to CBT, schema therapy is another widely used therapeutic approach. Schema therapy emphasises different modes, such as the vulnerable child, critical parent or healthy adult. To strengthen the connection between these modes, particularly between the vulnerable child and the healthy adult,

techniques like imagery or the empty chair exercise are often employed (Eesti Skeemiteraapia Assotsiatsioon 2024). However, incorporating elements of drama can take this work to another level. For instance, we can create dialogues between the modes, such as through letter-writing exercises where each 'character' expresses his or her feelings or needs. To make the process even more dynamic, we could transform these interactions into a play. By visualising these modes as distinct characters on a stage – each with their own wants and needs – we allow them to 'speak' to one another. This approach provides an opportunity to practise responding to the critical parent, strengthening the healthy adult's voice and fostering a playful, creative environment for healing. Using drama in this way makes the therapeutic process both more engaging and more accessible.

In the treatment of depression, we can, for example, take core beliefs such as "I'm a failure" from *4.48 Psychosis* and examine the memories associated with this belief. These memories often involve real-life people who function as characters and who have, directly or indirectly, contributed to the internalised thoughts the individual currently holds. Through role-play, such situations can be explored and analysed, and alternative scenarios can be created to examine what should have happened or what should have been said. Furthermore, given the presence of a harsh inner critic in many depressed individuals, drama-based approaches offer opportunities to rehearse more supportive and compassionate methods of self-talk. Patients are able to play out and experience new ways of behaving and thinking, which can be eye-opening. For instance, a patient who believes "I always disappoint others" might re-enact a childhood memory where a parent expressed disapproval. Through guided role-play, the patient can confront this internalised figure and explore new responses, such as hearing acceptance instead of rejection.

Unlike traditional talk therapy, drama-based methods allow patients to embody change rather than just thinking about it. This can be particularly powerful for those whose depressive symptoms include rumination or emotional numbness. In CBT, there is a technique called "acting as if" (Beck 2011: 226), where patients are encouraged to act as if they do not believe their dysfunctional beliefs, and instead adopt alternative behaviours. Playing a person who does not believe they are a failure can vividly demonstrate the contrast between two lifestyles, behaviours or cognitive patterns. In addition, it is now widely recognised that behavioural activation is often the first step in treating depression. Drama and acting techniques can support this process by encouraging movement and engagement, at the very least within the therapy room.

In trauma-focused therapy, patients are often guided to revisit distressing memories and 'rewrite' them by imagining alternative endings or resolutions.

These alternative endings can take various forms. For instance, they might be fantastical, offering a fairy tale-like rewrite where the past is altered to create better conditions. Alternatively, they might incorporate rational insights the patient has gained over time (as discussed earlier) or focus on future projections, imagining life in two weeks, six months, or even five years. This future-oriented approach allows patients to visualise how the traumatic incident can recede further into the past, how healing might progress, and the positive possibilities the future could hold (Beck 2011: 277–293).

Firstly, this technique creates hope, but more importantly, it demonstrates that life is not confined to one painful moment, it evolves and can offer much more. The process resembles the work of a playwright reshaping a story, carefully choosing details and reimagining outcomes. By doing so, patients take an active role in reframing their narrative, fostering empowerment and a sense of control over their healing journey.

Lastly, I want to point out narrative therapy. This therapeutic approach involves collaboratively constructing a patient's life story and then examining it without judgment but with curiosity. Through this process, we can uncover significant events and explore how the patient has interpreted them. These interpretations often serve as the foundation for 're-writing' or 'editing' the narrative, enabling patients to reframe their experiences and reclaim a sense of empowerment (Etchison and Kleist 2000: 61–66). This process is remarkably similar to working with drama, where playwrights create narratives built around pivotal events – often conflicts or obstacles that challenge the protagonist. In both real life and drama, the protagonist must find a way to overcome difficulties so the story can progress toward resolution, peace or a better life.

Conclusion

Drama might not be the first place to seek help for trauma or depression, nor should it be. However, we cannot overlook its potential to provide valuable tools for expression, analysis, visualisation, and exploration of different outcomes. A play often portrays people and their lives, and it can similarly depict mental disorders or traumas, leaving space for readers (or, in the theatre, the audience) to interpret and personalise the narrative. Well-crafted plays can accurately reflect real-life symptoms and demonstrate how they interact with everyday life and decision-making. For example, drama can depict a depressive stream of consciousness, as seen in *4.48 Psychosis* by Sarah Kane, or construct flashback-like scenes, as exemplified in *Emesis* by Heneliis Notton.

To facilitate reception, plays use various psychological processes that also influence the reader. Plays and their characters are intertwined with group processes, which can serve as a gateway to specific audiences who might greatly benefit from the content. Additionally, plays can illuminate or simplify the interpretation of situations or aspects that, in real life, might be obscured by emotional intensity or proximity to the issue. Drama also provides a unique space to explore different pathways, allowing spectators to draw conclusions or discover functional coping mechanisms to consider and potentially apply.

A play offers something that trauma often lacks, in the form of a cohesive narrative. It can construct or depict stories with a clear beginning, showing how events unfolded, how others behaved, and the circumstances leading to the traumatic incident. Additionally, drama can 'fast forward', illustrating what happens after the incident, showing the struggles and potential paths to recovery. By leaving room for the reader's imagination and personal details, drama can serve as a 'trauma simulator', providing a safe space to explore trauma and the associated thoughts. It can also facilitate engagement with beliefs by either activating existing ones or challenging them with counter-evidence. This process can create cognitive dissonance, a critical catalyst for changing attitudes and beliefs.

In the context of depression, drama can offer valuable tools for addressing core beliefs and cognitive patterns. By enabling patients to embody alternative roles and rehearse more supportive self-talk, such methods can enhance various behavioural techniques and facilitate the reworking of autobiographical memories. This experiential aspect of drama allows individuals not only to reflect on change, but also to actively live through it and potentially create new pathways to healing. Drama and theatre are closely tied to emotion, offering a medium that allows people to experience feelings they might typically avoid or have difficulty accessing. It provides a safe space to explore and process emotions, enabling individuals to live through stories in a controlled and constructive way. A play also fosters empathy by engaging the reader or audience with characters' experiences, which can be particularly beneficial for victims or individuals struggling with mental illness who often lack empathy for themselves. By building empathy for characters facing similar challenges, drama can help individuals redirect that compassion inward. Given these qualities, many therapy methods already incorporate drama-based techniques. Further exploration of drama's potential in therapeutic contexts could uncover new creative and emotionally impactful approaches to support those in need.

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