THE DEVELOPMENTAL METHOD IN DRAMA THERAPY: GROUP TREATMENT WITH THE ELDERLY

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The use of creative arts therapy groups with the elderly is achieving increased recognition as technical and theoretical dimensions of these modalities are being described with greater sophistication. Clinical reports of verbal group therapy indicate that socialization, life satisfaction, and insight can be improved through group therapy (Benaim, 1957; Berland & Poggi, 1979; Linden, 1956). Creative arts therapies provide unique and additional benefits in group work with the elderly. Numerous reports of art, music, dance, and drama therapy in the past decade conclude that the arts therapies provide structured group interactions that elicit coherent expressions of the person's inner life. The creative arts therapies particularly benefit patients with impaired cognition by providing interpersonal structure and communication that do not rely on verbalization (Berger & Berger, 1973; Caplow-Lindner, Harpaz & Samberg, 1979; Crossin, 1976; Fersh, 1980; Gray, 1974; Weiss, 1984). In the field of drama therapy, most contributions emphasize the description of specific activities (such as exercises, plays, theatre games) and basic leadership principles (Burger, 1980; Michaels, 1981; Thurman & Piggins, 1982; Weisberg & Wilder, 1985; Ziemba, 1985). However, there is evidence that a number of coherent technical approaches based on sophisticated theoretical frameworks are emerging (Feil, 1981; Jennings, 1973; Johnson, 1985). The purpose of this article is to articulate such a framework, identified as the Developmental Method, for drama therapy technique with the elderly. The Developmental Method is based, in part, on previous work with the elderly and other populations which has been described elsewhere (Johnson, 1982, 1984, 1985; Johnson, Sandel & Margolis, 1982; Sandel, 1978, 1979). After describing the technique and its theoretical rationale, I will report in detail on a complete session in order to provide a clear picture of its application with elderly patients, particularly those in nursing homes.

THERAPEUTIC GOALS

The basic goal of this form of drama therapy is to establish meaningful interpersonal relationships among group members. The therapeutic benefits of the group follow from the achievement of this goal. The activities of the group are not designed to be *specific* treatment for depression or disorientation, as antidepressant medication or reality orientation are. Nevertheless, it is expected that disorientation, interpersonal withdrawal, low self-esteem, and depression will lessen as a result of the drama therapy group.

This emphasis on interpersonal relationships is particularly important since the elderly person's struggles with issues of death and dying (Kubler-Ross, 1969), personal integrity vs. despair (Erickson, 1968), and life review (Butler, 1968) often result in an unnecessary withdrawal from others, leading to increased dysphoria and disorientation. Meaningful interpersonal relationships are established through the Developmental Method by (1) maintaining a stable and well-bounded social environment, (2) encourag-

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ing active engagement among group members through the verbal, physical, and dramatic activities, (3) utilizing reminiscence and reenactment to integrate past and present selves, and (4) openly addressing group members' physical limitations and approaching deaths. These elements are described in more detail in a previous article (Johnson, Sandel & Margolis, 1982).

Other possible goals of a group therapy experience, such as providing a daily structure, developing or maintaining specific skills, gaining insight into one's personality, or effecting change in one's external environment, are not primary goals of this technique. The Developmental Method is particularly effective, however, in improving relationships by ameliorating personal fears of being incompetent, stupid or awkward, feelings of humiliation and emptiness, and the projection of these feelings through antagonistic attitudes to others ("I'm not like those ugly old people"). The result is a greater tolerance of oneself and of others, and relief from the anxieties generated by rigid interpersonal stances.

THE GROUP WITHIN THE LARGER SETTING

The institution is the context within which the elderly resident and the therapy group are embedded. For this reason, it is important that attention be given to the institution's history, current structure, and primary goals. How will the group therapy experience complement or conflict with the overall social enterprise of the nursing home? Will it be seen as a part of the regular activities program, as a special and valued activity, or as a clandestine operation? Are its goals openly supported by the authorities of management and nursing, or is it necessary for the therapist to describe the group under a different guise?

The Developmental Method that is described here is best implemented when the group therapy and therapist are seen as integrated into the nursing home community. In order for significant interpersonal relationships to be established, the residents' feelings about the nursing home must be addressed. Their identity as patient-in-the-nursing-home needs to be integrated with other identities, and this is impossible when the group

or therapist represents anti-nursing home values. Development proceeds best when there is coherence and integration within the larger care-taking structure, whether that of the parents for the child, or that of therapists and staff for the elderly patient. Thus, the Developmental Method of drama therapy is enhanced by the leader's collaboration and familiarity with the nursing home.

First a period of *staff training and inservice* is required to familiarize the staff with the goals and techniques of the drama therapy group. This is followed by a *needs assessment* in which nursing and activities staff are questioned about which patients can benefit from the group, which patients are underserved, and what needs patients have that the group can address.

To establish a stable and well-bounded environment for the group, a regular time and place to meet weekly are required. The place should be a room that is a private space and is free from intrusion. A feeling of membership is reinforced by entry and departure ceremonies, and by having no unexpected visitors. Thus, patients, whether referred by staff or on their own, should be evaluated before they join the group.

Patients are best served when all function at a similar level of mental alertness and orientation, yet are heterogeneous in age, sex, physical disability, and background. If the range in cognitive functioning is too great, the group will have difficulty establishing a sense of cohesion. Due to the focus on interpersonal relationships, patients are also best served if there are two therapists who can play out different aspects of a relationship with group members and whose relationship with *each other* can become a useful focus for the group.

For purposes of identity and cohesion, it is helpful that the group have a name. The name can be determined by the institution, the therapist, or the group. Whether or not the name includes the word "therapy" depends upon the group's relationship to the institution and the preference of the therapist. Whatever the name, the patients soon catch on to the therapeutic nature of the group. I do not hesitate to use the name "drama therapy group" since it fosters an openness about the group among the patients and staff. When the group is supported by and integrated into the larger nursing home environment there is rarely a problem with patients avoiding the group because it is called "therapy."

THEORETICAL BACKGROUND

The theoretical framework for the Developmental Method in drama therapy rests on two bodies of knowledge: the concept of developmental level described in theories of cognitive development (Piaget, 1951; Werner, 1948; Werner and Kaplan, 1964) and the concept of internalized relationships from psychoanalytic object relations theory (Guntrip, 1961; Kernberg, 1976; Klein, 1975). The Developmental Method is applicable to drama therapy with any population since it is based on structural aspects of representation and thought. Nevertheless, modifications of technique are required for specific populations due to important differences in life-stage development (e.g., psychosexual, social, and moral development).

Developmental Level. Studies of cognitive development clearly show that the developing individual matures through stages within several dimensions of experience. The medium of representation begins with pure sounds and movements, shifts to symbolic gesture, then to imagery, and finally to the word (Werner & Kaplan, 1964). The person initially relies on task, space, and role structures maintained externally by the mother or both parents, but increasingly moves toward a state of self-reliance as s/he is capable of reproducing these structures internally (Kernberg, 1976). The ability to identify and tolerate greater complexity in one's experience increases throughout development, as does the ability to handle greater interpersonal demands from others. Finally, the capacity for containing and expressing intense affect without undue anxiety increases.

These principles of cognitive development, applied to drama therapy groups, suggest that the session be structured in a way in which ideas, images, and thoughts emerge from the group members in a developmental progression. Thus, the session should begin with sounds and movements, then utilize gesture and images, and later include role-play and verbalization; it should begin in a more structured manner and move toward less structure in its tasks, leadership, and spatial configurations; and the activities should increase in complexity, intensity of affect, and interpersonal demand. (See Johnson, 1982, for a more detailed discussion of these concepts.)

Object Relations Theory. This theory holds that each person builds a representation of the self and others by internalizing sets of interpersonal relations (object relations) from infancy through adulthood. Initially, these relations are characterized by a lack of differentiation and integration, so that the distinction between self and other, or inside and outside, is poorly defined. As one matures, these "images" of relationships become more differentiated and accurate, and are increasingly integrated into a coherent self-image, and coherent representations of other people and the world (Kernberg, 1976). Thus, the internal world of the person consists of layers of self- and other representations, some quite primitive that are derived from early experience, and others more sophisticated in form which are organized at later stages. Under stress or special environmental conditions, each person has access to these earlier forms of self/other relations. These earlier forms also tend to emerge when the media of expression are of an earlier developmental level, such as sound, movement, or gesture. In fact, Schimek (1975) has suggested that the unconscious is really these early object relations contained in nonverbal forms of representation, which explains why the arts therapies are so powerful in their ability to elicit surprising and otherwise hidden parts of ourselves.

The therapist attempts to encourage the expression of representations of the self and of others. The therapist assesses whether they represent early or late versions of the self, or hopes about future selves, and to which significant others in the person's life they are attached. The medium of drama is particularly effective in evoking these representations (Johnson, 1981). The complex internal world of each person, consisting of layers of interpersonal relations, emerges in his/her interactions with group members and the therapist, both in normal conversation and in the improvisational role-playing.

In a drama therapy group there are three worlds: the *here and now world* of the group of elderly residents and the therapists, including their actual behavior, personal characteristics, and relations with each other; the *internal world* of each participant, filled with many forms of relations between self and others; and the *external world* of family, nursing staff, and other patients to whom the group members must relate before and after the group experience. To a certain ex-

tent, the purpose of the Developmental Method is to stimulate a comingling of these worlds, so that the group serves as a safe crossroads or transitional space (Winnicott, 1971) where the internal world filled with past objects can come in contact with the external world and achieve a degree of interaction and integration. This is accomplished by introducing a new and temporary world of improvisational role-playing whose people, places, and activities become invested with aspects of the patients' real lives without being real. As a result, the role-playing serves as the vehicle for this integration of the internal and external, which is so often missing in the patient's experience in the nursing home. The fears and frustrations attendant upon entrance to the nursing home may tempt the elderly person to separate his/her past self, filled with youthful dreams and adult accomplishments, from the anticipated hopelessness of the future self. The result is an emptying of meaning from his/her current life in the nursing home. This separation attempts to protect the self from losing the valued past. "I am *not* this crippled patient who sits here now. I am who I *was*." The drama therapy group, by utilizing techniques that evoke expressions of both the internal and the external worlds in a safe group environment where real relationships are encouraged, serves to heighten the patient's continued adaptation to and dialogue with life.

TECHNICAL CONSIDERATIONS

A number of basic principles define the therapist's technique.

Active Participation. Since the goal of the therapy is to reestablish interpersonal relationships by overcoming symptoms of depression, withdrawal, and disorientation, the active participation of the therapist is crucial. The therapist becomes the patients' first and strongest link to other people, enticing them into engagement by playing roles that evoke memories of past attachments. S/he serves as a knowledgeable guide for the group through the mysteries and potential dangers of the dramatic medium. The therapist's activity is thus both an organizing and evocative influence in the group's environment.

Sustaining Flow. Central to the Devel-

opmental Method is the concept of flow or continuous transformation of feelings, thoughts, and group structures. Technically, each group structure should help to express the emerging inner state of the group, which is constantly changing just as the stream of consciousness of a person does. Since the nature of this ongoing transformation is spontaneous, group structures and exercises cannot be predetermined no matter how well the therapist is capable of designing an integrated sequence. Instead, in the Developmental Method, the group activity is in a constant state of transition, shifting somewhat ambiguously from one structure to another according to the therapist's understanding of the emerging imagery and movement of group members. Disruptions in this flow indicate areas of anxiety or conflict among or within group members and therapist.

The transition from one structure to another, and from one developmental level to another, entails a corresponding reorganization of the group members' relationships with each other, and each individual's connection to the group as a whole. This requires flexibility. Typically, some individuals experience anxiety during each transformation and resist it, thereby communicating important information to the therapist. By creating and maintaining an environment of constant transition and transformation, the therapist helps the group members to overcome their anxieties when faced with the necessity of change. This leads to an increase in the range and flexibility of their self-image.

The Developmental Method does not assume that a one-way movement up the developmental ladder (toward verbalization, for example) is the goal. Rather, it aims to develop the full range of expression across all modes of expression, all levels of self-representation, and to develop the ability to shift flexibly among them (Johnson, 1982). The therapist contributes to this effort by monitoring and sustaining the flow of the session.

Generating Hypotheses. As images, thoughts, and feelings emerge during each stage of the session, the therapist needs to be alert to the potential meanings of these images for the group; meanings that may not be fully developed or conscious, and that if fully acknowledged might please or distress them. At each stage in the group process the therapist attempts to construct

an idea of what is going on, continuously revising his/her understanding as the session develops. In the Developmental Method, the therapist uses this understanding to organize scenes, structure roles, and make comments that help the group to focus on its central theme. To the extent that the therapist's leadership is determined by his/her understanding of meanings rather than characteristics of the exercises, the session is more apt to follow a developmental progression that elicits the self-expression of group members. Despite its necessary inexactness, the therapist's currently-held hypothesis serves as a rudder which can keep the group on course toward the expression of important meanings. Without it, the therapist can miss the group's defenses against or detours around such expression at key moments in the session. The group may then be unable to achieve a sense of coherence or integration around the emerging issues.

Reverse Transference. The therapist needs to be aware of the complex nature of the transference in work with the elderly. The therapist is seen both as a parental figure, who is responsible for the organization, leadership, and safety of the group, and as the child, due to his/her younger age. This reverse transference (Meerloo, 1955) adds great complexity to the relationships between therapist and group in a developmentally-based therapy since at any given moment either the therapist or a patient may represent the stage of higher development. Knowledge of this relationship may help the therapist decide whether to enter the role-playing as the group member's child or parent (Johnson, 1985).

STAGES IN THE TECHNIQUE

The Greeting. The initial phase of the group includes gathering the patients, casual conversation, sharing of important events in their lives since last week, and reviewing what occurred last week in the group. The therapist is attentive to the themes and issues that are alluded to during this time.

The First Stage: Unison Activity. At some point in the conversation it will feel "right" to begin the opening movement ritual. Often a patient will initiate it. Sound and Movement is an opening ritual in which each member leads the group in a simple exercise or movement with an accompanying sound, such as raising a hand and saying "Ahhhh!" The group keeps the action going as each member in turn leads the group with their own sound and movement. Vowels is another ritual in which the group sings out each vowel (a, e, i, o, or u) several times in unison with accompanying movements. In Impulses, the group holds hands and passes a squeeze around the circle and then adds sounds.

The sounds and movements are repeated many times as alterations and intonations are introduced. Thus, the simple raising of an arm becomes more of a reach *for* something. The "Ahhhh" becomes more of an "Ahhh, ha!" The singing of "uuuuuuu" sounds more like "you!" That is, each sound and movement becomes imbued with nascent imagery of feelings and objects. Pure sound approaches early forms of speech, the movements become gestures, and the empty air becomes filled with mimed "things."

At this point there is typically some anxiety because what is emerging from the group is somewhat primitive, yet ambiguous and unformed. There is pressure to define it. Defined at the correct time, it will express and contain significant parts of the members' internal lives; defined prematurely, it will serve to avoid awareness of these meanings. The correct timing is always made clear by the burst of energy and often surprise that the group experiences when an apparently random action takes on an unexpected, but familiar, meaning.

Stage Two: Defining. As each member takes turns leading the group's unison activity and offers imagery, the therapist can quickly identify by the response of the group which developing image seems to express a group theme. This is helpful to the therapist in constructing an hypothesis about the salient concerns or conflicts that the group is attempting to express that day. At this point the therapist can make three kinds of suggestion that help in defining these issues further. Pairing: Here the therapist says, "Now direct that to your neighbor," and each person turns to his/her neighbor and directs the sound and movement there. This usually evokes more specific imagery and intonation concerning others, leading to further transformation. Going Around: The therapist says, "Pass that sound

and movement around the circle," and, one at a time, each person performs the action, often giving it new meanings. As the action moves around the circle, the therapist can choose to develop any particular intonation or meaning in which the group indicates an interest. Identifying: The therapist can also say: "What or who does this remind you of? What could this be?" Various group members will offer different ideas, each of which can be picked up on and used to transform the action further. Each of these techniques can be used many times as the group moves toward the expression of a particular set of feelings and roles that concern them that day. The therapist facilitates the transformation both by picking up on the most salient group theme, and by developing hypotheses about what the underlying theme or issue is, and how each group member might experience it differently. Going Around allows each group member to offer specific variations on the theme. Pairing evokes the different interpersonal meanings of the action. Identifying increases the articulation or fullness of the image.

The actions and images are in this way continuously transformed, moving around and around the group, and from one movement to another. For a while a particular image may be developed, or one person may keep the focus, but then variations are introduced and the therapist will facilitate the transition to these new underlying images initiated by other group members. As the group's images become increasingly defined, a pattern emerges more and more clearly, with vague feelings and objects turning into specific feelings between two or more people. For example, the "Ahh, ha" is added to a finger pointing action, and slowly the figures of a scolding parent and naughty child caught with his hand in the cookie jar may emerge.

Personification. The next stage involves the temporary crystallization of these images into differentiated roles, or characters, linked by an affective bond in an emerging "scene." The richness of these pre-character representations is impressive due to the fact that they are derived from multiple sources. These images may refer to people from the patients' past lives, alive in their reminiscences; they may also refer to aspects of their relationships to the therapist and other group members. Finally, they may also refer to people in their lives in the nursing home or fam-

ily, the people of their external world. These three worlds, internal, the here and now, and external, are copresent sources of the emerging scenes. Thus, the scolding parent and naughty child image may represent memories of themselves as children or memories of themselves as parents, or feelings about the strict therapist, or about themselves as older parents of the young and untrustworthy therapist, or of their fears of the nursing staff, or their desire to scold a careless aide.

Any one of these contexts can become the content of the ensuing role-play. This transition from the ambiguous and fleeting images of the early part of the session to the more overt and structured role-play is a crucial point in the session. What guides the decision by the therapist is not what the group's image "really" means, since an image has meaning at all of these levels, but the clinical intuition and hypotheses of the therapist in determining which context is currently the most salient and the one that the group will derive the most benefit from exploring. This period therefore deserves to be given a significant amount of time, though it is often tempting for the therapist to move too quickly from a developing image in the unison activity phase to a structured role-play. Unfortunately, this bypasses an important transitional phase in which the various fragmented meanings offered by group members are transformed into a collective group image of greater power.

A technique that provides a flexible structure for this phase is called the Magic Box. After the group has established several images and is on the verge of moving into structured role-play, the therapist or a group member may request that the Magic Box be brought down. The Magic Box is an imaginary box, usually stored in the ceiling, which contains anything that the group wishes as well as the contents of all previous sessions. The Box is always treated with great reverence. The group members bring it down by raising their arms slowly toward the ceiling and giving a loud hum in unison as they lower their arms. Then the lid is slowly unscrewed by the group, with accompanying groans of exertion. Following this, the group is encouraged to look over the edge of the Box and to peer into it. The therapist can leave the contents of the Box unstructured, simply saying, "What do people see? What's in

there?'' More often the therapist, based on his/her hypothesis about the current group issues, suggests that group members each take something out of the Box. What is taken out is often a feeling, an object, a wish, a person, a sound, a movement, a mask, or a memory. These are shown and described by each member to all the others. They can then be passed around, given to a partner, or articulated further; that is, the therapist can apply the same techniques for defining as above, noticing which images evoke the greatest interest and energy from the group as a whole.

Two techniques are useful in maintaining the flow of images produced by the Magic Box. One is to have group members return their images to the Magic Box and then repeat the process. For example, the Box may become an Emotional Soup. Group members take turns removing an emotion from the Box and leading the whole group in showing it (e.g., by growling and grimacing for ''Anger''). Then the group puts that emotion back in the soup and someone else pulls out another one. The other technique is called the Zap. Group members place all of the images that they have taken from the Box into the center of the group and, with their hands and feet, stir them together. The group often describes this as a ''mess.'' The therapist tells them that the group has tremendous power to transform this ''mess'' into something completely different by working together and ''Zapping'' it. The group then lowers their arms and begins a ''zzzzzing'' sound which increases in volume as their arms are raised above their heads, leading to a loud ''ZZaappp!!'' as they throw their arms quickly out toward the center of the group. In the hush that usually follows, the therapist may ask what people see, or ''what has it turned into now?'' The group can then again take objects, feelings, etc. from the center.

Occasionally the group finds it difficult to personify their images. A particularly powerful technique that can aid in transforming divergent feelings and images into a representation of a person is called Creating a Person. The therapist begins by noticing with great interest that a person is in the Magic Box. The therapist indicates that the person is familiar to all the group members, and, picking this person out of the Box, s/he says ''Hi!'' and engages in a short conversa-

tion with him/her. The person is referred to as ''you,'' ''my son,'' or ''Mom,'' etc., but with little articulation. This person is passed around the group, and each member in their conversation is asked to describe one additional attribute of the person, such as name, age, family, work, feelings, problems, or wishes. The person is passed around until s/he is fully articulated. Then the therapist builds a structured role-play around the character and his/her life. The person, as the group's creation, often represents important aspects of members' lives.

These dramatic structures allow the group to develop and transform a variety of images that express themes with interpersonal dimensions. The feeling of anger becomes anger at *someone*, the memory is about *someone*, the object becomes the gift from *someone*. When the basic pattern of roles has emerged in the session the therapist can lead the group into a focused role-play involving these roles. Usually these roles are explored in a structured format, provided by the therapist, in which group members play different characters in a scene. Later the role-playing will move to more unstructured formats.

Structured Role-Playing. This phase emerges smoothly from the previous stage and is a time for greater focus on one set of object relations that are of concern for the group members. Depending upon how the therapist has facilitated the personification of the group's imaging, the roles will either remain at a ''made-up'' level, or will be people from patients' memories (such as parents), or from their current living situation. Various scenes may be played, with different patients taking part, often taking turns at the two or three basic roles. Discussion and reminiscing are interspersed with the scenes, which are articulated in personal ways for each participant. The therapist may play a role with each person in turn, or each person may talk to an empty chair placed in the middle of the group, or a group drama may be constructed. In Phoning Home, for example, a group member ''calls'' a significant other in his/her family. The therapist plays the operator who connects the person to the people in his/her life, played by other group members.

The therapist is often tempted in this stage to focus exclusively on one issue or one person, as in psychodrama, or to turn the role-plays into a form of problem-solving. In the Developmental

Method these are not goals of the session. The purpose of this structured phase is to intensify the group's central theme so that past and current conflicts and anxieties are explored within the group process. This is expected to lead to a smooth transition into the next phase where the therapist helps the group move to a more complex and less structured format characterized by flexibility and transformation, that is, play. If the structured role-play becomes too concentrated on one person this transition is interfered with, since what was originally the group's issue has been placed in an individual.

Unstructured Formats: Playing. In the previous phase, images were crystallized in the form of structured roles and scenes. Now the group's images are allowed greater room again, though often the focus on past figures shifts to the patients' current relationship to the therapist and other group members. This is accomplished through three techniques.

1. **The Therapist as Subject.** The therapist enters into the role-play by picking up on a comment of a group member and transforming it into a new scene. The therapist purposely takes on a role that is consistent with the transferential image of him by group members (e.g., the strong parent figure, the naughty child), and then casts the patient in the complementary role (consistent with the original comment). If the therapist's empathy is accurate, there is usually a burst of energy or laughter. The similarity of the role-play with the members' actual feelings about the therapist often leads to a playful awareness on their part about these feelings. The therapist now establishes him/herself as the focal point of the playing, often by being the one who is the cause of the problem, and thereby anchors the spontaneity that is to follow.

2. **Expanding the Scene.** The therapist might play the son while a group member plays his father. As this scene proceeds, the therapist simply turns to another group member (up to this point an audience member) and addresses him/her as another character, such as his mother ("Mother, tell Dad that I didn't do that"). Group members quickly learn to respond to this invitation and, if role and person are appropriately matched, they enter the role-play with great energy. In this way, other group members are brought in, as brothers, neighbors, teachers, un-

cles, etc., creating a mini-society. Once the group members learn this structure, they too begin to spontaneously cast each other in roles. As the scene continues to transform, the "problem" person may change as conflicts among other characters become more interesting or relevant to the group. This is a simplified version of the technique of Transformation which is used with other populations (Johnson, 1984). The scene usually moves to a pitch of energy and spontaneity before members begin to tire. At this point, the therapist may allow the group to move toward closure or may initiate the following technique.

3. **Psycho-opera** (Klein, 1979). The therapist simply begins to sing his words, usually in an exaggerated manner similar to opera, signalling others in the play to do so as well. Choral responses, sounds of the orchestra, and gesturing accompany the ensuing interaction, which often departs from the previous scene. The spontaneity of the exercise usually incites group members into saying how they feel about one another, the session, and the therapist. It is rare for this opera to last long, and, as people tire, the therapist can lead them into a choral humming or group mime of an orchestra concluding the piece.

Closing Ritual. As the group finishes its playing or opera, characterized by rather direct expressions of how they feel about each other, they often burst into applause, becoming for a moment the audience that has viewed their performance. The need to close the group in a structured and safe manner requires a verbal discussion and checking in with each member as well as a unifying closing ritual that signals the end of the session. Often, when the Magic Box has been used, all of the material produced by the group is put back into it and its lid is screwed on. Then the group moves it back into the ceiling with arm motions and a hum, waving goodbye until the next session. The discussion allows each group member to raise concerns, questions, or make comments on the session and what it meant to him or her. Finally, the therapist may remind the group about any announcements made at the beginning of the group. Then the group members take hands and, as they raise them, they all shout the name of the group in unison.

I will now present an actual session which illustrates the Developmental Method described

here. The group consists of six nursing home residents, aged 80–94, who are oriented with moderate cognitive impairments. All are confined to wheelchairs due to limb amputation, arthritis, or stroke. One has had a diagnosis of schizophrenia. Two are nearly deaf. All are in stable condition. The group has met weekly for two years.

A DRAMA THERAPY SESSION

Greeting

TH: How are people feeling today?

ANNA: Lonely. I'm very lonely.

AGNES: Now? In the drama group?

ANNA: Not now.

TH: What is different about the group, Anna?

ANNA: I know the people here.

JOHN: You mean all of us good looking men! (laughter)

LILLIAN: At least you are congenial.

CHARLIE: I should hope so.

TH: How about other people?

ROSE: I'm thinking about the holiday.

(Group discussion about the upcoming holiday, including what they will be served for dinner. There is no mention of their children or relatives visiting.)

Unison Activity

TH: Why don't we start. Who'd like to lead off? [SOUND/MOVEMENT]

JOHN: (Begins a double arm movement outward, which the group joins.) Whee! . . . Whee! (joyous tone) . . . Whee (more declaratory) . . . We! (as the arms move out they seem to refer to the group members) . . . We! (then as the arms return, John initiates) . . . You! (one arm pointing into the center) . . . We! . . . You! . . . We! . . . You!

TH: (On "You," he points toward a member of the group; others follow.) We! . . . You! (acquires an ominous, accusatory tone). (As the sound and motion continues) Whose turn now? (Several people point at someone and say "You," laughter.) Ok, Anna.

ANNA: Ahhh! (changes the movement to a slow opening wide of the arms)

GROUP: Ahhh! Ahhh! Ahhh!

Defining

TH: Direct it toward someone! (Group directs their arm movement toward each other.)   `[PAIRING]

GROUP: Ahh! (more harsh) Ahh! (movement changes to one arm striking out at each other) Ahh, *ha*! Ahh, *ha*!

ROSE: You caught me!

LILLIAN: I didn't do it!

JOHN: Is this my hand in the cookie jar?

GROUP: (Continues) Ahh, ha! (laughter)

[The therapist notices the energy that this image elicits from the group, and decides to "poll" group members for specific variations.]

TH: Let's pass that around the circle. Agnes, direct that movement and sound toward Anna.   [GOING AROUND]

GROUP: (One at a time, each member directs the movement toward his/her partner. Members show childlike manners, as if they are children who have been caught by their parents.)

TH: What does this remind you of? [IDENTIFYING]

JOHN: When I was caught playing hooky from school.

GROUP: Ahh, ha!

CHARLIE: Ding, dong, school's starting.

LILLIAN: I was never late for school.

[The therapist senses that this school image holds importance for group members, and so attempts to facilitate its development into personified roles.]

Personification

TH: Who'd like to be the teacher?

CHARLIE: Come on, you'll be late, you'll have to stay after school.

ROSE: I'm coming! I was too busy playing jacks. My father would get upset. "Jacks is not the most important thing," he would say. You couldn't answer my father. He never touched us, but he would scold.

JOHN: When I misbehaved, he took out the old hickory stick.

ROSE: Maybe it worked better than scolding.

JOHN: Take us to the principal. "Hold out your hand." (He holds out his hand to Charlie, who pretends to slap it with a ruler.) Ohh!

TH: Let's all put out our hands in the center and receive our punishment for being tardy.   [UNISON]

GROUP: Ohh! Ohh!

ANNA: (to Agnes) What did you do wrong?

AGNES: I was late.

ANNA: Naughty girl.

[The therapist at this point is unaware of the possible link between this scene and the patients' concerns about their own children being tardy in visiting them for the holiday. Feeling confused, he nevertheless continues to allow the conflict to develop.]

TH: Let's go around the circle and each person take a turn being caught for being late to school.   [GOING AROUND]

AGNES: Charlie, you were late for school.

CHARLIE: I'm sorry, I'm sorry. . . . Now it's my turn!

JOHN: (To Charlie) I didn't mean to be late.

CHARLIE: Out to the woodshed!

JOHN: Ohh! This is like being pledged to my fraternity. They said, "Assume the position" and then whacked you in the behind! (He demonstrates.)

ROSE: (To Lillian) You were naughty.

LILLIAN: I know, I couldn't help it. (To therapist) You're so bad! You're always late! Why can't you be on time?

TH: I'm sorry, it will never happen again. I promise. (Group tension increases at this point.)

[The therapist was also tense. He had been late for a few sessions, but that had been several months ago. Yet Lillian's comments communicated an anger that was sincere. Confused, he did nothing.]

CHARLIE: Ding, dong! School's out. (He pulls his arm in a downward motion as if he was ringing the bell.)

TH: Let's join Charlie in ringing the bell.

GROUP: Ding, dong! . . . Dong. . . . Dong . . . (as the arms go up, the group adds a sound) Oh! . . . Dong. . . . Oh . . . Dong. . . . Oh! (As if something wonderful is above.)

TH: What is it?

AGNES: Sky. Wonderful sky.

JOHN: A big white cloud.

GROUP: Ohh!

LILLIAN: I want that rainbow.

GROUP: Ohh!

[The therapist now perceives the clear separation between "being bad" (as the bad children) and "good" represented by the sky imagery, which is "out there." He now attempts to help the group bring the good in.]

TH: Ok, let's take all that good up there, the sky, the white cloud, and the rainbow, and whatever else there is and bring it down, all together, bring it down and into ourselves (indicates by bringing arms down onto chest. Group follows in unison.)

ANNA: (Pats herself on the chest)

TH: Yes, let's pat ourselves.

ROSE: I don't deserve it.

TH: You don't deserve to be cared for?

ROSE: Half the time they don't mean it. They give you a pat, and say, "Looking good!" and then forget it. Oh, well, take it from whence it comes.

ANNA: Can be the doctor too. Sometimes he just says it. You think they mean everything they say.

GROUP: (general agreement expressed)

TH: You mean people who visit you often try to say something optimistic, but it doesn't feel real to you.

ROSE: It's not that they are lying on purpose.

CHARLIE: The doctor gets his $20.

TH: Let's go around and show us what you mean. Take turns being the doctor.   [GOING AROUND]

GROUP: (Group members take turns saying, "Looking good" in a false way to each other around the circle.)

[The therapist guesses that the group's insistence on holding onto the bad is in the service of preserving the good for others on whom they depend, such as doctors, or their children. He now feels comfortable enough to structure a specific role-play on the issue.]

Structured Role-Play

TH: OK, Agnes, why don't you play the doctor, and Rose, you be the patient, only as the scene goes along, turn toward us and tell us what you really feel inside about it.

AGNES: (As Doctor) You are looking very good, Rose.

ROSE: (To group) If she only knew. But I take it from whence it comes. (To Agnes) Thank you, Doctor.

AGNES: You're welcome.

ROSE: But why does my hip hurt?

AGNES: I don't know. We're depending on time to cure. It takes time, my dear.

ROSE: Yes, doctor.

TH: So what do you really think, Rose?

ROSE: I think he's a liar. But I have to have him. Whether you want to or not, if you don't call him, they wonder what's wrong. So you call him and don't listen.

TH: You don't listen?

JOHN: Yes, but it's a secret. Don't tell.

CHARLIE: Shh.

ROSE: Shh.

TH: Shh.

GROUP: Shh! (Repeat this to each other. Many smiles.)

LILLIAN: Let's bring down the Magic Box.

TH: Yes, it sounds like it's time. OK, group, with the power which we have, let's bring down the Magic Box from the ceiling.   [MAGIC BOX]

GROUP: (Slowly raise arms in unison toward ceiling and then lower them.) Hmmmmmmm. (Then group mimes unscrewing the lid.)

TH: (Looking into the Box) What's in there today?

ANNA: Secrets.

[The therapist realizes that the group has many secrets that they would like to express, though they needed to back off from the previous scene which criticized the doctor. Guessing that the important feelings are associated with their families, he takes on a parental image.]

TH: (in mock parental tone) If I ever find out what you kids have done, you'll be in big trouble! (laughter)

ROSE: Look, I see a fish here. (She forms a "fish" with her hands and pretends to swim.)

GROUP: (Others mimic her movements.)

ROSE: When this fish finds another smaller fish, he gobbles him up. (She grabs Anna's hands.)

ANNA: Splash!

TH: Let's all splash.

GROUP: Splash! . . . Splash! (They pretend to splash each other playfully.) Splash! Splee . . . lasshh! Lash! Lash! (Movement is changed to a lashing movement, as if a whip were being held by both hands. Nervous laughter.)

TH: You bad, bad child!

CHARLIE: I remember when my father lashed me. I

was supposed to have done the chores for him, and I didn't. He was very disappointed in me.

LILLIAN: One time I was twelve and I stole a candy bar from the pantry and put it in my pocket before we went to church. It was a hot day, so it melted all over my dress. My mother was so embarrassed. I looked like a mess.

TH: Sounds like some of the secrets are coming out.

(Other group members begin to reminisce about childhood memories in which they disappointed their parents.)

JOHN: My father worked in a machine shop. Worked all day. He only had a couple of hours off. I used to feel so sad for my mother. But now I realize how happy we were. We would have a big Sunday dinner after he scolded us. We never saw him during the week, so he had to scold us on Sunday before our dinner. My mother made such a wonderful dinner, though sometimes we had to eat standing up (smiles).

TH: Charlie, why don't you be John as a child, and, John, you play your father. Show us how he scolded you.

JOHN: Son, you've been bad this week. You haven't helped your mother enough. After we're gone, you are going to have to take care of yourself. We won't live forever!

CHARLIE: I know, Dad.

JOHN: I'm always right, aren't I?

CHARLIE: Yes, Dad. (John pretends to slap Charlie's hand as punishment.) Ouch!

JOHN: That's the way it was!

TH: You really looked up to your Dad, didn't you?

JOHN: Yes, I did . . . at least until he died.

TH: How did he die?

JOHN: He worked himself to death. I was still young when he died.

TH: He never got to see how you did as an adult?

JOHN: (very sad) No, he didn't.

TH: I wonder what he would think about your life.

JOHN: I do too.

TH: Perhaps we will phone him, wherever he is, up there, and ask him? Who'd like to call John's father?
                    [PHONE HOME]

CHARLIE: I will. (Pretending to phone) Rringg. Rringg.

[The therapist, sensing a great deal of emotion in John, offers some comic relief to lighten the atmosphere so the scene does not intimidate other members.]

TH: (In nasal tone of an operator) Yes. Who are you calling?

CHARLIE: John's Dad, in Heaven.

TH: Is this a collect call? No, OK.

JOHN: Hello, John, how are you?

CHARLIE: Fine, Dad. I wanted to ask you what you thought about my life.

JOHN: I thought you'd turn into a bum for sure, but you have done all right for yourself. I have to admit I'm surprised.

CHARLIE: I wish you had been here to see it, Dad. We never had much time together. I've worked really hard.

JOHN: That you have, my boy—though I did too, and look what happened to me!

CHARLIE: I miss you. Goodbye.

TH: Would anyone else like to call their parents?

(Other members take turns calling their dead parents. Most are matter-of-fact conversations, except for Anna, who becomes tearful in telling her mother that she misses her. A general discussion and more sharing of memories follows.)

AGNES: (To therapist) Now its your turn! You have been thinking about other things. Pay attention!

[The therapist notices that the group members have not felt comfortable to express their angry feelings towards their children or parents during the entire session, continuing to take a depressive or victimized stance. Agnes now expresses this anger by displacing it onto the therapist, presumably a safer target. The

therapist hopes to address this displacement by responding in a role that matches the true object of the patients' anger—in effect, by offering an action interpretation.]

Unstructured Format

TH: (Speaking to her in a whining voice) Mom, I'm sorry I didn't visit you last month, you know how busy I am.   [TH AS SUBJECT]

AGNES: (Recognizing that the therapist has initiated a role-play) Well, David! You have been very negligent. Why haven't you visited?

TH: Shelly and I have been very busy. You wouldn't want me to risk my career just to visit you?

AGNES: (Outraged) Just to visit your mother! Insolent child. You should show greater respect for your parents!

TH: Besides (indicating John), my brother Bill visits you all the time.

AGNES: Who?

TH: You know, Bill, your favorite son.   [EXPANDING ROLE-PLAY]

JOHN: (Accepting the role) You've always been a problem in our family. You don't show any respect or appreciation for your parents.

AGNES: Yes, Bill dear, you do appreciate us (smiles at John).

TH: But I appreciate you too, isn't that right, Shelly? (indicating Rose)

ROSE: Yes, David cries every night because he loves you so.

JOHN: He sure doesn't show it!

TH: (To Charlie) Dad, I think Mom is being too harsh on me.

CHARLIE: No she isn't. We haven't seen you in weeks. Where have you been? She's a sick woman and you don't even care.

(In the same way, Lillian is brought in as Bill's wife, and Anna becomes David's grandmother.)

TH: (falsely) I think she's looking good.

CHARLIE: I'm very disappointed in you, son.

TH: You always liked Bill better. At least Grandma likes me, right Grandma?

ANNA: Yes, my dear, you're a good child.

(The scene develops into a heated argument, with David receiving much criticism for his obnoxious attitude. In the end, he leaves his wife to stay with his grandmother who is the only one who can tolerate him. As the story ends, there is laughter and some applause.)

TH: That was quite a scene.

ANNA: Children today don't appreciate their parents like we did.

[Rather than helping the patients verbalize their angry feelings about their children, which he intended to do, the therapist now redirects them toward their loving feelings for their parents. The patients then temporarily resume externalizing the "good" and internalizing their bad and empty feelings.]

TH: I can tell you loved your mother and father very much.

ANNA: Yes, I do.

TH: They're gone now.

ANNA: Many years ago. A long time.

ROSE: But it feels like yesterday that they were here. It was the most painful thing to lose them. I'll never get used to it.

ANNA: My father is dead now a long time. No use talking. How long can you mourn after the dead?

TH: Lillian, you are feeling something now?

LILLIAN: (crying) I miss them. They were so good. They took care of me, watched over me. . . .

TH: You have your children.

LILLIAN: Yes, and grandchildren, but it's not the same. . . . I don't know.

CHARLIE: My parents died 35 years ago. I took care of them for a long while.

TH: Lillian, did you have to care for them at the end?

LILLIAN: Yes, but it didn't do much good.

ROSE: God takes us all when He decides. (A long tense silence)

CHARLIE: You're a strong person, Lillian.

LILLIAN: (smiling) I wouldn't have lived so long if I wasn't strong! (Laughter)

[On their own, Charlie and Lillian have pointed out that they are not completely sad, weak, and lost souls, even though they have suffered losses. Her humor, in reasserting the integration of good and bad, results in a burst of energy within the group. The therapist, back on track, now encourages more spontaneous expression by introducing psycho-opera.]

TH: (singing in a mock operatic voice) Oh, you wouldn't have lived so long, if you weren't so strong, so strong! . . . From now on we sing instead of talk.
[PSYCHO-OPERA]

JOHN: (singing) She's a strong old ladeee!

TH: (leading the chorus) Strong old lady! Strong old lady!

LILLIAN: I've lost my mo-ther!

GROUP: Oh, no! (They now add sound effects mimicking trumpets and drums.) Boom, boom, boom.

LILLIAN: And I've lost my father!

GROUP: Oh, no! Boom, boom, boom.

CHARLIE: And God has taken them all to a safe haven, safe haven.

GROUP: Hallelujah! Hallelujah! (Laughter) Bruagghh! Bruagghh!

ANNA: But I am lonely.

TH: Oh, we are all, so lonely.

ROSE: Our children don't visit us enough.

GROUP: Visit us, visit us! Boom, boom, brannnggg!

TH: Parents gone, children gone, I'm the only one around.

AGNES: No, you're not! You're only here once a week.

GROUP: Once a week, once a week!

LILLIAN: And he takes vacations.

GROUP: VACATIONS . . . VACATIONS!

TH: You're not being fair.

GROUP: Life isn't fair. Life isn't fair!

TH: I guess you're right, life isn't fair.

GROUP: Ha - le - lu - jah! Ha - le - lu - jah! (applause)

TH: Each person take a bow! (Each person leans forward while others clap. There is a moment of relaxed silence. John holds Lillian's hand.)

TH: If only your children came to visit. If only your parents were still alive. That *would* be a fair trade for the love you have for them.

CHARLIE: Are you still lonely, Anna?

ANNA: I know you care for me, Charlie. (To therapist) Where are you going for the holiday?

TH: Sounds like you have been wondering how much I care about this group, too? (Smiling) Actually, I'm not going anywhere this time. We will have the group next week as always. . . . But, if you prefer . . .

JOHN: Sure, go ahead. We don't need you! (Laughter)

TH: That would be pretty embarrassing, to need someone a third your age?

AGNES: A baby! . . . Pipsqueak!

TH: *Mom!* (Laughter) Well, I don't think we will be able to resolve this problem today.

Closing Ritual

TH: Let's put everything back in the Magic Box. What do we have?

ROSE: My parents.

AGNES: Sadness.

TH: Put it in (points to the Box in the center of the circle). What else?

JOHN: My lashing.

LILLIAN: My memories.

CHARLIE: My bad son, David.

TH: Yes let's all put him in. (They do so with pleasure.) Now, let's put that lid back on and, with the power of our group, let's begin a hum and lift it back into the ceiling for safe keeping. Okay? Here goes . . .

GROUP: Hmmmmmm (Lift arms toward ceiling).

TH: Say goodbye.

GROUP: Goodbye (waving).

TH: What did people think about today's session?

(Group members briefly report that they enjoyed it, particularly the scene with the therapist as the bad son. Several again bring up the holiday and talk about their families visiting.)

TH: Our time is up for today.

GROUP: (The group holds hands and as they lift them up they chant) Drama Group! Drama Group! Drama Group!

This group continued for five years. The members developed very intense, positive relationships with each other which sustained a sense of play and warmth. They as well as the therapist benefited greatly from this group, through which they held firmly to an appreciation of life and learned to forgive themselves for some of their own faults.

DISCUSSION

This case example demonstrates the Developmental Method with an established group of nursing home residents who were familiar with the therapist and drama therapy. At the time of the session the group had been meeting for two years and had overcome initial resistances to role-playing, fantasy, and the spontaneous atmosphere. They had also become comfortable sharing their personal feelings with each other, though the major interpersonal exploration was focused on their relationship with the therapist.

The session's major theme centered on the patients' resentment arising out of their dependency on their children, who they feared did not love them sufficiently, and secondarily upon the therapist, to whom they looked for care. However, to express the anger directly toward these figures risked retaliation or abandonment. Over the course of the session, they were able to express this anger more directly without becoming overwhelmed with feelings of guilt or fear of abandonment. The therapist's use of humor supported a sense of safety in the session by reassuring the members that he could tolerate the increasingly intense emotion. Both the humor and the role-playing provided a buffer in which the feared emotions and interactions were tested. Group members initially preferred to absorb the bad feelings by representing themselves as weak, sick, and naughty, and to idealize the therapist and their parents. At first, the therapist did not understand these images of naughtiness and punishment presented by the group. Gradually, as the dramatic images were defined and personified, the major themes involving their family members, and himself in the transference, emerged. The deaths of their parents obviously still haunted them, indicated by the regrets and expressions of guilt that were voiced. The loss of their parents required the patients to turn to their children and the therapist to meet their dependency needs, subjecting them to feelings of embarrassment and resentment.

In the last part of the session, the therapist was uncertain whether to continue to focus on the patients' feelings of loss or to help them express their anger at the children. When Charles and Lillian indicated that they were capable of tolerating the idea that, while they had suffered, they were still strong, he was able to lead the group into a spontaneous opera that allowed for more direct expressions of aggression.

Overall, this session followed a developmental progression which I have described in a previous paper (1982). The level of structure began at a very high level and slowly decreased to allow for more spontaneous expression and control by group members. The level of complexity of the exercises increased from unison group activities to role-plays with differentiated roles, to highly

complex improvisations in which people shifted roles. The developmental level of the media moved from pure sound and movements, to images, then verbal role-plays, discussion, and finally improvisations in which pure sounds, images, and words were interspersed. The interpersonal demand of the activities increased from low levels to intense contact and interaction, and the expression of affect began at a humorous, superficial level and moved to more intense and distressing affects. The anxieties aroused in the key transition points at the beginning and end of the session were contained by group rituals, and familiar group events (like the Magic Box) were used to structure more intense parts of the session. Thus, drama therapy serves a differentiating function by simplifying and concretizing feeling states and interpersonal relationships. Group members become more able to identify and structure aspects of their experience, which increases their sense of personal control as well as their capacity to verbalize.

The Developmental Method facilitates the unfolding of the murky, ambiguous, and shifting feelings of the group into more coherent, concrete group themes and issues. The therapist is constantly developing hypotheses about the meaning of the group's activities and uses this understanding to choose structures through which the issues will emerge more clearly. From an object relations view, the session demonstrates how the improvisational role-playing becomes symbolized as a projective container of the patients' psychological worlds. The characters and relationships in the role-playing come to represent the patients' past relationships, here-and-now relationships with the group and transference to the therapist, and relationships with family and nursing staff. The safety of the group's structure encourages them to place these parts of themselves into the dramatic images and scenes which serve as transitional containers. The Magic Box is the most explicit example of this holding function of drama. The initial period of intense projection is eventually followed by periods of re-introjection during which the group members take these parts of themselves back, only in a modified form: (1) in that they have been expressed, they are now conscious; (2) in that they have been shared in a group format, they have been modified by social interaction;

and (3) in that the therapist has maintained the level of anxiety at manageable levels, they are modified in intensity. The result is a linking of the past with the present, the internal with the external. The therapist facilitates this linking foremost by maintaining the flow of the session and supporting the transitions between images. Verbal interpretation also makes conscious these links between a dramatic scene and the patients' other relationships. For example, the therapist offered a verbal interpretation near the end of this session when he pointed out members' concerns about how much he cared about the group. However, the drama therapist usually offers *action interpretations* by introducing new characters or variations in character that are shaped closely to the patients' internal, here-and-now, or external relationships. The therapist offered such an interpretation when he addressed Agnes in a whining voice as her child who hadn't visited. The scene was transformed according to the therapist's understanding of the meaning of the patients' dramatic role-playing. Agnes' energetic response indicated that the therapist was empathically in touch with her feelings. The result was a more conscious awareness in the group that they had angry feelings toward their children, and that these feelings were tolerable. The drama therapy session thus serves an important integrative function for group members by facilitating the linking among split-off areas of experience and by acting as midwife to the emergence and recognition of meaning in their interpersonal relationships.

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