The dramatherapist 'in-role'

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'A dramatherapist out of role is like a fish out of water.' (Ancient dramatherapy proverb)

INTRODUCTION

Most people assume that the dramatherapist participates in the ongoing drama with the client. Yet often the dramatherapist is not wholly within the drama, serving instead as a witness, director, or sidecoach to the action. In private practice settings, it is not uncommon for creative arts therapists of all types to participate less and less with their clients. The pressures for objectivity, for distance from sexual or intimate transferences, and for verbal processing, lead many a dramatherapist to remain outside their own medium, and leave the drama to the client. The verbal therapist enters the client's world through empathy, an internal operation. The therapist remains seated, receptive, wise.

In this chapter, I will discuss the various ways the dramatherapist participates with the client, examine the difficult transference and counter-transference issues that arise under these various conditions, and then describe several methods of intervention 'in-role' and illustrate them with a case example.

First, what do we mean by 'in-role'? Technically, this means that the therapist enacts a role in the drama, that is, participates with the client in the enactment. This is the therapist's second role, the first being the role as 'therapist'. Yet the therapist plays even more roles: as the client and therapist interact, the client also casts the therapist according to roles from his past or current life, through the transference (Johnson, 1989; Landy, 1986). Figure 8.1 illustrates these different roles of the therapist.

In this chapter I will focus primarily on the therapist's enactment of dramatic roles.

While 'role' is the commonly used term, I would like to introduce a broader concept which takes into account other states of imagination and drama that do not have the form or structure of typical roles. The *playspace* is an interpersonal field in an imaginative realm, consciously set off from the real world by the participants, in which any image, interaction and physicalisation has a meaning

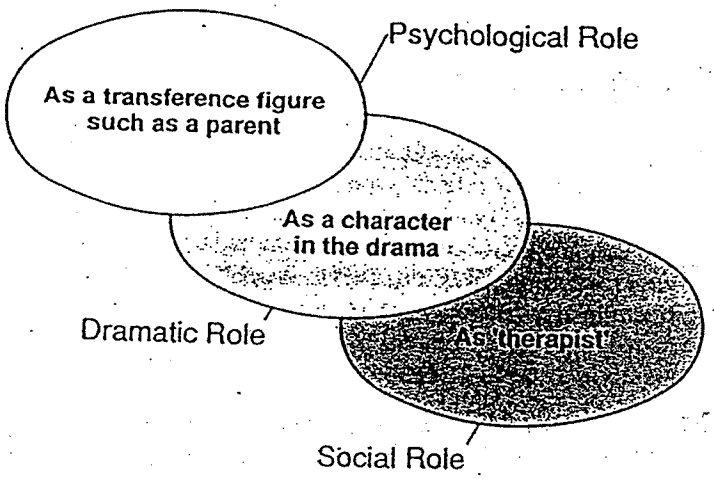

Figure 8.1 Three major roles that dramatherapists play

within the drama. The playspace is an *enhanced* space, where the imagination infuses the ordinary. The playspace is where dramatherapy takes place, and therefore the dramatherapist's primary task is to introduce and sustain the playspace for the clients, whether he or she is outside it or inside it. The playspace embraces the constituent elements of roles: pure movements, sounds, gestures, stillness, and wonder. For example, one can bring most latency-age children into the playspace simply by leaning over, whispering 'shhhhh', and furtively looking from side to side. The playspace is summoned merely by the creation of the illusion of an alternative reality, without necessarily establishing with clarity what the roles are. In this sense, the playspace is a form of trance.

I will now discuss the implications of the dramatherapist being in the playspace with the client, versus remaining at some distance from it.

MODES OF PARTICIPATION BY THE DRAMATHERAPIST

Dramatherapists place themselves along a continuum of distance from the playspace, and in fact, learning to be a dramatherapist involves practice in moving smoothly along this continuum, depending upon the clinical need. Well-trained dramatherapists should be comfortable with all of the following roles:

a) As the witness or mirror

At the farthest remove from the drama, the dramatherapist as witness or mirror observes the client or clients in the playspace, and then after they finish their role-play, sand-tray, artwork, or improvisation, the therapist gives them feedback or mirrors back images or feelings aroused by the work. This form of participation is often used by client-centered, analytic and Jungian therapists. The role of the witness is extremely important and involves deep emotional involvement in the client's journey. The witness is like a receptacle of the client's images. The concepts of empathy (client-centered: Rogers, 1951), projective identification and evoked counter-transference (analytic: Ogden, 1986; Searles, 1979), and kinesthetic counter-transference (authentic movement: Adler, 1985; Bernstein, 1985; Chodorow, 1986, 1991) are used to describe this phenomenon. The client in dramatherapy also communicates many unconscious images to the therapist. The challenge for the therapist is to be able to sort out and process these images in a way that provides useful feedback to the client.

b) As director

This mode of participation is often used by psychodramatists and dramatherapists using performance technique. The director sits outside the ongoing drama, but will be very active in setting up the scenes, conversing with the protagonist, sending in auxiliary egos, and in general directing the scene (Moreno, 1964). A good director shows great empathy, and does not act 'directorial'. He or she is the manager of the playspace, and serves to protect it and facilitate transitions within it.

> The director is the prime co-ordinator and catalyst of a session. In a sense, the director is a field general and orchestrator of the session. S/he must not only be aware of the protagonist's emotional state but also must constantly survey the mood of members in the group.
>
> (Yablonsky, 1976:111).

However, while the director in a psychodrama is a central figure in the group, he or she, like the director of a play, is not on stage.

c) As sidecoach

Best known by those influenced by Viola Spolin (1963) and theatre games, the sidecoach position of the therapist is outside the ongoing dramatic activity, and also includes directorial functions of setting up the game or activity, but goes a step further by becoming a voice in the scene itself (similar to a double in a psychodrama). The therapist reminds, cajoles, speaks suggested lines, or adds sound-effects from the side-lines, at times modelling for the participants as if he or she is in the scene.

> The therapist, as sidecoach, becomes a fellow player, drops roles, attitudes, and judgments, puts aside immediate goals of performance, social adjustment, or rehabilitation, and becomes a support to the players, lends eyes and ears to the playing, and in turn is supported by the players. The sidecoach looks for what the players need to keep playing.
>
> (Spolin, 1981:217).

The sidecoach functions at the boundary of the playspace, every once in a while opening the door and making a suggestion.

d) As leader

Characteristic of creative drama approaches to dramatherapy, the therapist as leader participates fully in the group's activities. The therapist leads them in various warm-ups, imagery exercises, and then 'goes with' them on journeys, helping them to make decisions from within the scene (Way, 1968). No longer on the side-lines, the leader stands in the circle, crawls on the floor, and takes on a role in the story. Nevertheless, the leader remains somewhat removed from total participation and attempts to keep the focus on the clients' experiences. The leader avoids taking central roles or becoming the protagonist.

> The leader has to be able to become involved in a situation, to be part of it, without losing his overall awareness of the group. If we consider him as being involved eighty per cent, then the remaining twenty per cent remains detached and provides the framework.
>
> (Jennings, 1982:6)

Psychologically, the therapist as leader is on the inside of the playspace, encouraging members to look around and to explore the playspace.

e) As guide

Often applied in the developmental method (Johnson, 1982, 1986), the therapist can also act as a knowledgeable guide into the imaginative realm. While similar in function to the leader position, the therapist as guide is allowed a greater degree of centrality in the imagery of the drama. In this case, the group or client uses the therapist as a projective medium through which the drama itself can develop. In a developmental technique called 'Therapist as subject', for example, the therapist actually becomes the major focus of the drama (Johnson, 1986). Thus, the guide places himself or herself fully within the framework of the story and the playspace, and leads the clients into the unknown, whereas the leader encourages them from behind. The guide says metaphorically, 'Come with me!' Though the leader also brings the group into the playspace, he or she – like them – is of the real world. The guide, in contrast, lives in the playspace, and welcomes the clients when they knock on its door.

f) As shaman

Finally, the most intimate relationship between therapist and playspace occurs when the therapist, as actor, enacts the images in the drama, while the clients watch as audience. The therapist as shaman submits to the spirits of the *illud tempus* (Cole, 1975) in order to bring the client revelation. Thus, the therapist takes the imaginative journey alone, but *for them*. This mode of participation is characteristic of story-telling, therapist-performances, and trance-induced methods, many of which are increasingly being used by dramatherapists (McNiff, 1981). The effectiveness of these approaches is based on inducing an altered state in the client, whose distance from the drama supports a state of receptivity, not unlike that intended for the theatre audience. The client, then, becomes the witness.

Figure 8.2 summarises these relationships between the therapist and the client, in and out of role.

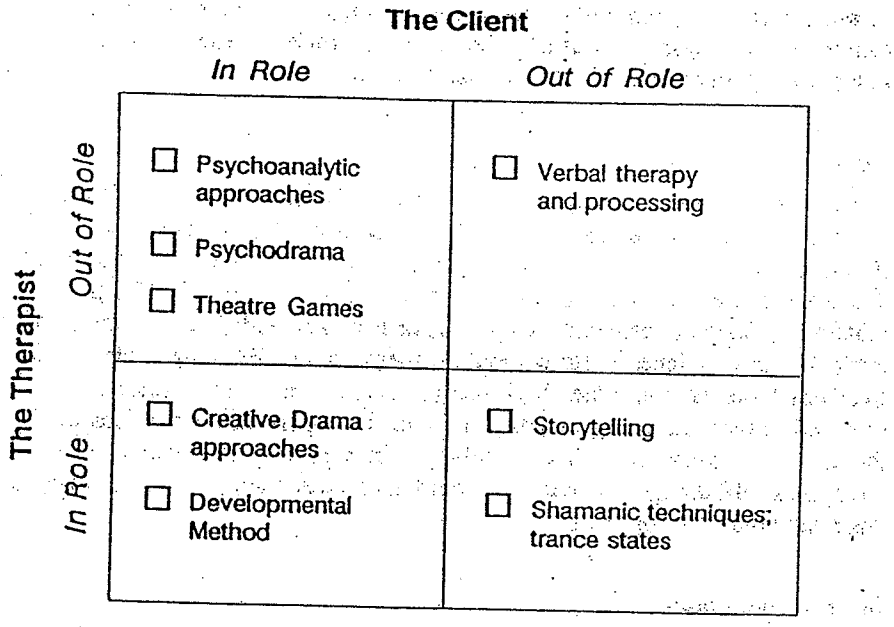

Figure 8.2 Relationships between therapist and client in and out of role

While different dramatherapy theories and techniques favour different modes of participation, and therapists with different styles will have their own favourite,

most dramatherapists use each of these modes at different times during their work and with different clients. We need to develop a better understanding of how each of these modes can best be used to further therapeutic work, when to use them and when not to, and with which clients. Short of that study, we are left with the personal (albeit well-informed) preferences of experienced dramatherapists.

TRANSFERENCE AND COUNTER-TRANSFERENCE ISSUES

Imagine going to a dramatherapist who at times sits on the side while you improvise, or play with puppets, or make a sand-tray. Occasionally the therapist makes suggestions, and afterwards talks with you about your enactments. Imagine going to another dramatherapist who improvises scenes with you, plays all sorts of roles to yours, and at times is physically in contact with you. Would this make a difference to you? For most of us, yes, it would. Yet we have very little idea *how* this difference affects the therapeutic process. Does the participation of the therapist enhance or interfere with the client's immersion in the imaginative world? How can the therapist participate without introducing extraneous, personal elements that merely distract the client? For these reasons, the therapist's mode of participation has a complex influence on the process of the therapy, particularly individual therapy, where there are not other members who can share the playspace with the client. Let me review these influences from interpersonal, intrapersonal, and cultural dimensions.

Interpersonal dimension

The relationship between the client and therapist is apt to be greatly affected by the therapist's involvement in-role. The therapist who remains outside the playspace is apt to retain the image of the wise, objective presence, whose detachment is protective, and who evokes parental transferences. The therapist maintains a state of abstinence toward his or her own needs, and you are free to explore your own inner world without the therapist's needs being made evident. In contrast, the therapist who plays with you seems more human, since his or her own self is more fully expressed, along with its imperfections and biases. The therapist may seem more like a sibling than a parent. The exposure of the therapist's self, though, can become a burden or a constraint, thereby distracting you from your own concerns.

Intrapersonal dimension

The client's inward journey and confrontation with self is also affected by the therapist's participation. Therapists outside the playspace remain a mystery that stimulates your fantasies: your wish to find out about them or love them is as strong as any unrequited love. On the other hand, the ever-present 'look' of the therapist as you prance around or perform for them, gives rise to concerns about

judgement and criticism, and shame for all of your faults and failings. In contrast, to play with the therapist is partially to gratify many of the fantasies you have about him or her, to physicalise your relationship, to be intimate, even to de-throne. As a result, you are often not so aware of the therapist's 'look', or judgement, since he or she has been with you through it all and may be just as much to blame for everything. Yet, the fact that you have been this intimate, and have gratified some of your wishes to be close, raises feelings of guilt – you have done it, you are a pair, you are his, he is yours.

Cultural dimension

The arrangement of therapist and client also matches different cultural structures. The caring detachment of the therapist out of the playspace more closely matches the social roles prevalent in patriarchal cultures. The intimacy, gratification, and guilt of the therapist within the playspace, matches the social roles of the matriarchal cultures. These cultural effects impact on the expectations and social norms of the therapy relationship and match or mismatch the personal preferences or family patterns of both therapist and client. One might predict that men and women, or certain types of men and women, will feel differently about the therapist's participation in role. Do male therapists tend to prefer greater

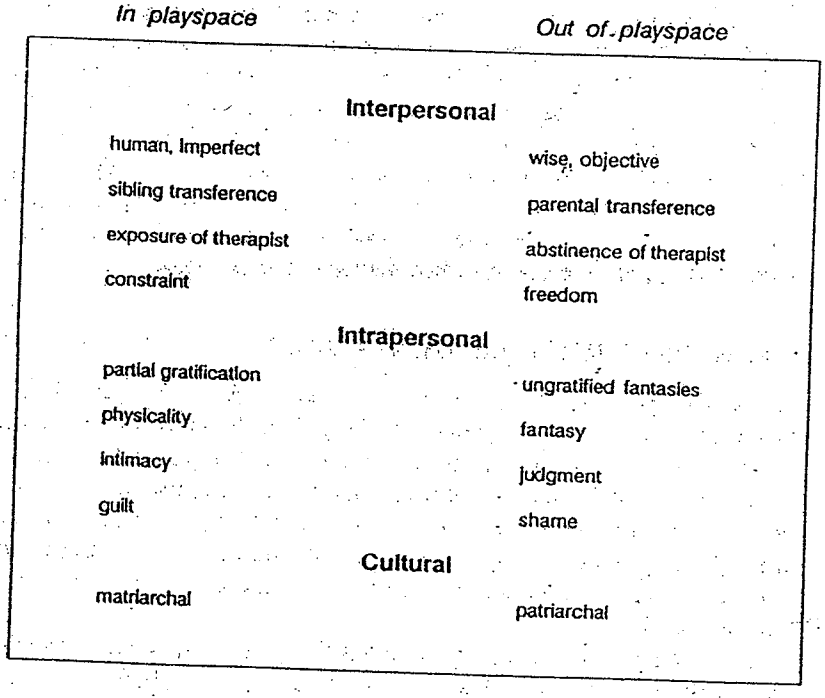

Figure 8.3 Comparison of the dramatherapist in or out of the playspace (role)

distance from the playspace, consistent with a patriarchal structure? In ancient Greece, for example, the oracle herself was usually a woman, while the priests (who interpreted her utterances) were usually men, once removed from the spirit world.

These dimensions are summarised in Figure 8.3.

SEXUAL ISSUES

While sexual attraction between client and therapist can become an issue in any therapy, dramatherapists working with individuals have a special problem when they decide to 'play with' their client. The enactment of powerful images and scenes and the potential for physical touch may evoke strong sexual attraction, and provide a means of acting it out. Can a dramatherapist really roll around on the floor with the client? This problem leads many dance- and dramatherapists in private practice to take greater distance, or to leave the playspace entirely.

For example, one of my clients, a 32-year-old woman, experienced my asking her to role-play with her as a seduction. We spent several sessions discussing the roots of this reaction. When we did role-play, she had a strong feeling that I might fall in love with her, and that she would not be safe if we continued to role-play. She asked to stop. When we examined her reactions, she informed me that her previous (verbal) therapist had suddenly terminated treatment because 'he said he was falling in love with me'. Later I learned that another previous therapist had indeed initiated a sexual relationship with her. In this case, the intimacy and physicality of role-playing with a male therapist was too evocative of past traumas to be workable. Sensitivity to these potential issues is essential for the therapist who chooses to participate with the client. Entering the playspace can be experienced as entering the client, and what should be play, instead, becomes a rape. Fortunately, these dynamics are significantly reduced in group therapy, with children, or severely disturbed patients in institutions.

METHODS OF INTERVENTION IN-ROLE

By far the most common intervention used by dramatherapists is the verbal processing after a dramatic event or activity. The client(s) do an improvisation or theatre game or sand-tray or mime, and then the therapist and clients talk about what feelings or issues were evoked during it. Here, the therapist acts like a verbal therapist in processing a previous experience. Surely, being a dramatherapist includes using sophisticated methods of intervening during the dramatic activity. Yet very little has been written about the *details* of therapeutic improvisation.

So what do dramatherapists *do* when they are role-playing, improvising, or playing with their clients? This is an important question, because if there is one skill that distinguishes a dramatherapist from all other therapists, it should be the

ability to intervene while in-role! The capacity to be thinking therapeutically while engaged in the drama, and then be able to carry out a specific intervention designed to help the patient, is indeed a key challenge of our work.

There are of course many purposes of different types of dramatherapy, and I will not try to enumerate them all here. In my experience there are five general goals that dramatherapists attempt to achieve through interventions in-role. They are: (1) to help the patient tell his or her story or to solve a problem; (2) to achieve a catharsis of emotion; (3) to extend the depth and breadth of the client's inner experience; (4) to help the client understand the meanings of images, and (5) to strengthen the client's observing ego and mental flexibility. I will now describe eleven types of specific technical interventions that attempt to fulfil these goals. While the first seven are applicable to all types of role-playing, the last four are used in the developmental method and its more advanced form, 'Transformations', in which roles and scenes are constantly transformed and re-shaped according to the client's ongoing stream of consciousness and internal imagery. Highly improvisational methods such as these give the therapist a great deal of flexibility in altering elements of the drama.

Transformations is a technique designed to be an autonomous form of dramatherapy that operates fully within the dramatic and symbolic interaction between client and therapist. Here interventions in-role are the primary form of therapist influence. The flexibility of the improvisational procedures allows for an integration of the cognitive processing important in therapy with the spontaneous symbols arising from the drama. An example of Transformations will be presented in the case study.

INTERVENTIONS IN THE PLAYSPACE

1. Faithful rendering

This is used by the therapist in-role when the goal is to have the patient tell their story or try to solve a problem. The therapist tries to portray the character or image just as the clients want it to be, faithful to what really happened, or how the ritual is performed, or what the emotional conditions are. The therapist may have to 'check in' with the client, or have the client demonstrate or describe the story beforehand. In problem-solving approaches, for example, when a client is trying to become more assertive, and the scene is between him and his boss (played by the therapist), the therapist attempts to re-create the kind of problem or situation presented by the client to give them the opportunity to discover solutions. In improvisation, the therapist tries to faithfully portray the types of characters that the client indicates, matching the level of tension or conflict and depth of emotion projected by the client. Faithful rendering is a fundamentally empathic technique in which the therapist follows the client's clues, and does not attempt to alter the natural course of the scene.

2. Act completion

Here the therapist attempts to help the client complete an inhibited, suppressed act for the purposes of achieving a catharsis, followed by reparation. The wish to complete an unfinished action (what Moreno has called *act hunger*) is often countered by anxieties and fears. Inhibitions and impasses in the role-playing are signals of this stage. The therapist may decide to help the client follow through on this unfinished business and complete the act. Examples include saying goodbye to a dead parent, expressing anger at someone they love, or acknowledging a vulnerability in the self.

Example: Henry and the therapist were role-playing two friends who were out on the ledge of a cliff in the Grand Canyon. They had been arguing over many things, and Henry showed suppressed anger.

Henry:	So you go first, Bill.
Therapist:	No, it's too dangerous, and you have more experience.
Henry:	Oh, but it will be good for you. Don't worry, I'll be right behind you.
Therapist:	Really? And of course I can trust you.
Henry:	Oh, definitely.
Therapist:	I am safe in your hands, dear friend.
Henry:	Oh, yes.
Therapist:	(goes out on ledge, gets shaky, leans forward) Henry? Henry!?
Henry:	Yyarggh! (pushes therapist off the cliff)
Therapist:	(takes a magnificent fall and crumples into pile at bottom)
Henry:	(rushing to the aid of the therapist) What happened, dear friend?

Here the therapist volunteers for the role of victim, and offers Henry the opportunity to express a wish to kill. Later Henry was able to discuss his anger at people more directly.

The next five technical interventions are used for the purpose of extending the depth and breadth of the client's experience, and achieving a greater tolerance for the inner-world.

3. Defining

The therapist asks the client while in-role about an element in the drama that is yet undefined, bringing to the client's awareness a new aspect of the situation (see Johnson, 1989). The therapist leaves it up to the client to actually define the element's characteristics or identity.

Example: Ellen and therapist are on a journey.

Ellen:	Let's go up here.
Therapist:	Okay. You're sure?

Ellen: Yeh, even though it's muddy.
Therapist: I hope it's all right.
Ellen: Oh I suppose there might be snakes or creatures in the mud.
Therapist: Did you feel this?
Ellen: Yes, I can feel it.
Therapist: What is it? It's, it's . . .
Ellen: Yes, round and hard.
Therapist: Yes, let's pull it out.
Ellen: All right (both reach down and pull it out).
Therapist: Wow! I can't make it out exactly, it's round, it's a . . .
Ellen: A skull!
Therapist: Oh, my god!

The involvement, physicalization, and prompting of the therapist facilitates the emergence of more detailed imagery.

4. Repetition

Here the therapist in-role brings back a situation, image, conflict, word, or action again and again, so that the client has a number of opportunities to be confronted with it. Instead of moving on and avoiding a situation, the therapist underscores its importance, and places some pressure on the client to deal with it.

Example: John had difficulty accepting help from other people, even though he felt alone and complained about life a great deal. This pattern was evident in his role-plays. In this example, John and the therapist are playing room-mates fixing up their apartment.

Therapist: John, let me help you with the curtains.
John: No, thanks.
Therapist: But it looks like you need someone to hold up the end.
John: No, really I'm okay.
Therapist: (works on painting for a while) Oh, John, you've worked up a sweat, how about a soda?
John: Okay.
Therapist: Here's a Coke.
John: I don't like Coke.
Therapist: That's all we have.
John: Then skip it.
Therapist: All right. (works some more) Let me help you with that bookcase.
John: I don't need any help!
Therapist: Then let me help you with your homework.
John: What!
Therapist: Maybe you need help dealing with your Mum and Dad?

John: No, I don't. Besides, Bill, you're my room-mate not my therapist!
Therapist: Maybe you need help accepting help?
John: I can never accept help.
Therapist: Really? I'd like to help you with that, but I'm not your therapist.
John: Yeh, too bad. (laughs) Oh, how about helping me move this stereo?

The rapid repetition of an interaction at first intensifies the scene, then provokes a shift in the dynamics, and finally leads to the client's recognition of the problem.

5. Intensification

The therapist uses exaggeration, dramatic presence, physicalisation, or staging to heighten the power of a particular scene or image, in order to stimulate a greater depth of feeling in the client.

Example: Susan and the therapist were in a Transformations scene in which they were walking around the room.

Susan drops her arms down in a tired manner. Therapist drops his arms down and says 'Huh'. Susan repeats with 'Huh'. Therapist and Susan do this several more times, then the therapist lifts his arms up higher, pauses, then drops them down more forcefully. Susan follows suit with obvious involvement. This then develops into a movement image of taking something off a tall shelf, and smashing it on the floor. Susan shouts, 'Take that!' They repeat this motion and 'Take that' several times. Then the therapist lies down on the floor and shouts, 'No, don't hit me again.' Susan shouts, 'You deserve it!' and continues her action, while the therapist groans in pain. The therapist then used *defining* to help Susan determine who she was hitting, and the scene continued.

Here the therapist used physicalisation and personification of a role to intensify the effect in the scene. At times the therapist may also attempt to de-intensify a situation if the client is overwhelmed with affect.

6. Pre-empting

The therapist takes on the attributes, position, or even identity (as in Transformations) of the rigid roles typically taken by the client, in order to force the client into the complementary role he or she has difficulty taking. This form of role-reversal has the opposite effect of *faithful rendering*, in which the therapist allows the client to play the more comfortable role.

Example: John often took dependent or needy roles, or turned competent characters into needy ones. In this scene, he plays a client coming to a lawyer for help.

John: I really need your help. My neighbour is building a garage on my property!
Therapist: (as lawyer) That's terrible. Yes, I can help you. I assume you have the money to pay me?
John: Oh, yes.
Therapist: Oh, that's great. That's really great, because, I don't like to tell my clients this, but I really need the money. (whispering) Just between you and me, my practice has been suffering terribly recently. When I saw you come into the office, today, I just knew you'd be able to help me out.
John: Well, yes, I guess so.
Therapist: Thank you *so* much. (gets teary) And can you pay me weekly?
John: I should think so.
Therapist: Wonderful, I knew I could rely on you. (gets down on knees in front of John) You have saved me. Thank you, thank you!

Here the therapist pre-empts the needy, demanding role, forcing the client into the stronger, competent position.

7. Joining

The therapist takes on the attributes, position, or even identity (if allowed, as in Transformations) of the client's role or image. This may be done either to support the client during a difficult moment, or as a means of countering a repetitive split by the client, who keeps placing the therapist in rigid, antagonistic roles.

Example: Let's use the same scene as above with John.

John: I really need your help. My neighbour is building a garage on my property!
Therapist: (as lawyer) That's terrible. Yes, I can help you, because I know just what you mean. My neighbour is building a garage on my property, too!
John: Really?
Therapist: It's irritating, isn't it?
John: Yes, but what have you done about it?
Therapist: Nothing yet. Heh, maybe we should go in on this together, you know, a joint action or something.
John: Who would represent us?
Therapist: We. . .we'd have to go find a good lawyer.

Here the therapist has joined with the client and avoided playing the competent role to his needy one. Together they now go looking for the competent figure, transforming the dynamic between therapist and client.

8. Action interpretation

An action interpretation is used to increase the client's understanding of the meanings of their images. When one aspect of a scene is reminiscent of another issue in the client's life, the therapist transforms the scene to that of the other issue. It is difficult to do an action interpretation without the guideline that roles can be shifted during an improvisation. Thus action interpretations are most often used in the developmental method or Transformations, that is, open-ended improvisations.

Example: Jill was a 37-year-old single woman who had not been able to sustain a relationship with a man, and yet who strongly felt she should get married and have children. She just didn't understand why 'I drive men away'. This example begins in the middle of a Transformations in which they are playing two children in a sand-box.

Jill:	Voom, voom.
Therapist:	Da da, da da.
Jill:	Bom be bom bom.
Therapist:	Oh, look at that! (pointing to the ground).
Jill:	They're so small.
Therapist:	Yes, really really small.
Jill:	Very interesting (transforming to a more adult, scientific kind of character).
Therapist:	Hmm. I have not often seen this variety before (picks one up between thumb and forefinger to examine closely).
Jill:	(picking one up) Look at him wriggle! I think he's scared. (talking to the little creature) You have nothing to worry about, little one. (pops him into her mouth and swallows him with delight)
Therapist:	(doing the same) Yumm, yumm! Aren't they tasty! (they both pick up the little people and gobble them down)
Jill:	Look at them run!
Therapist:	They're scared now! Come on, men, run for it! She's after you! [This is the actual *action interpretation*, because at this point it is made clear that the scene is about men running away from her.]
Jill:	(with great delight) Ha ha ha! Can't get away from me! [Her reaction indicates that the therapist had actually sensed the confluence of these two themes, and as with many well-timed action interpretations, a burst of energy is released.]
Therapist:	(transforming into one of the men and running around the room, with Jill after him) Help! help!
Jill:	Come back, come back, I won't gobble you up. (they run around the room)

Therapist: Well that's how it feels, and besides I feel so small when I'm with you.
Jill: Honey, I want to be with you, but I need to be treated with respect.
Therapist: Sure, I'll be glad to treat you, from a *respect*-ful distance!

The action interpretation is possible because of the co-mingling of the dramatic world and the client's psychological world within the playspace. The issue Jill comes to therapy for emerges out of a sand-box, not the therapist's verbal analysis: a discovery sure to be most convincing.

The next three methods are used to strengthen the client's observing ego and flexibility to shift between involvement and observation. These are often used in Transformations.

9. Bracketing

This distancing technique involves a transformation of the scene by pretending it is not real, and instead is a play, a photograph, an audition, a performance, television show, etc.

Example: Mary and her therapist are in a scene between husband and wife.

Mary: You never say I love you any more.
Therapist: (as husband) I do too.
Mary: No, you don't. Say I love you.
Therapist: Well, of course I do, Honey, I, uh,
Mary: See, you can't say it!
Therapist: [*bracketing*] You did that quite well, Georgette. I think the scene really works. Right amount of intensity. We've got it down.
Mary: Great. Let's go through the scene one more time and we'll call it quits for today.

Bracketing psychologically places the client and therapist together as viewers of the scene while still role-playing within the playspace. They are *out* and *in* at the same time.

10. Transformation to the here and now

Here the scene is transformed into a commentary of what is really going on among the participants, like a process comment. The effect is the opposite of bracketing in that it decreases the distance in the session. Using the same example as above:

Example: Let's use the same scene as above with Mary:

Mary: You never say I love you any more.

Therapist: (as husband) I do too.
Mary: No, you don't. Say I love you.
Therapist: Well, of course I do, Honey, I, uh. . .
Mary: See, you can't say it!
Therapist: [transforming to here/now] You know why I can't say it, I'm your therapist!
Mary: I know that! But it's not fair. Why can't therapists express their feelings about us, just like we do about you?
Therapist: Standards! Ethics!. . .Fear! (at this point, Mary and the therapist break out into a song about malpractice)

Transforming to the here and now allows the client and therapist to discuss their relationship, or for the therapist to offer an interpretation of the transference, without leaving the playspace. Thus, they are both speaking about real feelings and role-playing at the same time.

11. Witnessing

This is a special technique of Transformations in which the therapist temporarily leaves the scene (often to a pre-arranged spot) to witness the client, who continues improvising. The therapist returns at a later time. Technically this is coming out of role and leaving the playspace, but because it occurs within the scene, the therapist's witnessing spot is experienced as within the playspace and many clients will relate to it during their time alone. Witnessing is a distancing manoeuvre that helps the client become aware of projected aspects of him or herself, via the 'look' of the therapist. The therapist uses the feelings that are evoked while watching the client as guides for re-entering. Thus, the therapist feeds back the projected parts to the client in bodily and dramatic form, rather than verbally, as it is done in authentic movement. An example of witnessing is provided in the case study below.

TRANSFORMATIONS

Before I present the case study, I will briefly review the background of Transformations (Johnson, 1991). Transformations is an improvisational technique that has been used in various forms for decades. It was first described by Viola Spolin (1963) in her book on theatre games, and was used by *avant-garde* theatre troupes in the 1960s.

Transformations begins by the two actors beginning a scene. How they start and how they select their initial roles is up to them. Then, during the enactment of the scene, whenever an action, posture, sound, word or anything about the scene reminds one of the actors of another person, or situation, he or she *initiates a transformation* of the scene by simply beginning to act as if they were in the new situation. The other actor picks up on the change and then selects a role in

the new situation also, though the initiator may have already selected the role for them, and the whole scene becomes transformed to the new one. The only rule is that each actor must go with the transformation and must not object or refuse to take on a new role. As the actors become more familiar with this method, they collaborate in creating the transformations so that the session has the seamless, flowing quality of free association.

The purpose of dramatherapy work of this type is to increase the client's access to and tolerance of internal states that have for various reasons been cast aside, labelled as unacceptable, or are seen as threatening. The technique is really free association in drama, similar in many ways to authentic movement (Adler, 1985; Bernstein, 1985), or Jung's active imagination method (Chodorow, 1986, 1991). The therapist's major responsibility is to enhance the client's journey, to expand their capacity to experience, and to seek out critical, super-ego elements that are obstructing acceptance and forgiveness.

CASE EXAMPLE OF A DRAMATHERAPY SESSION

The following is a transcript of a dramatherapy session from my private practice. Parts of the session have been revised to protect the client's identity. Elaine is a 36-year-old woman employed as a therapist, who had come to me because she felt depressed, had a problem with over-eating, and had lost interest in sex with the man she had been living with for several years. She had been sexually abused once by her father when she was about ten. She had no children, but had had two abortions about which she felt very ambivalent. I had been meeting with her for several months, and she had become very comfortable with the transformations. She had made substantial progress and at the time of this session was feeling much less depressed. Our sessions had evolved in structure so that the transformations began as I opened the door to the office. Specific interventions will be identified in italics.

Knock on door. Therapist opens door.

Elaine: My word!
Therapist: My word!
Elaine: *My* word (entering room).
Therapist: (laughing to self) No, no, it's *my* word. [*faithful rendering*]
Elaine: No it's not, that's *my* word (pointing to a spot on the floor).
Therapist: That? Are you kidding? That word there, is *mine*. I put it there only yesterday.
Elaine: Then what about *that* word?
Therapist: No, mine.
Elaine: Or that? (going around the room frantically).
Therapist: Nope.
Elaine: Then where is my word?

Therapist: (shrugs shoulders)
Elaine: I can never find the right word.
Therapist: For what?
Elaine: For it. (makes large, vague gesture)
Therapist: For *it*? [*defining*]
Elaine: Yes, for it. (look at each other mysteriously)
Therapist: Well, what *is* the word for *it*?
Elaine: (shrugs shoulders and opens mouth)
Therapist: (opens mouth, tries to talk, nothing comes out) [*joining*]
Elaine: (whispers) I'm speechless!
Therapist: Me too. (Therapist and Elaine try talking, showing distress that they cannot speak. They begin to signal each other with their hands in strange ways. Gradually, guttural sounds begin to emerge, gibberish that grows to sound like bubbling noises. Their hands move like they are swimming, then like they are treading water.)
Both: Ohhhhhh!
Elaine: It's hot!
Therapist: It's boiling!
Elaine: Oh my God, we're being cooked!
Both: Help! help!
Therapist: What's this? (holds up something) [*defining*]
Elaine: It's a potato.
Therapist: You mean we're soup?. . . Whose soup?
Elaine: Hers. (pointing in corner)
Therapist: (transforming to witch) Ha, ha ha, my my my, aren't you going to spice up my brew, Honey! [*faithful rendering* – Elaine often played these masochistic, victimised roles]
Elaine: Oh please Gertrude, please don't cook me!
Therapist: Why not, you little twirp?
Elaine: I haven't done anything.
Therapist: Oh yes you have! (therapist puts spices into pot and stirs) [*act completion*]
Elaine: Oh! Oh! (in different tone, more enjoyable, she wriggles comfortably) What have I done to deserve *this*?
[This was an advance for Elaine, who had had difficulty turning negative, victimised images into positive ones. In this case, it even had a sexual connotation.)
Therapist: (changing tone) Why, Honey, just being you. [*faithful rendering*]
Elaine: (smiling) This feels wonderful.
Therapist: I knew you'd like the jacuzzi, isn't it great?
Elaine: Can you put a little more bubble-bath in, Dear?
Therapist: Sure. (goes to other side of room to put away bubble-bath)
Elaine: I'm done. What should I do with the bath water?
Therapist: Oh just throw it out.

Elaine: (picks it up and throws it in corner) I hope I didn't throw the baby out with the bath water! (laughs)

Therapist: (turning, looking very serious) Honey, did you throw the baby out with the bath water? [*intensification* – Elaine had worked on her feelings about the abortions many times, and had felt terribly guilty about them. Her humorous way of bringing them up was striking, so the therapist decided not to let it pass.]

Elaine: Oh, I, oh, I . . .

Therapist: You didn't! (rushes over to corner with Elaine; both gasp). You DID! [*act completion* – The therapist felt it was important to acknowledge the act, so that the full intensity of the experience could be evoked.]

Elaine: I'm so sorry!

Therapist: I can't believe this, this is the fifth time you've done this. Look at all those dead babies. You should feel ashamed of yourself! [*intensification*]
(both now walk around the room in despair) What are we going to do?

Elaine: I just had to do it.

Therapist: You had to do it. Really, and what do *they* think about *that*?

Elaine: I don't know.

Therapist: Well, then, why don't you go over to that dead baby corner and find out! (Elaine goes over, and therapist leaves to the witnessing circle – a section of carpet) [*witnessing* – Having evoked the anxiety situation and the internal self-criticism, the therapist heightened the tension by leaving her alone with her 'deed'. He wondered what she would do.]

Elaine: (turns around in middle of room, sighing) Ohhh, (drops down onto floor) I'm dead. She killed me. (silence) I'm dead. She killed me. (long silence, turns on floor, sighing) Please! Please! Take me back, Mummy! (begins to reach out into space, her eyes are closed) Pleeaase, take me back Mummy! (turns again to therapist, and reaches out toward him) Please, please, take me back, take me back! (she cries, while still reaching toward the therapist, the reaches now turning into grabbing motions, which she expands into a motion of grabbing food and stuffing it into her mouth. She continues this with great energy, stuffing herself more and more, grunting, acting as if she is growing fatter and fatter. She leans back and rubs her tummy as if it is huge, and lets out a monstrous growl, standing up with arms out, and begins to stomp around the room.) Pow, pow, boom boom, (laughs) I am a giant, take that! (stomps on floor – clearly image of stomping on little people)
[The transformation from guilt over the abortion into reaching out for her mother, into filling herself up with food, to becoming a

powerful, mighty giant, showed a great deal of flow, indicating minimal inhibition. This was the first time she had actually played the babies. The therapist decided to join her after the scene had transformed. He was particularly taken with her willingness to represent the issue of fatness/pregnancy/female power.]

Therapist: (enters also as giant) Pow, booom, (Elaine laughs) Hi Bertha! Heh, this is fun. . .squish! [*joining*]

Elaine: Yeh, boom, boom.

Therapist: Boy, are you fat! I've never seen you looking so good. [*action interpretation* – This paradoxical use of humour pointed out to the client that her over-eating was connected to the issue of her sexuality, and at the same time supported tolerance of the issue.]

Elaine: Yeh, and aren't you fat? God you look great!

Both: (laugh)

Therapist: Oh we're fat! (begins to sing; Elaine joins) [*intensification*]

Both: Oh we're fat, oh we're fat, it's so great to be fat. . .if we weren't fat, we'd have to be bad. . . (they dance together in a ridiculous way, then begin to hum) mmmmmm, mmmmmm! *bad* . . . (The tone begins to change into a lower pitch, which quickly becomes more ominous. As they keep moving back and forth, holding each other by one hand, they begin to look over their shoulders furtively.) Mmmmmmm, ooooohhhh, oh! (they look and see something horrible) Ahhhhh!

Therapist: Run for it!

Elaine: Hide, hide, it's going to get us!

Therapist: Where are we going to hide?

Elaine: I don't know, we can't hide from ourselves.

Therapist: (stops and motions Elaine over; whispers) You don't mean that this improvisation really represents our running away from the fat, ugly, or destructive parts of ourselves, do you? [*transformation to here/now*]

Elaine: Could be.

Therapist: Oh, I don't think so. How can you hide from yourself?

Elaine: I've been doing it for years.

Therapist: (turning outward to room) Ladies and gentlemen, I would like to introduce to you, the one, the only, a spectacle beyond belief, yes, the woman who can hide from herself! (applauds) [*bracketing*]

Elaine: (runs around, turns around quickly in place, puts hands over eyes, puts head under a pillow, crosses her arms over her genitals)

Therapist: Yes, ladies and gentlemen, this woman has been hiding important parts of herself, from herself, things so obvious to you and me, things anyone should know, but no, she hides from them, yes, she hides them from . . .whom? But why? Why, ladies and gentlemen? Well, let's ask her. . . (he turns and pretends he doesn't see her; she

moves around room as if to avoid him; he begins to stalk her) Where is she? Where are you? You, who . . .Where are you? (Elaine now sits in a corner of room, fiddling with the carpet) Where are you, Suzy? (pretends to knock on door) Suzy, let me in so we can play. [*action interpretation* – The imagery of hiding developed a sinister quality that evoked in the therapist a feeling that he was the evil one she was hiding from. He realised this might be related to the father-image and the sexual abuse.]

Elaine: I don't want to, Daddy.

Therapist: Come on, Suzy, let Daddy in, he wants to play with you.

Elaine: (both as Suzy and herself) We always get back to this.

Therapist: (both as Daddy and therapist) Yes, that's true. This is what is called an 'early childhood trauma', Suzy. [*transformation to here/now* – This interpenetration of dramatic role and real self is characteristic of a successful creation of a transitional space, in which the drama is sustained and at the same time the therapist and client are talking directly to each other.]

Elaine: I know, Daddy, but do I have to go through it again?

Therapist: Don't worry, Suzy, you will be able to work it through in your therapy years from now. You'll want to have enough material for the sessions won't you? [*transformation to here/now* – Through this somewhat provocative humour, the therapist communicates that traumas are part of any human life. He also makes reference to an earlier concern of hers, that she wouldn't have enough to say in their sessions.]

Elaine: That's outrageous! (comes to the pretend door, opens it) Listen, you daddy-therapist you, you think I make these things up just to entertain you? Well, leave me alone with my own traumas, I can deal with them myself!

Therapist: (leaves to the witnessing circle) [*witnessing*]

Elaine: Good riddance! (wipes hands, looks down at them) Blood. Blood on my hands. (looks over at therapist) Blood everywhere. A bloodbath. Hum. Maybe it's my blood (goes over to wall and rubs hands on wall, then rubs both hands at once, then begins to hug the wall softly, places her cheek against wall; silence) I want to go back in. I am going back in. (Turns and crawls under a big pile of pillows; silence; then peeks out at therapist, then extends a hand through the peekhole like a tentacle, then retracts it; long silence; therapist enters quietly and sits near the pillow pile)

[Elaine again shows a remarkable ability to stay with her associations, and again the image of a retreat to a mothering presence emerges. The therapist senses her wish to have him come to her rescue, an often repeated pattern.]

Therapist: Hmmmm (sternly). My client has gone back to the womb. As a

result of my work, she has regressed terribly. I therefore have failed. [*pre-empting*]

Elaine: (begins humming to herself, obviously trying to drown out the therapist) Hmmmmmm, hmmmm!

Therapist: It must be safer in there than out here with me, can you believe that? Where did I go wrong? How have I frightened her? Answer me, someone, give me some advice!

Elaine: I want you to take care of me, but you are my therapist, so I have to take care of myself.

Therapist: Hmmmm. That's probably good judgement. I have another interesting clinical case to present to you today, of a therapy that's reached an impasse. This is a woman who takes complete care of herself because she can't get what she wants from her therapist. Every time she wants him, he reminds her of terrible people. [*bracketing*]

Elaine: That's right! (gets up holding several pillows around her 'for protection' and walks around the room)

Therapist: You can see, for example, that she carries her nurturance around with her. (Elaine has trouble holding all of the pillows, and drops several, picks them up with difficulty) Let's see what happens when someone offers to help her. Maam, may I help you with your nurturance? [*faithful rendering*]

Elaine: No thank you, I'll keep my nurturance to myself, if you please.

Therapist: I beg your pardon. Where did you get all this self-nurturance?

Elaine: Why, at mother mountain.

Therapist: Really, can you take me there?

Elaine: Sure, follow me. (They walk around and then go to the pillow pile. Elaine puts rest of pillows together and sits on top.)

Therapist: Can I join you?

Elaine: Sure, come up here.

Therapist: Wow, you can see a lot from here. It's nice to know that there is a solid place like this around. How long has this been here?

Elaine: For generations. My grandmother lived here for many years, and I would come to her when I was frightened or worried, and she would comfort me. She was like a mountain!

[This was new information for the therapist, who had not known of the positive influence of her grandmother.]

Therapist: What's that place? (pointing to the corner where she had hidden) [*defining*]

Elaine: Oh, that's the hideaway, that's a great place where I can go to get away from it all. Works like a dream.

Therapist: And that?

Elaine: Oh, that's the dead baby corner.

Therapist: It's so dark there.

Elaine: Yeh, not as dark as it used to be. A sad place, for sure, but I realise it's a part of me.
Therapist: What do you mean?
Elaine: Well, these are all parts of me. (gestures to the room)
Therapist: No! You mean mother mountain, the hideaway, and the dead baby corner are parts of you? Forget it. They are *out there*, not *in here!* (pointing to her) [*intensification*]
Elaine: I wish you were right, but it is an inescapable conclusion.
Therapist: I thought we just made it up. . .Well then, how are they related to each other?
Elaine: I'm not sure exactly, that's why I came to see you (laughs).
Therapist: Okay, hmm, we could measure them.
Elaine: Great idea! (leaps off pillows and goes over to hideaway and pretends to measure it with a tape-measure. Therapist follows, and they both scurry around taking measurements, mumbling numbers to themselves, and then both begin to write numbers and strange symbols on the blackboard, until there is a messy, complicated diagram.) [*joining* – Jointly, client and therapist are making fun of their own attempts to understand, and in so doing acknowledging the limitations of their profession, and more specifically, that Elaine is not ready to connect these parts of herself without intellectualising.]
Therapist: Well, there it is.
Elaine: Perfect understanding.
Therapist: It's amazing that we achieved so much after, literally, *minutes* of psychotherapy!
Elaine: Yeh. really, you know, I'd like to hear you summarise it for me, you know, your *formulation* (sarcastic).
Therapist: No, I think that's something that *you* would gain a great deal from, since you're the client.
Elaine: But I'm paying *you*, and I want a report, *doctor*.
Therapist: Okay, after all, it shouldn't be much trouble. Hum, (looks at diagram) well, let's see. I (laughs) can say that, uh. . . (becomes silent, mouth opens but nothing comes out)
Elaine: My word, he's speechless. (laughs)
Therapist: Nope, that's *my* word! (both laugh)

Discussion

Throughout this session the therapist acted as a guide who travelled with the client through her inner landscape, which consisted of memories of the past, current conflicts, and feelings about her therapist. The therapist tried to help her keep in touch with her stream of consciousness, at times underscoring and intensifying images, at times helping her to link different meanings between

themes, and always trying to increase the depth and breadth of her experiencing – to allow the most enriched and variegated world to emerge. Maintaining a playful, humorous, and intimate environment sustained the 'transitional space' in which inner and interpersonal worlds combine (Winnicott, 1982). Merely by allowing these processes to continue most freely, the healing message is given: you are right, you are filled with many things, good and bad, and you can live with them all. The discovery of oneself and achieving forgiveness for being human is the intended result. Elaine used this and other sessions to acknowledge her feelings about not having children, her fears that such a decision would be a rejection of her mother and grandmother, and her doubts as to whether her career was enough to fill her life.

CONCLUSION

Dramatherapists effect change in their clients through a variety of techniques and a variety of modes of participation, ranging from positions at great distance from the playspace, to those completely within it. I have reviewed several specific interventions dramatherapists can make within the playspace and within a dramatic role. There are no doubt many others. The case example of Elaine illustrated the advanced technique of Transformations in facilitating self-acceptance and enrichment of the three worlds we live in: the imaginative, the psychological, and the social.

Nevertheless, perhaps we tend to take improvising with clients for granted, and a more in-depth analysis of what we actually do, and when we should do it, will be helpful in training. In my experience, working with the client in-role can be a very powerful process if practised with care and respect for the client. With experience, the therapist can maintain intimate contact with the client and still have plenty of 'headroom' to be thinking about the process. The achievement of this participant-observer status, or aesthetic distance (Landy, 1986) on the part of *both* the therapist and the client is an important step for them in their healing journey together.

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