

Chapter 5

DEVELOPMENTAL TRANSFORMATIONS IN GROUP THERAPY WITH THE ELDERLY

David Read Johnson, Ann Smith, and Miller James

This chapter describes the basic principles and methods of a play therapy modality, called *Developmental Transformations*, with elderly populations. We attempt to communicate the potential significance of play with the elderly and illustrate these methods by several case examples.

PLAY AND THE ELDERLY

The elderly is such an interesting term for a condition that clings to ambiguity and contradiction. Perhaps it refers to a certain age in years, such as 70 or 60 or (God forbid) 50? Perhaps a state of infirmity or illness or weakness is implied: To be elderly means to be sick and old. Or, perhaps it is merely a state of mind involving feeling that you have lived long and seen much, whether that is accompanied by fatigue or exhilaration. Being elderly is a mixture of being wise and old, sick and immune-contradictions that can give rise to either irony or annoyance.

The term *play* similarly slips through our grasp: Play can mean a game or hobby or interest that is taken very seriously. Play can mean being "playful," which means not taking things very seriously. Some play/creative therapists use play to access serious issues, while others attempt to achieve a state of playfulness as an end in itself. These attitudes roughly correspond to adopting a tragic versus a comic view of life.

In our American culture, adults are subject to social constraints regarding their display of seriousness and playfulness: To be too serious is often seen as a sign of

anxiety, difficulty, or rigidity; while being too playful leads to not being believed, trusted, or authorized. Paradoxically, the elderly are less subject to these constraints because of the perception that they are no longer upholding the economic or social structure of society. Thus arises the common stereotype of the rigid, old person "set in his ways," the curmudgeon who insists on repeating the same things each day, expounds worn-out opinions and stories, and views the world concretely, in all senses of the word. Death and stillness surround this stereotype: sitting in his chair, lying in her bed, waiting. Against this stereotype is contrasted another—that of the youthful, playful, whatever-may-care elderly, who tell off-color jokes, encourage young people to take risks, travel to far-off places, and embrace spontaneity and surprise, usually to the delight of others. It is not unusual for these elderly to be featured at the end of the nightly news shows; the message is that a person can be victorious over death—he or she can spit in the face of destiny. Between these mostly imaginary stereotypes lies the quiet playfulness of many older people, who find a mixture of spontaneity and custom in their activities of gardening, fishing, carpentry, or knitting, activities lying somewhere in between work and play, craft and improvisation. Thus, we reluctantly return to the notion—though we can cite no research—that the elderly may be no different from younger adults or even children in the range of their playfulness.

The position we take in this chapter is not that the elderly are in need of play, or that play can be used as a method of processing serious concerns, but rather that each person may have areas that are not allowed entrance into a *playspace*; that is, are not permitted the natural transformations of perspective, meaning, and development. Our task through a play therapy approach is to gently dislodge their grip on this sustaining framework, giving permission for the elderly to more fully enter the natural flow of time and being in which each of us is suspended.

DEVELOPMENTAL TRANSFORMATIONS

Developmental Transformations is a method of drama therapy that uses free play as a central concept (Johnson, 1982, 1991, 2000; Johnson, Forrester, Dintino, James, & Schnee, 1996). As such, Developmental Transformations can also be seen as a play therapy method. The method was developed out of creative arts therapy work with a number of clinical populations, including the elderly (Johnson, 1985, 1986; Sandel & Johnson, 1987; Smith, 2000), schizophrenics (Johnson, 1984; Schnee, 1996), and veterans with combat-related posttraumatic stress disorder (Dintino & Johnson, 1996; James & Johnson, 1997). It is also currently applied in individual therapy with normal-neurotic adults (Johnson, 2000). The approach has been deeply influenced

by dance therapy (Johnson, 1993), experimental theatre (Grotowski, 1968; Spolin, 1963), educational drama (McCaslin, 1990; Way, 1967), and play therapy with children (Axline, 1989; Schaefer & O'Connor, 1982).

Over the course of development of this approach, numerous theoretical perspectives have been incorporated to understand the processes involved. These have included the psychological perspectives of cognitive development (Piaget, 1951; Werner & Kaplan, 1963), psychoanalysis, particularly free association (Freud, 1920/1966; Kris, 1982), object relations theory (Jacobson, 1964; Klein, 1932), client-centered therapy (Gendlin, 1978; Rogers, 1951), authentic movement (Whitehouse, 1979), and dance therapy (Sandel, Chaiklin, & Lohn, 1993); philosophical perspectives of existentialism (Sartre, 1943) and deconstruction (Derrida, 1978); and the spiritual perspective of Buddhism. These widely divergent sources have been used to understand aspects of the therapeutic method, concepts of the self-structure, and images of being.

The work with elderly populations has been conducted largely in nursing homes and senior centers, and was influenced by many previous contributors to the use of the arts with the elderly (Caplow-Lindner, Harpaz, & Samberg, 1979; Weisberg & Wilder, 1985; Weiss, 1984). Developmental Transformations was initially conducted in small groups, but has since been applied to individuals, large groups, and milieu/community interventions (Sandel & Johnson, 1987). A training institute has been established to provide in-depth training in the method to clinicians with the appropriate background, though many of the basic clinical principles can be easily applied by any play-oriented therapist.

THEORETICAL RATIONALE

The central concepts of Developmental Transformations include (a) the playspace, (b) embodiment, (c) encounter, and (d) transformation.

The Playspace

The *playspace* is the mutual agreement among the participants that what is occurring is in play. The playspace is the container of the entire therapeutic action in Developmental Transformations. Verbal discussion or processing occurs in the playspace, not at the end of the session outside the state of play. The kind of play that takes place in the playspace is free improvisation, in which clients are asked to play out dramatic movements, sounds, images, and scenes based on thoughts and feelings they are having in the moment. Thus, as these thoughts and feelings change, the scenes, characters, and actions change. Similar to meditative practice, the client is asked to allow thoughts and feelings to arise, to engage with

them, and then to let them go as others arise. In Developmental Transformations, this process takes place in an embodied, interactional, and dramatic form, rather than sitting in silent meditation.

Inevitably, thoughts and feelings arise that do not seem playable to the client. The therapist's job is to help the client maintain the state of play through these moments, often by temporarily shifting to other images. Over time, the goal is for the client to be able to play with the unplayable. The play process serves the deconstructive process, largely through repetition. As difficult issues repeatedly arise, are then avoided, and are then addressed again, the client and therapist find ways of playing with different aspects of the issue until, with time, the issue becomes like a cliché and loosens its grip on the client, who eventually lets what is to come next arise.

The playspace is defined by three fundamental and necessary conditions. First, there must be a *restraint against harm*. When playing with someone who pushes a little too hard or gets a little too angry, we say, "Hey, that was too hard, remember it's only pretend!" and thus articulate a boundary condition. Play ends when harm occurs; play deteriorates rapidly when harm is possible. Thus, in our work, when clients fear harm, when the action is getting "too real," their energetic presence diminishes and their playspace shrinks. These are signals to the therapist. When the playspace is strong, more intense issues can be represented, including aggression, hate, sexuality, love, and intimacy. Representing love or horror is not equivalent to living love or horror.

Second, the playspace is a *mutual agreement*: A person cannot be in a playspace alone. When we play together, we look to see confirmation from the other that he or she understands that we are pretending. In this way, knowing that the other is in play with us is the playspace. If the father wearing a mask sees that his young child seems intimidated or afraid, he moves the mask more to the side, revealing more of his face, until he sees the recognition by the child that it is Daddy under the mask. Once this mutuality has been reestablished, the play can continue.

Third, the playspace is intrinsically a *discrepant communication*, meaning that reality and fantasy (and thus the boundary between them) are revealed simultaneously. In the previous example, the father shows both the mask and his real face; in theatre, the proscenium stage frames the imaginal world of the play. Other activities such as magic, lying, or disguise attempt to reduce the discrepant elements so that a person is made to believe that what he or she sees is real. Play, on the other hand, is a lie that insists on revealing itself as a lie. To be in the playspace is to know the boundary between fantasy and reality.

Together, these three characteristics—restraint from harm, mutuality, and discrepancy—provide a basis for the proposition that the playspace, as defined here, has a moral or ethical dimension (Johnson, 2000).

The next three central concepts of Developmental Transformations are derived directly from the notion of the playspace, expressed in the arenas of the body, interpersonal relationships, and the process of development.

Embodiment

Developmental Transformations places value on the body as the source of thought and affect. Following Piaget and other developmentalists, this method uses body activation to evoke sensorimotor, then imagistic, and, finally, lexical representations of thoughts and feelings, and it attempts to maintain an energetic, physicalized environment in which the therapeutic process unfolds. Using embodiment as a foundation for interventions provides a concretization that many clients benefit from; it tends to minimize intellectualization and avoid well-rehearsed schemas that are often verbalized; and the stimulation of kinesthetic sensations often evokes unique imagery and memory that may not otherwise be accessed.

Encounter

Developmental Transformations also places value on the exploration of the interpersonal encounter among group members and with the therapist. The content of the play may initially involve generic problems in interpersonal relationships, then more specific matches and/or mismatches among individuals' social roles, and eventually move to the deeper existential anxieties of being in the presence of another, of being seen and grasped by another consciousness. Because of this emphasis, the therapist joins the client(s) in the playspace, allowing them to use him or her as their *playobject*. Real objects or props are not used in this method because they serve as displacements from potential interpersonal encounters (Johnson et al., 1996). Here, it is the therapist who becomes the client's projective playobject, or toy.

Transformation

The principle of transformation is embraced because the stream of consciousness, the flow of images and feelings, is always changing. Thus, as images and roles arise and are played with in the therapy session, the method allows for and encourages the letting go of these scenes and ideas so that the next ones pressing for expression can be acknowledged. In this sense, the aim of the work is not to crystallize core issues or explore specific problems, but rather to achieve a certain success in tolerating and being with a person's own and the other's embodied presence. Thus, the method attends to those moments when the play becomes

stuck or impeded, called *impasses*, and attempts to help the participants discover or rediscover their freedom within these intimate bonds.

Summary

For elderly clients, these principles are directly relevant to their major concerns. Embodiment immediately confronts the elderly client's attitude toward his or her own body, including fears of illness, limitation, disability, and ultimately death. Asking a client to move his or her arm may bring up worry about pain or memories of times when movement was a joy. Movement also has meaning in terms of life, for the dead do not move; to move even just a little is to defy death.

Encounter raises issues of presence, of being gazed at and grasped by another. Fears of being ignored, "treated like furniture in the hall," objectified by medical personnel, being hidden from sight, being a burden to their families, being a "has-been," wishing to disappear—all are potential reactions of elderly clients to being encountered. Pride and humiliation are the coin of this realm, and they can cripple interpersonal relations.

Transformation is change, development, and growth—all threatened by age and disability. Why not narrow your field to what is safe and known; why not play the same song now, until the end; what is the point of being spontaneous, now? Each moment in a session when a transformation occurs, clients are asked to let go of a previous image or scene and embrace a new one, not yet fully known. The desire to hang on, to maintain, to hold tight, is tested numerous times in each hour. Each passing image must be mourned, when many have had enough of mourning.

Therefore, working toward embodied encounters in the playspace could be seen as the opposite of dying, that immobilized, unseen, unchanging still point that we imagine is waiting for us.

IMPLEMENTATION: CLINICAL PRINCIPLES

Establishing the Playspace

The therapist's main task is to help the client enter and remain in the playspace. Important in this process is the healing charisma of the therapist, who, by showing spontaneity, creativity, and humor, encourages the client to engage in the imaginal realm. Rather than encouraging participation in play from the sideline, the therapist represents himself or herself more as having come from the imaginal realm, and reaches out to the client, encouraging him or her to follow, as Alice follows the Rabbit down the hole. The therapist must find some symbolic

means to indicate to the client that he or she is partly "elsewhere." This can be a colorful item of clothing, a manner of speaking, or posture. Because the play-space is established as an understanding between participants, it is important that the therapist draw clients into a play mode and get their acknowledgment that they are there. Over time, this activity on the part of the therapist helps create what we call a *therapeutic persona*, consisting of both real and imaginal components (Johnson, Agresti, Nies, & Jacob, 1990).

Throughout the therapeutic process, the therapist begins where clients are capable of playing and moves into territory that they have had some difficulty playing with. These areas are inevitably more personal concerns about their current situation; relationships with loved ones or authorities; fears of illness, disability, or death; or painful memories. In this sense, it is not accurate to say that the playspace is a pretend space, for what will eventually be played with are very real things.

EXAMPLE

In one nursing home, the drama therapist had to go room to room to gather the clients, all of whom were in wheelchairs. This was a laborious process, made more burdensome by numerous obstacles that the clients, staff, and families placed in his way. The more serious he became about this problem, the larger the problem grew. One day, simply out of a feeling of surrender, as he was meandering down the hallway, he shouted out, a bit too loudly, "Drama therapy group!" in a somewhat singsong manner. To his surprise, one of his group members, supposedly deaf, shouted back from her room, "Drama therapy group!" As the weeks went on, the therapist incorporated this "gathering song" and soon not only clients but also staff members responded to him, and "Drama therapy group" could be heard in call-and-response form, all along the corridor. Now resistance diminished, and nursing staff volunteered to wheel clients to the room, all the while basking in the belief that the drama therapist was obviously a silly person. Ironically, the breakthrough occurred exactly when the therapist was no longer afraid of being seen as a silly person, and his status in the institution rose instead.

Engaging Clients in Bodily Movement

It is critical in this approach for there to be bodily movement. Because, for many elderly clients, so much of their lives has become absent, establishing their presence becomes an essential intervention. The awareness of presence is facilitated by moving your body, and by witnessing others move their bodies. Bodily movement also allows the therapist to track more accurately the flow of energy in the

clients, for after each intervention or introduction of a new element, the rise or fall in the group's energy is the determining factor in the therapist's next action.

Group sessions, therefore, nearly always are begun in wordless movements in unison and allowed to develop from these movements. The therapist attends to the qualities and variations in movement qualities of each member, picking up silently on them in his or her own movement. The therapist models being embodied throughout the session. As images and, eventually, verbalization emerge from these movements, movement is maintained. For example, the therapist may be in the role of an incompetent medical doctor when a client reports a real memory of a past medical complication. During the verbalization, the therapist maintains his gestural/postural behavior indicative of his imaginal role to sustain the possibility of engaging the client in the ongoing scene. The real memory is not transformable, because it occurred; however, the situation of the memory can be incorporated into the scene with the therapist/doctor, allowing the thoughts and feelings associated with it to enter the playspace.

Client: (Reporting a real story.) "And then the doctor took out the needle and dropped it on the floor, and I saw that the nurse looked at him as if he was a klutz and had done this many times before."

Therapist: (As doctor, using a funny voice he had been using for the character.) "That's terrible, John. Now in my case, I have never dropped equipment. Let me show you."

Client: "I guess so, but you have no idea how I felt; I wanted to knock his block off!"

Therapist: (Pretending to pick up some equipment and then dramatically dropping it onto the floor.) "Oops, these electrodes go somewhere (turning to another client); can you hold these electrodes? Which one is the red one?"

Client: "You're just like him, an idiot!"

Therapist: "Now, John, steady now, this won't hurt much, if I can just find the red one."

Client: (Pretends to bop the doctor over the head with a club. The doctor falls to the floor.)

Therapist: "Nurse! What happened? Where's the red one? Who's the patient?"

Emily: (As Nurse) "You are, you idiot! Come on everyone, let's hook him up!" (Several members put pretend electrodes on him.)

John: (Delighted) "Ah, and I found the red one!" (Putting it on him.)

The therapist successfully brings a personal memory into the playspace, allowing the client to more fully embody the feelings inherent in the memory.

Despite the value of the actual, reported memory, the goal in this method is to sustain the transformative potential of each person's underlying flow of affect and imagery.

Being Available as a Playobject

The reverse transference, which has been noted by clinicians working with the elderly (MacLennan, Saul, & Weiner, 1988; Meerloo, 1955), occurs when older clients project not only parental but child images onto their therapists, who are often much younger than they are. However, we have found that the reverse transference is merely one aspect of a more general condition: that elderly clients tend to express interest in their therapists. (All clients have interest in their therapists, but perhaps elderly clients feel less constrained to express it.) This natural arrangement is incorporated by the Developmental Transformations therapist in taking on the role of the client's playobject (Johnson, 1992).

By allowing and encouraging clients to express and expand on their thoughts and feelings about the "therapist" as a persona in the playspace, often a great deal of energy is mobilized that is highly revealing of the clients' issues, concerns, and strengths. This process also allows the therapist to be directly engaged in the dynamics of a relationship with the clients, which provides him or her a great deal of therapeutic power. Once a particular therapeutic persona has been sufficiently developed and invested in by clients, the therapist's task is to heighten their encounter with it by presenting the character to them with greater intimacy.

For example, in one session, the clients had often expressed interest in why the therapist had not had any children, and thought that he should have some soon. The therapist attempts to move this real concern into the playspace.

Therapist: "Well, perhaps you're right, I should have a child."

Client A: "Good! Tell your wife to get on it right away."

Therapist: "Don't you think I'd be a great father?"

Client B: "Excellent."

Therapist: "In fact, I plan to raise the child myself, because my wife works."

Client C: "Men don't know how to raise young children."

Therapist: "Yes, but I am a modern man (laughter). I can do it. Let me show you! Someone give me an infant."

Client C: "I wouldn't give you mine."

Therapist: "No, really, here is one. (Pretends to hold a baby, which he does in a particularly awkward manner.) Now let's see, I know, I'll change its diaper!"

Client B: "This is going to be a disaster!"

Therapist: (Showing difficulty, nearly drops the baby.) "Oops. That was close."

Client A: "You remind me of my husband. I didn't let him in the same room with our daughter until she was two."

(Other clients begin to comment on their past child-rearing memories, as the therapist continues to work with the child. Eventually, he passes the pretend baby around the circle, as each one demonstrates a child-care activity such as feeding, diapering, or disciplining. Past (real) and present (imaginal) are woven together. The therapist's tolerance of the clients' interest in his real life has been turned into a deepening of the playspace and a revelation of the clients' real lives. The therapist's self-disclosure has remained minimal and of a generic meaning.)

In general, the therapist's countertransference and/or real characteristics can be used as stimuli for the clients' play. What guides the decision of the therapist is whether the image facilitates the flow of energy in the play. Thus, as long as the therapist attends to the clients' response to the emergence of a particular image or situation, the source of it (client or therapist) is less relevant.

Establishing Nonlinear Norms

Developmental Transformations seeks to establish a nonlinear process, in which the roles, stories, and images that are currently being expressed and played with are open to be replaced by those that are emerging, even if such replacement appears to disrupt a meaningful, sequential story. It is therefore essential that the therapist be attentive not only to what is being played with (*the existent*), but also what is about to rise up from within group members (*the emergent*). The emergent images are often first seen as discrepant variations in current roles or stories. These discrepancies become the material that the therapist uses to shape the next intervention. Thus, typical dramatic structures such as plot, consistency of character, storyline, ending, moral, and climax-denouement, are intentionally disrupted through such methods as repetition, transformation of the scene, introduction of divergent elements, and shifting attention to discrepant elements in a scene. As the therapist brings attention to the emergent images, he or she helps the group let go of the existent scene to fully embrace what is coming. This method thus differs from others that use convergent interventions to reduce discrepancies in the service of maintaining the organization of the play.

EXAMPLE

In the following group of elderly clients, a family scene was being enacted.

Therapist: (As son) "Dad, I am old enough now to take the car out by myself."

George: (As father, sternly.) "You may be old enough, but you are not responsible."

Therapist: "Oh, Mom, please let me!"

Emily: (To father, smiling.) "Now, dear, aren't you being a little harsh?"

George: "Harsh? Am I being harsh?"

Therapist: "Harsh?" (A feeling of some levity springs forth among the group; the repetition of the word *harsh* and the incongruent giddy feeling are indications of an emergent image; the therapist attends to these.)

Emily: (Looking at therapist, but speaking about George.) "He's always been a little *harsh* with me." (At this point, two members of the group giggle; Emily is positively seductive.)

Therapist: (Softly) "Why, Mother, it's always been so easy to be *harsh* with you."

Emily: "Son, you are so *fresh*!"

George: "Yes, *fresh*!"

Therapist: "I am fresh, you are harsh. (Pause.) Let's all say that together."

All: (With a rise in the energy.) "I am freshhh, you, are harshhh." (This is repeated three times. Several members begin to continue the Sshh sound. Several put up their fingers to their mouths as if indicating: "Be quiet." The therapist opens his mouth to speak and the entire group "ssshhhs" him, with great delight. Other members then follow suit, opening their mouths to speak only to be ssshhhed. The action appears to make complete sense to the entire group, though it is not possible to put that meaning into words here.)

By attending to the discrepant elements arising within organized scenes, the therapist allows the unfolding of a new, as yet unnamed, entity. The resulting process, however, is far from unorganized—it has been organized at a different level.

IMPLEMENTATION: GROUP THERAPY PROCEDURES

Groups do not often leap into free play, so the therapist uses a developmental perspective to help members gradually achieve higher levels of play. The therapist accomplishes this task through interventions in five dimensions of play behavior: ambiguity, complexity, media of expression, interpersonal demand, and affect expression (see Johnson, 1982). These are based on developmental principles described by Piaget (1951) and Werner and Kaplan (1963), among others. *Ambiguity* is the degree to which the therapist does not determine the spatial configuration, tasks, or roles in the group at a given moment. *Complexity* is the

degree to which these space, task, and role structures include multiple elements (such as numerous, different roles). *Media of expression* refers to the level of representation of the action along the developmental continuum of movement, sound, image, role, or word. *Interpersonal demand* is the level of interaction required among members, as well as whether the roles are expressed in inanimate, animal, or human form. *Affect expression* is the degree to which the action and imagery is personal (i.e., about self vs. a fictional character), and intense (i.e., superficial vs. aggressive, sexual, or intimate).

In general, the group session begins at the earliest developmental level, which means therapist-directed sound and movement, in unison, with little interaction, and impersonal, nonintense imagery. The therapist gradually makes interventions that increase the developmental level of one or more of these dimensions toward greater ambiguity, complexity, interpersonal demand, and intense, personal imagery. The therapist uses the group's responses to these interventions (in terms of fluctuations in the energy or flow of the play) as a signal of whether to continue or to linger at a particular level. It is important to understand that the therapist's attention is largely on these developmental dimensions, not on the content of the client's imagery or scenes, nor on an agenda of planned exercises or structures. This is because the Developmental Transformations therapist is managing the state of play, not the content of the play.

For many clinical populations, typical stages of the (usually one-hour) group session include greeting, unison movement and sound, defining, personification, structured role playing, unstructured role playing, and closing. A more detailed description of these stages is included in Johnson (1986). Group work usually begins by inviting the group members into the playspace (greeting), and then engaging in unison movement while sitting in a circle (unison movement). Over a period of time, transient images begin to arise (defining), followed by more organized roles/characters (personification), which then may be focused on for a period of time (structured role playing), only to dissolve again into more free-flowing improvisation (unstructured role playing). The departure from the playspace occurs during the closing ritual. We have found that as groups become more familiar with the method, and as the therapist becomes more seasoned, these stages become less distinct.

In longer term therapy, participants have the opportunity to develop a much deeper sense of trust in the process and in the ability of the playspace to contain and express their core anxieties and insights. The overt content of the play thus deepens, moving from the level of social role to personal history to here-and-now experience among the participants. This method is best designed to evoke and process basic existential issues, in contrast to addressing current life problems. For the elderly in particular, this type of work speaks to the questions of "What's the point?" or "Why bother caring anymore?" as opposed to symptom reduction.

CASE ILLUSTRATIONS

A Small Group Session

The following transcript is based on a Developmental Transformations session that occurred in a long-term nursing home in New York City. Client identities have been disguised, and some events have been changed to make aspects of the method more explicit. Reflections on the session-in-progress are noted in brackets. Although several of the ten clients had participated in other drama therapy groups, this particular group was only a few weeks old, and several of the clients had never participated in drama therapy. Most of the clients were dealing with intense physical problems, such as complications from stroke, heart failure, and diabetes, among other medical conditions. Many of the group members also had some form of dementia, although not of sufficient severity to prevent their participation in the group's activities. Following is a description of each of the clients:

Alan, 90, dementia, heart disease, poor circulation; large, physically imposing, in wheelchair, bilingual English/Spanish, can be verbally/physically abusive to staff, not enthusiastic about groups.

Andrea, 95, alcoholic, dementia, ambulatory, former taxicab driver, talkative, sociable.

Bill, 82, stroke, expressive aphasia, wheelchair, religious, occasional angry outbursts but sociable.

Debbie, 79, depression, mild dementia, walks short distances with a walker, sociable and cooperative.

Jackie, 88, stroke, schizophrenia, memory deficit, teacher, active group participant.

Jocelyn, 69, paranoid schizophrenia, mistrustful of others, but participates in activities.

Manny, 80, heart attack, ambulatory, Hispanic, abusive to wife, inappropriate sexual behavior, plays guitar.

Mark, 68, stroke, heart disease, uses walker, poor background, active, sociable.

Myron, 80, dysphoric, wheelchair, poor eyesight, estranged from mentally ill wife.

Sandra, 80, ambulatory, grew up in Caribbean, active in groups, superficially pleasant.

The group took place in a common dining area on one of the nursing home units. The group was kept as private as possible by closing the doors to the dining room and discouraging staff from entering during the session.

[GREETING PHASE:] The therapist (AS) arranges the group in seats or wheelchairs in a circle, and then gives a brief explanation of the name and purpose of the group, indicating that "everywhere there are signals or invitations for you to hang it up, to be still, to die, for your life to be over. But in this group, we are going to work to remind ourselves that we have so much life left, to breathe life into our bodies and play together. Okay? So let's begin by doing some breathing." The therapist then leads the group into taking deep breaths and slowly letting out sounds on the exhalation.

[UNISON SOUND AND MOVEMENT PHASE:] Soon, simple hand motions (e.g., lifting, twisting) are added that everyone performs in unison. Mark makes a hand gesture with the words "Can't do it." Everyone follows him, repeating the movement and phrase. Each person then introduces a variation, for example, saying "Can't do it" matter-of-factly, opening the hands away from each other, or doing it by waving the hands in a snobby, elite way.

Therapist: "Do it toward your neighbor." (They do.)

Therapist: "Do it to the people across from you." (There is a burst of energy and laughter.)

[Reflections: *There is a feeling now of being above it all; we can't do it because we don't need to do it; we have others to do it for us.*]

Alan: Wags his finger, "Heh, heh, heh." (Everyone follows.)

Jackie: "Sounds like a donkey."

Myron: "Ha, ha, ha." (Everyone follows. The sound changes to that of witches cackling. The group turns into witches.)

[*Note the rapid transformation of images. It is important not to grab onto an image such as "Can't do it," because it rapidly shifts to something else. At this phase in the group, the importance is to simply build some momentum and continually note the level of energetic flow of the play. DEFINING PHASE:*]

Therapist: "Here we are again as witches. This happened last week, too."

Jackie: "We need a house to haunt."

Therapist: "How can we haunt the house?" (One by one, they think of different ways to haunt the house. Ghosts, spider webs. They act these out together.)

[*From haughty to haunting, the feeling here is both an empowered one and an emergent sense of loss, as in being mere ghosts of our former selves.*]

Mark: "Dracula!"

Therapist: (Moves into the center of the circle and acts out Dracula for them, baring her teeth and approaching each one in turn.)

Jackie: "First, they say I have long teeth. Then they say I have no teeth."

Therapist: (Now as a toothless Dracula.) "Argghh!" (Laughter, delight.)

[The feeling is now powerlessness, an impotent ghoul, a sexual being that no longer can touch or be touched, only the desire to control remains.]

Myron: "No, now she's a bat!"

Therapist: "A bat? Now I'm a bat?"

Andrea: "Yes, a blind bat."

[Now blind as a bat . . . the references now fully evoke bodily deterioration, disability, dependency. Yet, there is a feeling of need, of wishing to be helped, of looking for redemption somehow, or seeking love.]

Therapist: (Reaches out to individual clients, sometimes touching them lightly. Some reach back, some hold her hand, some shy away pretending to be disgusted or afraid. The clients are energized and laughing. Someone starts clapping. Others join in, and the clapping turns into a rhythm.)

Jackie: "Sounds like an old horse."

Mark: "A bunch of horses."

Therapist: (Taking the role of an old horse as she walks around the center of the circle. PERSONIFICATION PHASE:) "Oy, my back hurts."

Mark: "You don't have a saddle."

Bill: "No—no—no teeth!" (Laughter.)

Alan: "You have nothing in the world. I am like you!"

Sandra: "You have a limp."

Therapist: (Faithfully renders all of these images.)

[Despite the levity, the room seems filled up with loss. The character has lost everything: body, senses, family, friends. The therapist silently remembers a recent personal loss.]

Myron: (Singing) "The old gray mare ain't what she used to be." (Everyone joins in. Much laughter.)

Therapist: "No, I'm not what I used to be. (To Myron) Are you what you used to be?"

Myron: "No, I am not. Definitely not."

Therapist: (Asks each person in the circle. One at a time they answer "No.")

Manny: "No, Miss, I am not what I used to be."

[The therapist uses Transformation to the Here-and-Now, which means that while staying in role as the horse, she addresses the clients as clients, though some ambiguity remains as to whether they are answering "for real" or as a

character in this ongoing drama. That ambiguity is sought at this moment, for it provides the freedom to speak the truth, or lie. Perhaps it is this that allows Manny, a proud and guarded man, to admit to a weakness.]

Therapist: "You're not? Yes, I can see. Neither am I."

Myron: "You're just like the rest of us."

Therapist: "I'm in good company."

Alan: "You're in the right place."

Debbie: "You're home."

Jocelyn: (Laughs nervously and loudly. The energy in the room drops.)

(The therapist senses a feeling of anxiety, of wanting to go no farther down this path, of images of homes that perhaps were not the best, of family members who brought pain—not solace, of brokenness.)

Therapist: (Again in role as the old gray mare) "Can you help me? I need something, but I don't know what exactly."

Debbie: "A feedbag."

Jackie: "An apple."

Therapist: "I lost my teeth in this apple. You can probably find yours in there, too!" (Laughter.)

Bill: "Here, you can have my teeth." (He pretends to pull out his false teeth and offers them to the therapist. People roar with laughter. There is a pause.)

[There is now a buoyant feeling in the room, a lift gained by the welcome retreat from the emergent shadow encountered moments before. However, the therapist assumes that what is to emerge comes on its own, and it is not her job to force it into the playspace. This assumption is supported by a feeling of anticipation held by the group. There is more to say. As the silence continues, the therapist merely looks around the circle at the group members. STRUCTURED ROLE-PLAYING PHASE: Myron speaks first.]

Myron: "The biggest for me was losing my eyesight. I so much loved to watch things: sunrises, flowers, people. I try to see them in my mind's eye now, but it isn't the same."

Debbie: "I lost my parents when I was young, maybe 30. That was a long time ago. I could have used their advice so many times. But, what is there to do?"

Therapist: "What other losses have people had?"

(Several other members mention their losses, with a mixture of poignancy and puck.)

Bill: "Do you have any idea what it is like to be in this wheelchair all day? I think about the times I could walk and run, I was a sports nut, you know, skiing, hiking. This is tough."

Andrea: "But you have your mind. It is worse to lose your mind." [The therapist has an initially negative reaction to this comment, as if Andrea is invalidating Bill's and others' losses out of a fear of suffering and death. However, the group members react positively to her comment, as if reminded of a pleasant summer day.]

Andrea: "We still have things that make life good." (People nod in agreement.)

Therapist: "Okay, let's put all those good things we still have into our Magic Box." [The MAGIC BOX is a pretend box that is kept in the ceiling and brought down by everyone raising their arms and pulling it down with a hum. The lid is then opened.]

Therapist: "What do we have?" (Members put in "my sense of humor," "love from my son," "being together here," "no bowel problems.")

[The therapist, though beset with various judgmental thoughts and therapeutic agendas, tries to put these aside and continue to faithfully render the flow of the group's play, based on the evidence of their energetic involvement, which remains high.]

Therapist: "Now, let's close the lid and return the Magic Box to the ceiling."

(The group does so with a giant, "Whoosh!" and then several members spontaneously applaud. There is clearly a good feeling in the group. CLOSING RITUAL:)

Therapist: "So it seems we were able to accomplish our goal for today, which was to breathe some life into ourselves. I was touched to hear about the burdens you have been facing, for they are certainly big ones."

Myron: "Not as bad as the old gray mare's!" (Laughter.)

Therapist: "No, definitely not that bad. So let's end the group for today. As usual, we will close our eyes, take a slow breath in, and then out. Okay, open your eyes, take the hand of your neighbor, and look around the room at each person. (They all do so in silence.) See you next week!"

Discussion

This is an example of an early Developmental Transformations session in a nursing home context. The group had met for only three weeks before this session and demonstrated a high degree of cohesion and cooperation. The therapist structured the opening and closing, and offered herself as the central playobject during the main action of the session. Her attention centered on sustaining a state of

engaged play rather than the content of the issues arising from the group, though she had numerous personal reactions to these. Importantly, when the group moved forward into more effectively laden issues, it often made a quick retreat into safer topics. The therapist did not interfere with this ebb-and-flow of the group's play, trusting that each foray into darker territory left a note of familiarity that allowed the group to imagine returning at a later time. The group was not at a point that it could move into unstructured role playing, which is not unusual for groups at this stage of development. This session did appear to achieve a level of communication, sharing, and affective release around some significant issues for these elderly clients.

A Large Group Session

Developmental Transformations can also be applied to large group meetings, in which clients are usually arranged around tables in the dining room, facing the front. An excellent format is to use a public address system with one or two microphones, connected by long extension cords so that the emcees can walk into the audience. In this format, the two therapists attempt to take different angles on a particular issue and recruit audience members to articulate one side or the other in a point-counterpoint type of interaction. The purpose is to maintain a dynamic, slightly off-balance atmosphere that calls out for participation from the group "to put things right."

The central principles of Developmental Transformations are adhered to: The large group is invited into a playspace by the therapists, who take on an enhanced "therapeutic persona" (Johnson et al., 1990). The therapists emphasize interpersonal encounters both with the clients and each other, and allow the focus to be directed to them as the central playobjects (or characters) in the unfolding action. Through their movement in space and by varying their proximity with the clients, the therapists are cognizant of the need for embodiment. Transformation is achieved by the therapists' picking up not on the overt content but on the divergent affect or imagery that is evoked by the various encounters. In this way, the issue being discussed changes over the course of the session and the therapists do not attempt to stick to one topic.

In this example, the therapists (Dr. Johnson and Dr. Jacob) were staff members of the nursing home and led a weekly community meeting. Each had a microphone with an extension cord and moved through the room to clients who signaled them they wished to speak. Over the past several weeks, Dr. Johnson's therapeutic persona could be characterized as a somewhat pitiful remnant of the patriarchy, which had meaning in the context of the arrival of a new administrator who was female. Dr. Johnson began:

Dr. Johnson: "What's on people's minds today?"

Eloise: "Not much."

William: "Aren't you supposed to lead the discussion?"

Dr. Johnson: "I'm supposed to lead the discussion?"

Dr. Jacob: "Yes, aren't you supposed to lead the discussion? You're the leader, aren't you?" [The leaders do not have any preset ideas about the issues to be explored, and plan to pick up on whatever is offered them.]

Dr. Johnson: "Yes, of course I am the leader. Don't I look like a leader?"

Margaret: "Yes, you are big and strong!" (Laughter.)

Dr. Johnson: "Thank you, Margaret."

Dr. Jacob: (To a member showing disdain) "What's your view?"

Frank: "You call that leadership?" (Laughter.)

Dr. Jacob: "But he appears to be big and strong?"

Frank: "Yes, but is there anything up here (pointing to the head)?"

(Laughter.)

Dr. Johnson: "Ellen, they don't believe in my leadership! (Moves close to her and smiles.) But you do, don't you?"

Ellen: "Oh, yes." (Very submissive.)

Dr. Johnson: (To Dr. Jacob) "Now here's a very intelligent woman! Ellen, don't you think strength is a critical part of being a leader? Think of our generals, our presidents! Who do you want? A wimp? Someone who has *feelings*?"

Ellen: "Oh, no!"

Dr. Johnson: "You want a REAL MAN, don't you, Ellen?"

Ellen: "Yes, a real man!"

Dr. Jacob: "What's your view, Bill?"

William: "I think people like that have gotten us into real trouble."

Dr. Jacob: "What do you mean?"

William: "Like despots and dictators."

Dr. Johnson: "You think I'm great, don't you, Andy?"

Andy: "Not really."

Dr. Johnson: "Andy! (Steps closer, looming over him.) You think I'm great, DON'T YOU?"

Andy: "If you say so." (Laughter.)

Dr. Johnson: "That's what I want to hear!"

Dr. Jacob: "Ever come across anyone like this before?"

Greta: "Yeah, my husband. (Laughter.) He was very bossy and thought I should do what he commanded. He was a stern man." [There is a great deal of energy in the room at this point, which the leaders use to guide them.]

Dr. Jacob: "A lot of men act like this, don't they?"

Greta: "You'd better believe it."

Dr. Jacob: "So how did you handle it?"

Greta: "I pretended to do what he said."

Dr. Johnson: (To Bob) "So Bob, man to man, don't you think men deserve to be the head of the family?" [Here the leaders shift the focus from Dr. Johnson to family relationships, following the group's response to Greta's contribution.]

Bob: "Absolutely."

Dr. Johnson: "That's how it was in your family, right, Bob?"

Bob: "Well, actually, my wife was the boss." (Laughter.)

Dr. Johnson: "Bob, you let her take over!"

Bob: "I never had a chance."

Dr. Jacob: (To Emily) "How about in your family?"

Emily: "I had him wrapped around my little finger."

Dr. Jacob: "Really. He let you do that?"

Emily: "Women are stronger than men in general. That's why men die off earlier."

Dr. Johnson: (stomps around) "This is terrible. This is going in the wrong direction. Where are the men anyway? Look here, the patients are mostly women; the staff are mostly women! Andrew, look at this place, most of the staff are women, right?"

Andrew: "Right."

Dr. Johnson: "And you are the PATIENT, right? And here, the PATIENT is the one in charge, right?"

Andrew: (Does not answer.) [There is a definite drop in the flow of energy in the room, indicating to the therapists that there is some anxiety about addressing the nursing/patient power relationship.]

Dr. Johnson: "Andrew!"

Andrew: "Not really."

Dr. Johnson: "Andrew, this is awful. You are a man, you have had a long career as a manager, you have been a successful husband and father and grandfather, and you are telling me that AS A MAN you are not in charge here! You can tell us. What can they possibly do to you?" (Dr. Johnson and Andrew look at each other.)

Andrew: (Playfully) "Women can do a lot."

Dr. Johnson: "Hmm, come to think of it, I imagine you're right."

Andrew: "Frankly, I'm not sure if I ever was in charge."

Dr. Johnson: (Becoming very upset) "Oh no, this is terrible!"

Dr. Jacob: "Now don't become so upset, Dr. Johnson!"

Dr. Johnson: "I am upset! This is frightening, this is horrible, this is impossible."

Dr. Jacob: (In a directive way) "Now CALM DOWN."

Dr. Johnson: "Yes, Dr. Jacob." (Laughter.) [The leaders have now moved away from the previous issue back to Dr. Johnson, in response to the decreasing playability in the room.]

Dr. Jacob: "You see, you have to be strong with them. Right?"

Emily: "Right. That's how I did it with my husband. Though you have to be careful."

Dr. Jacob: "What do you mean, Emily?"

Emily: "Sometimes they get violent."

Dr. Jacob: "Then what do you do?"

Emily: (Tearfully) "You cry. You leave home for the night. You wait for him to come back and apologize." (Long silence in the room, though the flow appeared to be high again.)

Dr. Johnson: (To Eloise) "Is an apology ever enough?"

Eloise: "No, never enough. But what else can you do?"

Dr. Johnson: "I don't know. That would be a hard one to figure out."

Eloise: "It's a problem."

Dr. Jacob: "Is it a problem?"

Emily: "It's a problem." Silence. [This was a remarkable moment, because nearly all in the room were on the edges of their seats, and the silence was filled with many layers of this issue: past family abuse, present nursing/patient conflict, and the pitiful Dr. Johnson, all woven together.]

Dr. Johnson: "So Dr. Jacob, I apologize for getting so upset earlier. I don't think it really matters if I am the leader or not. I had a good time hearing from everyone here about this issue."

Dr. Jacob: "I agree. But you are going to have to work on your feelings, I think."

Dr. Johnson: "Perhaps you're right about that. But how?"

Dr. Jacob: "After the group, I want to see you in my office."

Dr. Johnson: "Yes, Ma'am." (Laughter.) [The leaders, cognizant of the time as well as the intensity of feeling, again drew the attention back onto their therapeutic personas.]

Dr. Jacob: "So, thank you, everyone, for coming today. I think we made some progress in discussing the topic of leadership, though we certainly did not come to any conclusions! See you next week."

Discussion

In this example, the guise of the therapists' playful personas allowed this large group of nursing home residents to name and speak about several important issues related to power dynamics, both in the nursing home itself and in their past relationships. The discussion served to normalize these problems, providing

permission for these issues to be addressed directly during real interactions in the institution. Indeed, because nursing staff were in attendance at this meeting, sensitivity to these issues increased, and client-staff violent incidents remained extremely rare.

This approach does not require agendas or even particular knowledge on the part of the therapists, other than comfort in improvisation and being the object of large group projections. The talk show format used here provides a normative structure that most participants are familiar with; therefore, it serves as an organizing influence in the session.

Influencing an Entire Milieu

In one Veterans Administration nursing home, the collective influence of the creative arts therapy groups, holiday ceremonies, and theatrical plays that had been performed began to be felt in all areas of the milieu. Introducing norms of playfulness and creativity into an institutional environment may have, in the long run, far more positive effect on the health of its clients than a series of disconnected treatment components, however competently run (Sandel & Johnson, 1987). Originally, the nursing home did not celebrate any major holidays, because staff were often on vacation on those days. This included National Nursing Home Week, which was ignored largely because the staff identified themselves as the Veterans Administration, not a nursing home. The first attempt to acknowledge this week was met with resistance and concern, because it brought to awareness that the unit was a nursing home. The first several years, the week was acknowledged by a special ceremony held in the dining room, in which the hospital director and other staff spoke about the importance of the nursing home, some awards were given, and a blessing spoken. The next year, the staff felt they wanted to celebrate the week by putting on a health fair, in which the whole hospital was invited to come and see what the nursing home was like. This was the first time the nursing home opened itself to scrutiny from others, requiring staff and patients to don "presentational" personas that had otherwise been discarded in the previously self-contained unit.

The following two years, the staff and clients organized a talent show, again inviting the rest of the hospital to attend. The first talent show was a somewhat standard display of the staff's and clients' limited talents, including some singing, dancing, and reading of poetry. The second one, however, demonstrated a much higher degree of playfulness and spontaneity, with participants presenting more idiosyncratic aspects of themselves. For example, a male and female patient sang a love song to each other, hamming it up tremendously. In a magic act, the psychologist—assisted by two patient amputees—sawed the head nurse in half, only it went "wrong" and (fake) blood spilled out onto the floor, to the howls of staff and

clients, who understood the actors were making fun of their very real competition with each other. The head nurse, the typical stoic and rock-hard manager, the kind of person everyone would love to saw in half, became instantly loved.

With the success of this project, the following year the staff and patients went well beyond previous efforts and transformed the unit into a truly remarkable playspace. For months, the patients, staff, and a new medical director planned the event, which had been suggested by one of the patients. The event was the re-creation of a 1920s speakeasy, in which the dining room was transformed into a gambling casino and saloon, with staff as the employees. As people arrived in the unit from the elevators, however, they entered a "funeral parlor," in which a real casket was displayed with a staff member lying in it (welcoming the public), a physically imposing male staff member playing an organ, and a very sexily dressed staff woman "in mourning." Word was passed around before the event that to get into the speakeasy (which was hidden behind the funeral parlor screen), you had to say "Harry and Mo asked for me." The entire hospital became interested in this event (the casket being set up in the nursing home turned more than a few heads), so much so that the hospital police asked if they could stage a fake raid on the speakeasy, which was arranged, to the delight of everyone. The new medical director of the nursing home was arrested and hauled off by the police.

This event, by being so deeply involved in a mutual playspace for the whole unit, brought out a liveliness and meaningfulness in nearly every client and staff member. Instead of being ashamed of their status as a nursing home, they were the pride of the entire hospital. The event simultaneously re-created a historical event of importance to the clients, played with the notion of death in a dramatic way, and overturned the shame of the unit by making others in the hospital hope to gain entrance into the home, where the action was.

The following year, the unit staged a wedding, in which the unit social worker married his female intern (well, actually, their characters got married). The unit medical director, a female, who was really pregnant at the time, played his mistress; and other clients and staff played the whole gamut of both families, one of which was a lower-class Mafia family, and the other an upper-class and uptight New England family. Again, the hospital was invited for the black tie affair. To standing room only, the hospital chaplain conducted the ceremony, and the dance afterwards included ballroom dancing (with rotating globe above), and a dance exhibition by the same psychologist and head nurse who tripped over each other, ending up in a heap on the floor. The issues addressed included sexuality, staff-client intimacies, and ethnic and social class dynamics. The wedding brought back memories that were processed in the various therapy groups. Only because the staff were not afraid to be seen this way could these issues be addressed in play, with no known incidents of confusion or misunderstanding among the clients.

Discussion

Though certainly not the standard group therapy intervention, the healing effects of such milieu interventions cannot be underestimated. In this example, the principles of Developmental Transformations were followed: The playspace was established and maintained, staff offered themselves as the clients' playobjects, embodied action was emphasized whenever possible, and attention was paid to emergent images in the community rather than proscriptive agendas based on what staff had learned was therapeutic for their clients. Rather, the staff was able to trust that what emerged from participants' playfulness would be meaningful and relevant to them. This proved to be true, and allowed one Veterans Administration nursing home to be deeply transformed.

CONCLUSION

Developmental Transformations is a play therapy approach that can be applied in a variety of contexts in work with elderly clients. The application of improvisational play that emphasizes embodied encounter gives rise to many important issues for elderly clients. Following developmental principles in which the flow of play is maintained by constantly altering the level of structure, complexity, and interpersonal demand, the therapist can successfully implement this approach even with severely disabled clients. Perhaps most uniquely, this approach uses the therapist's own participation as an object of playful encounter, made even more possible by the reverse transference often existent in these groups.

These principles also support the application of Developmental Transformations in larger group meetings and in the milieu, and offer a course of action for transforming agencies and communities into more healthy playspaces, characterized by restraint from harm, mutuality, and the disclosure of boundaries between reality and fantasy.

The limitations of this approach include the need for a high degree of spontaneity and improvisational skill in the therapist, and a willingness to actively participate in the developing playspace. Second, this approach may be difficult to integrate in other formats because of its emphasis on process and lack of discrete structures that could be applied. Third, this method is designed to address more existential issues, rather than specific symptoms or life problems, and so may not be applicable in situations where a focus on a particular issue is appropriate. Nevertheless, Developmental Transformations can be used in short- or long-term therapies; in individual, group, and large group formats; and with severely disturbed or high functioning populations. In addition, the central principles of playspace, embodiment, encounter, and transformation may be useful to the creative play therapist in enhancing his or her therapeutic style.

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