



DRAMA THERAPY IN THE TREATMENT OF THE HOMELESS MENTALLY ILL: TREATING INTERPERSONAL DISENGAGEMENT

GRETA SCHNEE, MA, RDT*

Providing treatment and health care for the homeless mentally ill is a major unmet challenge. Although studies differ on the actual size of the mentally ill homeless population, it is clear that their numbers have grown over the last decade and that they have become a familiar, albeit unsolved problem. In New York City, their estimated number was 24,500 in 1991. The United States Conference of Mayors estimated that there were 69,000 mentally ill homeless people in 21 major cities (*New York Times*, 1991). Psychology and creative arts therapies have not kept apace with the crisis. The focus in the literature is on the clinical attitudes that are useful in working with this hard-to-reach population: flexibility, trust-building and acceptance (Susser, Goldfinger & White, 1990). Treatment is described less in terms of the psychotherapy process than in developing management and social skills (Katz, Nardacci, & Sabatini, 1993). Even the one study of drama and art therapy groups with the homeless emphasized "adaptive ways of coping and problem solving" (Golub, Nardacci, Frohock & Friedman, 1993). Nevertheless, the fundamental and pervasive problem confronting the treatment of the homeless mentally ill is social disengagement. Their attitudes toward the social world, of apathy and negativity, are carried over to the treatment setting they are sent to, including the drama therapy group. If these postures of disengagement can be influenced in group therapy, the beginning steps toward socialization can be taken. This paper will discuss how drama therapy groups can be utilized to facilitate such social reengagement.

Disengagement

Homelessness is best viewed as the end result of a long process of disengagement and disaffiliation. Family, friends and institutional supports are lost. Seventy-six percent of homeless mentally ill patients in one hospital study had never been married (Katz et al., 1993). In a study of homeless mentally ill patients and non-homeless psychiatric patients, the former were found to have greater psychomotor retardation, apathy, social withdrawal and hopelessness than the latter patients (Tsemberis, Cohen & Jones, 1983). Also noteworthy among the former are severe chronic substance abuse and Organic Brain Syndromes of unknown etiologies (Katz et al., 1993).

Having lost connection to the social world, their encounters with others are marked by mistrust, fear and suspiciousness. In a series of psychological tests administered to homeless mentally ill patients, the results clearly indicated deficits in object relations (Caro, Nardacci, Silbert, Golub & Madiwela, 1993). Self-report assessments indicated mistrust and suspiciousness toward other people and a desire to be left alone.

Psychosis itself can create disengagement. Delusions serve as an alternative "object world" that provides patients with feelings of well-being, omnipotence and intimacy that compensate for their actual condition (Searles, 1965). Thus, one homeless man thought he was helping the crossing guard on the street by beaming light to help the children return home. He never had actual contact with the crossing

*Greta Schnee is a drama therapist currently employed in a Transitional Living Community program for homeless mentally ill men connected with Bellevue Hospital. She is an associate instructor of the New Haven Drama Therapy Institute.

guard. Another homeless man thought he had recorded two hit records that were then stolen from him by a successful, vengeful record company. He came to New York from Denver to find the culprit. Instead, he meandered around Central Park. Attachment to delusion is intense even after successful engagement in treatment.

Many homeless mentally ill patients exhibit cognitive impairment that makes simple life tasks more difficult for them. In one study of homeless "street people," many did not remember how they became homeless, how they lost touch with family or how they lost their last job (Belcher & Toomey, 1988). One inpatient could not recall the name of his first wife. Without consistency and predictability in the social environment, cognitive functions inevitably erode (Werner, 1948).

The inpatient psychiatric unit that houses the homeless may contribute to their detachment. The homeless mentally ill are taken to the hospital involuntarily when they meet the criteria under New York State law. New York Mental Hygiene Law 9.39 states that "a patient who lacks the ability to recognize self-risk, and who is endangered by significant self-neglect (as a result of inadequate or inappropriate food, shelter, or medical care) can be admitted." An average of 75% are admitted involuntarily (Tsemberis, Cohen & Jones, 1983). Patients then receive medication that interferes with their psychotic thinking. Without the streets and psychotic symptoms to mask their pain, what remains is the stark reality of an empty and meaningless life. No wonder the patients hide in their beds all day! At least half of all patients on the homeless psychiatric unit prefer lying in bed most hours of the day, despite every effort made by staff to engage them. Usually even their heads are not visible from under their blankets. When invited to join groups, they offer a wealth of rationalizations against participation.

The primary treatment objective of the unit, in addition to the amelioration of psychotic symptoms, is to reengage the patients socially, to "provide the necessary corrective experiences that would facilitate return to more functional living" (Caro et al., 1993). In order for drama therapy to meet this objective, improvement in their interpersonal relations is required.

Interpersonal Relations

Many of the homeless mentally ill suffer from schizophrenia and have been unable to maintain healthy object relations. Their capacity to establish

emotionally sustaining relationships with others and with themselves is impaired (Searles, 1965). Having suffered multiple traumatic losses, the world is a scary, unsafe place to be. For them, perceived relationships with others are threatening to their precarious sense of self. Lacking secure boundaries between themselves and others, they detach themselves from the object world and they are returned to narcissistic modes of relating to others.

Relationships with others are perceived by what the other will do for them or against them. For the patient, unable to tolerate complexity or ambivalence in relationships, the "other" becomes either good or bad. Through splitting, patients create a sense of safety in relation to good objects and defend against anxieties aroused by people who do not meet their needs. These modes of relating provide clarity and familiarity that patients could not achieve in complex relationships.

A similar process of splitting can occur within the self, where the self is split into parts that are either good or bad. One patient, who developed no relationships on the unit, believed he was the devil. The narcissistic self is the lens through which the world is perceived. The object world is decathected, which intensifies the profound isolation of the homeless mentally ill. Group therapy with them is characterized by intense interpersonal avoidance. Sandel and Johnson (1983) termed groups such as this *nascent groups* because the members of the group do not recognize the group as an entity:

The structure and process of these groups are distinctly different from those whose members maintain some degree of relatedness . . . In groups with severely disordered patients, there appears to be no cognizance of group identity . . . The therapist alone is able to maintain an internal representation of the group, s/he becomes the primary link among the participants, as well as the tie to social reality . . . If the therapist can maintain such an internal image of the group there can be tremendous therapeutic benefit to the nascent group members. As the group develops and its defenses against relatedness diminish, the possibility increases that patients will be able to perceive and experience the therapist's internal representation of the group which emanates from his/her behavior. Patients may then be able to internalize that image. (pp. 131-133)

Drama Therapy

Drama therapy with the homeless mentally ill seeks to develop object relatedness or engagement in the object world. In the case study that follows, the playing out of self and object representations occurs within a continually modulated group interaction consistent with the Developmental Method of drama therapy (Johnson, 1982, 1984, 1986).

What are the elements in a developmental drama therapy group that allow patients to engage in the group process and surpass impoverished modes of interaction and expression?

The Therapist as Primary Player

In the developmental method of drama therapy, the therapist is the central player and risk-taker. Otherwise, how will the patients know that it is safe to play, that it is socially appropriate? For the homeless mentally ill, play may seem irrelevant. However, play serves to enliven them, rekindle feelings of joy and offer contentment that has been lost. Play, and the playful therapist, are the primary vehicles for engaging the patients.

Modulation of Cognitive Structure

The use of movement, sound and imagery have been found to be very effective in engaging schizophrenic patients (Johnson, 1984). The preverbal structures are simple and direct and they allow the patients more access to their feelings than language alone can provide. In some groups, where cognitive impairment is most severe, the group can engage in spontaneous sounds and movements for an entire session, whereas they would lose focus and concentration if we were to advance developmentally and use words primarily (Johnson, 1982). Movement, sound and imagery also have a more immediate relationship with the body, providing a holistic involvement. Role-playing is most effective when the group has established sufficient spontaneity and flow of energy via preverbal structures.

Playing Out Object Relations and Tolerating Affect

Because patients are so removed from interpersonal relationships, it is especially engaging for them to interact with imaginary objects. Animals often create a great deal of excitement. They are safe and easy

to identify with. By allowing patients to play with "bad objects" (object representations that hold negative projections and feelings), the patients develop tolerance of their own fears and rejected parts. As the inner world is integrated, the outer world becomes a safer place. Tolerating affect and object relatedness, without splitting off, go hand in hand with being in the world.

Afraid that their feelings will overwhelm them, the homeless mentally ill avoid awareness of their feelings (Spotnitz, 1976). Therapists must pay careful attention to when feelings are too strong so that they can provide safety. Otherwise, group members will sit down, leave or wander about the room. Just as they disengage from the real world, they will disengage from the group. Therapists can deal directly with a scary image and say, "Let's get rid of that" or they can create security by countering with a very safe image, such as a purring kitten.

Eliciting and Playing Out Group Themes

Patients often cannot articulate personal issues that have impacted on their lives and ability to function. Issues related to having a mental illness, not having a home or a person to connect with, feeling their lives are shattered and hopeless, are often elicited even if they are manifest in simple, symbolic forms. Issues emerge in subtle ways; for example, a sound/movement of "plunging into water, to escape the outside," gives patients a form for expressing their shared experience of disaffiliation. The eliciting of group themes is usually met by an increase in the group's concentration, interest and energy. The use of dramatic play in exploring group themes helps to maintain patients' involvement. These issues are so painful that without expression in playful, symbolic form, the group members would not be able to maintain relatedness to each other and to themselves. Play provides this useful emotional distance (Landy, 1983).

Providing Consistency and Predictability

Homeless psychotic patients live in an unsafe world marked by chaotic interactions. The establishment of consistency, simplicity and predictability in the group helps them to develop a sense of the world as a dependable and safer place to be. The use of the simple circle formation, the use of clear, simple directives and strong group leadership all serve to buffer

the raw vulnerability with which they encounter the world. The group begins and ends with a ritual in which the entire group shouts, "The drama therapy group Zap," which seems to instill such delight and release of energy.

These are the vehicles by which the patients become engaged. Once there is a level of engagement in the group, the work deepens, evoking and playing with split-off parts of themselves and their relationships. By bringing to life the inner world, the patients seem more alive. By building tolerance for the inner cast of characters, they develop strengths to meet the outer world.

Case Example

The drama therapy group that I led at Bellevue Hospital's homeless unit meets twice weekly. Patients are not required to attend, but attendance is strongly encouraged. Patients need some degree of psychiatric stability before attending, achieved usually after a week on medication. As patients arrive on the unit at different times, there are differences in patients' familiarity and comfort with drama therapy. Some people may be involved for many weeks, whereas others may be newly arriving. Likewise, there are differences in degrees of pathology.

The following case study illustrates a fairly well-related group that had been working together for several weeks. They had already established a basic level of intimacy and familiarity with drama therapy. There were also a few more patients than usual with some object relatedness. In addition to a core of eight schizophrenic patients, there were two manic-depressive patients, one depressed and one schizoaffective patient.

The mood of the group at the start was withdrawn, somber and anxious. As I explained what we would be doing, people fidgeted in their chairs, looked down at the floor and did not respond when I asked if there were questions. We began by sitting, which reinforced their need for safety. Although patients did not directly look at me, they were able to follow my simple, playful stretches, and the rhythmic quality served to keep them engaged. I was aware that if I broke the rhythm, people would lose interest (Sandel, 1980).

Feeling that the patients were sufficiently engaged and curious about what would come next, I asked them to push the chairs away and stand in a circle.

The energy level of my voice, high but not overbearing, also served to maintain their attention and communicate that I was invested in the group. We began with a spontaneous flow of expressive movements, which I led and the group mirrored. As we did bounces to the ground, Dan initiated a Dracula character and voice to go along with the movement. Some followed him, but other patients laughed nervously. The group was not yet capable of tolerating such a character. However, no one disengaged from the process and they welcomed the sense of play accompanying it.

As we developed a flow of expressive sounds and movements, Maude said playfully, "Greta always does these silly things. I think she should be on medication." Reacting to the increased level of involvement, Maude was expressing her fear that, in participating, she might be seen as crazy. How would I, the leader, be able to help her? I responded to Maude with confident and bold gestures, thus showing her that playfulness and spontaneity could be contained, that I was not upset by her criticism of me nor should she feel something is wrong in playing; thus she might be safe.

While Maude now felt more secure, Larry, a patient who awaited discharge the next day, could not engage in the group process. Larry said he wanted to leave. The group encouraged him to stay. He soon left. He could not relate to the group; he was so preoccupied with his own anxieties. This had been his behavioral pattern in groups during his hospitalization.

Involvement soon increased again, which was evident by the free associations to their expressive sounds and movements. We did a swinging movement and shouted, "Whee!" Someone mentioned swings. We did a loud, grotesque snort. This created some anxiety for certain patients, so I did a movement to soothe them—petting a cat and added an "Aah" sound. Dan said that he wanted to pass a hug around the group. I suggested that each person gently hug the next person on the shoulders. This was met with some reservation. As a safer alternative, I went around to each person and gave them a gentle hug. Faces lit up. Energy and interest increased. It gave patients a sense of security without being overbearing.

Patients were now secure enough to initiate their own movement, each person taking a turn while the rest of us mirrored them. Jo did a sound/movement that she called, "plunging into water." Dan added, "to escape the outside." Maude did a movement of climbing a ladder. The patients were expressing their

desire to escape—from what? The group, the world, the unit?

Patients became less repetitive in their movements. Vicky moved her arms in a way she had never done before. She usually repeats the same movements in each group. Jo did a movement of smoking a cigarette. This created a surge of energy in the group, so I highlighted this by asking each person to smoke an imaginary cigarette. Faces lit up and people smiled. They even made eye contact with each other while they smoked, something they do not often do. Highlighting this served to mobilize their strength as cigarette smoking is one of the few activities that patients take comfort in when they are not in the hospital, where smoking is not permitted.

Thus far I was supporting the group, both in their attempts to express themselves openly and in their need for defensive withdrawal at other times. Paying attention to the level of safety maintained the flow of energy in the group.

Dan did a sound/movement of flinging the arms, "the way they shoot guns on Mars." Henry did a sound/movement of "operating on a lizard." This was the first time since the introduction of the Dracula image that object representations were evoked, even if delusional. At this point in the group there was a surge of excitement and interest in the symbolic gestures. I passed Henry's lizard to each member to gauge the nature of their relationship to it and provide further opportunity to engage with it. Some people playfully expressed fear or disgust while others withdrew when the object reached them.

As we passed one imaginary object around, patients were invited to transform it to what they wished. The object transformed from a sack of wheat to 3,000 silver dollars to a Mercedes Benz to a grasshopper. I decided to further develop the relationship with the grasshopper image because I felt it might be related to the lizard image. I put it on my head and then inside my eye, pretending it got stuck in there. When I pulled it out and handed it to Dan, he turned it into "angel kisses." I told Dan there was more goeey stuff in my eye and the others seemed drawn in by this. There was an increase of energy and delight in the group as Dan and I played with this image. As Dan pulled out the goeey stuff, he changed it into more angel kisses (i.e., from intrusive object to nurturing object). Henry took the angel kisses and turned them into a telephone. He called his girlfriend and I immediately answered in the role of his girlfriend. Here, the role-play had become more complex in that

actual interaction between human characters was occurring (Johnson, 1982).

Henry role-played with me. "Honey, where were you last week?" he asked. "I went to pick you up and you were not there." I pretended to be flustered and to have another boyfriend at my house. Jim played my second boyfriend and I highlighted the betrayal by shushing Jim in the background while feigning innocence to Henry. The energy in the room increased. There were Aahs! and bursts of laughter by the group members. I felt the theme of this role-play was love and rejection. Because the level of engagement was high, I developed the theme further in a structured role-play.

Four people, including myself (in order to modulate engagement), enacted a scene about two sets of lovers who were out on dates with the others' lover. They were all friends, but didn't know of the others' cheating. The scene was set in an elegant restaurant. Dan gallantly played the waiter, welcoming the first couple "to New York's finest!" He opened a bottle of imaginary champagne for them and took their order. As the first couple placed their order—French-fried onion rings with croutons—Dan grew anxious because the restaurant did not serve this. When he went to call the manager, the second couple came in. As I entered the scene, I let out a loud scream because I saw my boyfriend sitting there with my best friend. They got up and tried to run away after we spotted them. As if they did not want to deal with being confronted, they broke out of the scene. Maude said, "What a scream! That was so much fun!" We ended the scene at this point because the level of expressed emotion seemed to reach a threshold that might lead to further disengagement.

Themes of loss, rejection and betrayal were played out. Love quickly soured. Feelings of mistrust and shame were evoked as the lovers confronted each other. The shame in having been "bad" was too much to tolerate and the adulterers broke out of the scene. The image of cheating lovers gave the group members an opportunity to re-play object relationships that have certainly been a part of their lives in one form or another. How many times have they been hurt by a loved one or abandoned by a special caretaker? As the group talked about their disappointments in relationships, there was a feeling of hopelessness. I felt pulled to talk of hope and staying open to the possibilities of love. On another level, I was addressing my own need to have our group remain engaging and alive. But also, the level of loss, hope-

lessness and pain were so profound that I felt compelled to soothe them just as I had when I had introduced a soothing cat earlier in the group to counter the anxiety. This is one of several intense countertransference responses evoked by work with the homeless mentally ill.

As soon as we took off our pretend uniforms and sat down to discuss the group, the sense of intimacy decreased. The patients' comments had no relevance at first. Jim asked, "What do you want us to discuss?" Henry said, "You should do the 'mash' game with us." People became very curious about the "mash" game and pursued this, trying to figure out what it might be. Finally, Henry disclosed that he was not sure.

They were dodging the intimate moments that had transpired. Then Dan mentioned that the group reminded him of "Romper Room," and I reassured him that drama therapy was for adults and that adults can play. He thanked me. Finally, Dan said that he had wanted more hugs during the group. Maude said, "It's funny that you want to live on the street and get hugs; the two don't go together." We talked about developing relationships over time. Vicky said, "Even here we're just getting to know each other. It takes time." Dan replied, "Oh well, in the past it never worked out anyway."

Countertransference

Countertransference, defined by Robbins (1988) as the total emotional response of the therapist to the patient, is a tool for understanding oneself in relation to the patient. It can serve as a vehicle of engagement for the therapist, especially with the homeless mentally ill. My countertransference feelings have included anxiety, hopelessness, fear, confusion and gratitude.

Anxiety

At the beginning of a group, patients commonly exhibit ambivalence about participating. They sit passively, arrive late, excuse themselves to leave the room, raise unrelated topics or seek to divert my attention with personal requests. The display of ambivalence generates a strong reaction. "Will they stay for the group? Will they return next week? Who cares about group? I don't feel like doing this. It's too hard." Despite the fact that attendance in drama therapy is high and consistent, these initial moments are

often accompanied by a worry that attendance will fall off or individual participation will become inconsistent or that no one will stay long enough to give the group a chance.

This perception of the group as unstable is directly related to my level of anxiety. It also reflects our cultural image of this population as transitory and unreliable. Having suffered the annihilation of social bonds, internal representations of groups are extremely negative and fragmented for the chronically mentally ill (Sandel & Johnson, 1983).

However, having witnessed so much joy and love in patients who become involved, I developed an image of the group's existence stronger than these perceptions. My own strong image of the group is the link that draws people to it. No matter how anxiety-producing it may be for patients to be in the drama therapy circle, I know that they have the capacity to emerge with a greater experience of social relatedness. At the same time, I accept the level of fragmentation that they may experience in group. When a patient like Larry, for example, leaves the group or the group's boundaries are threatened by someone else's agitation, I savor my internal image of this group and use this as a shield from my own and the patients' anxiety.

Hopelessness

The interpersonal deficits of the patients, combined with the lack of social supports available upon discharge, induce in me a sense that the work we do together does little good (Lamb, 1982). I find myself resisting the therapeutic process. Why bother to engage the patients in drama therapy inasmuch as they are destined to a fate of extreme suffering? The psychological and socioeconomic "cards" are stacked against them.

The temptation, felt most strongly prior to the group, is to provide the patients with a recreational diversion, such as showing a video to temporarily relieve their pain and suffering. At the same time, a structured period of recreation would allow me to escape from my own feelings of hopelessness. Alternatively, I wish for external events that would force me to cancel a group and allow me to withdraw into my office.

In addressing both my own and my patients' sense of hopelessness, I have found Victor Frankl's existential approach helpful. From his experience in the Auschwitz concentration camp, Frankl derived an un-

derstanding about survival in the face of history's most hopeless situation. He observed that those individuals who survived, including himself, were successful in finding reasons to persevere despite the extreme forms of terror and humiliation to which they were subjected. "Survival in extreme circumstances," wrote Yalom on Frankl's approach, "depends upon one's being able to find a meaning in one's suffering" (Yalom, 1980).

Frankl identified three categories of meaning that can be derived from all life experiences: "(a) what one accomplishes or gives to the world in terms of one's creations, (b) what one takes from the world in terms of encounters and experiences, (c) one's stand toward suffering, toward a fate that one cannot change" (Yalom, 1980). Frankl's concept of meaning has enabled me to view my patients in a more hopeful way. More importantly, his approach reaffirms how drama therapy supports the development of essential survival skills among my patients. Drama therapy may give substance, through experiencing, to these potentials of meaning.

For example, in the drama therapy group I seek to structure an experience that values each individual's unique contribution. I emphasize that the group is a product of each member's creative participation. The drama therapy group is especially supportive of reframing the experience of suffering, Frankl's third category of meaning. By the very act of sharing one's personal suffering, in creative and expressive forms, each member is engaged in meaning making. Thus, by the end of the group, the mood is often more hopeful and patients are more open and available to positive aspects of experience.

Fear

"Will anybody take any risks and get involved today? Will they then criticize me or their work in the group? Will I be able to use this to help them understand its relevance in their own lives or will they throw it back on me?" There is a feeling of dread in the room, a fear of the unknown. It feels as if the patients are saying to me, "Oh no, what will she do to us today?"

Fear of the unknown is related to the experience of play and spontaneity. I feel afraid that the patients will perceive drama therapy as childish, stupid and irrelevant to their lives. Likewise, I am afraid that they will regard me, the playful drama therapist, as foolish and trivial.

It seems that, for the patients, there is a direct correlation between playing and letting go, and feeling self-critical and critical of the group. In the case study, this is reflected by Maude and Dan. In the beginning of the group, Maude seems to feel unsafe by my invitation to play. She equates play with loss of control, with decompensation. Patients are overly controlled when they are not psychotic in an effort to hold onto themselves. Likewise, when Dan equates the group with Romper Room, he is expressing the fear that, in playing, he will be seen as childish.

I believe that my patients are afraid to play, in part, because they feel infantilized as mentally ill patients and they are afraid of any experience that hints at this. Therefore, the act of play offers patients the opportunity of developing a more integrated perception of self. If Dan, who feels like an infantilized mentally ill patient while playing, learns to accept this feeling in himself, then he can also accept and let go of this feeling as it arises in other circumstances on or off the unit.

As the group leader, I become the container of the critical voices of the patients. As the group becomes more spontaneous and free from rigid behaviors, I become more vulnerable to the unrelenting forces of their inner judges and critics. If I can tolerate these and reflect them back to the patients with playfulness, there is more likelihood that the patients will integrate their self-perceptions on a higher level.

Confusion

"What is going on here? I feel like I'm in a fog. I feel as if I'm the only one in the group and everyone else is a zombie." There are moments when, if I would stop structuring tasks for the group, everyone would sit down and forget about the group. In fact, sometimes, even though patients are going through the motions of the group, they seem to be off in their own private worlds.

This resembles Searles' (1965) "out of contact phase," when the therapist feels depersonalized and not available to the patients' feelings. The patients are so disconnected from what is happening in the moment that it elicits a hazy feeling in the therapist. I have come to realize that the best response at such moments is one of empathy, for "the less satisfaction a person gains from interacting with people, the more he turns to his private world within" (Nelson, 1994). Empathy, in response to their dissociation from the consensual world of reality, can help patients return from their fantasy worlds.

Gratitude

"Adoring." I am truly fond of the patients and feel a great deal of warmth, affection and protection. I believe that they like my feeling this way, otherwise they would not evoke my reaction. Sometimes, I feel overwhelmed by gratitude that they have opened themselves to me, for our culture has clearly given them the message that we do not care, as we are not willing to give them the services they need or opportunities that would encourage their return to society.

The experience of working with people who have been ostracized from the culture is extremely moving. The homeless mentally ill have lost much of themselves, their families, their dreams, but the one thing that remains is "big heart." Along with the bitterness and self-centeredness, there is grace and compassion for others. It seems to me that the human virtues that we culturally reject in ourselves are to be found in this culturally rejected group. The patients have helped me to stay mindful of the values and virtues that our culture disowns in cutting itself off from its own people.

Conclusion

Although I have described a treatment approach to working with the homeless mentally ill, the degree of their pathology, social and personal rejection are so great that nothing works consistently. I have found that the work progresses in spurts of relatedness. Because the unit is an acute care facility, patients move on after a few weeks to either state hospitals or group residences if they are ready. At these other facilities, there is little likelihood that they will be offered drama therapy. Although art and music therapies may be found there, dance and especially drama therapy are still perceived as threatening. Yet the richness and depth of expression that can be reached through these modalities is exciting for the patients and the therapist.

The growing emphasis in health care is on the development of daily living skills, and psychotherapy is viewed as contraindicated (Paul & Lentz, 1977). This paper has shown that the drama therapy process can contribute to the basic socialization of chronic patients, especially through nonverbal, symbolic processes. At the core of all living skills is the ability to integrate and relate to all aspects of one's personality as well as the ability to relate confidently with other people. Given the high level of responsiveness of these patients to drama therapy, the effects on an ongoing basis might prove to be a powerful vehicle

for restoring the social and psychological functioning of the homeless mentally ill.

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