The Arts in Psychotherapy 39 (2012) 87–94

Contents lists available at SciVerse ScienceDirect

The Arts in Psychotherapy

Playing with madness: Developmental Transformations and the treatment of schizophrenia

Jason D. Butler, RDT/BCT, LCAT

Institutes for the Arts in Psychotherapy, 526 West 26th Street, New York, NY 10001, United States

ARTICLE INFO

Keywords:
Developmental Transformations
Drama therapy
Schizophrenia

ABSTRACT

This article explores the possible application of the Developmental Transformations form of drama therapy to the treatment of schizophrenia. Developmental Transformations is an embodied approach to psychotherapy that involves the therapist and client engaging in free flowing improvisation. Within this paper, the symptoms of schizophrenia are reviewed as well as common treatment methods and protocol in working with both the positive and negative symptoms of the illness. These are then compared to Developmental Transformations and its approach to illness and healing. In particular, schizophrenia is looked at through a Developmental Transformations lens, seeing it as a disorder of embodiment, encounter and transformations. Through these connections it is then suggested that Developmental Transformations has the potential to be an effective intervention in the treatment of the illness. Finally, a sample session outline is presented applying the principles explored.

This article will explore the application of the Developmental Transformations method of drama therapy to address the complex issues and needs of those diagnosed with schizophrenia. As an expressive, embodied form of drama therapy, Developmental Transformations (DvT) utilizes improvisation and spontaneity to assist clients in healing and recovery. With its flexibility and wide range of possible interventions, DvT has the ability to confront both the positive and negative symptoms of schizophrenia. Through examples and theoretical connections, this article will propose that DvT is well poised to address the needs of those with this debilitating illness.

Psychotherapy and schizophrenia

Over the years, in treating schizophrenia, a pessimistic attitude has developed among clinicians toward the illness. Kingdon and Turkington (1994) referred to this idea as "catastrophization" or the idea that individuals with schizophrenia are too catatonic, thought-disordered, or otherwise limited as to be unable to participate in educational or rehabilitation activities (p. 12). The primary treatment goal often is a psychopharmacological one: get the patient on medication and the problems will be solved. It seems that institutional cultures often develop with the implicit purpose of merely occupying the patients until the medication has a chance to do its work. Due to the catastrophization, many institutions can focus wholly on finding the most effective medication without addressing fully the needs of the individual.

Unfortunately, in some cases of schizophrenia, it takes a long process of trial and error in order to find a medication that can help alleviate the symptoms. In other cases, the medication can work in lessening positive symptoms, however, many patients are still left with negative symptoms of the illness that are less likely to be treated by medication (Crawford & Patterson, 2007). Despite common practices, it has been shown that psychopharmacological treatment along with psychotherapy is the best combination for producing positive results (Patterson & Leeuwenkamp, 2008).

While many institutions working with schizophrenia do offer some form of psychotherapy, usually in the form of groups, their primary focus is to increase insight around the need for medication as well as to improve activities of daily living and ameliorate suffering. While this approach addresses some of the debilitating effects of schizophrenia, it does not often focus on the individual's own efforts to have some sense of social agency in addressing their own mental illness (Davidson, Shahar, Lawless, Sells, & Tondora, 2006).

Currently the most common forms of psychotherapy used with schizophrenia are Cognitive Behavioral Therapy (CBT) and other skills based therapies. In particular, CBT with schizophrenia is used in engaging patients in "collaboratively challenging their interpretations of events or experiences" (Silverstein, 2007, p. 265). Once these beliefs are challenged, an effort is made to correct these beliefs and assist the individual in implementing new patterns of thinking. Although CBT is widely used, it also has its limitations. CBT

E-mail address: jasondbutler@yahoo.com

0197-4556/$ – see front matter © 2012 Elsevier Inc. All rights reserved.
doi:10.1016/j.aip.2012.01.002

requires an individual to be capable of gaining insight into their situation and behavior. Due to the frequent cognitive limitations associated with schizophrenia as well as the interference of fixed delusions and other psychotic behavior, this insight can be difficult to achieve. Silverstein also noted that "CBT is not particularly effective with patients who are not distressed by their delusions and/or hallucinations, who are not motivated to rid themselves of these symptoms, or who have limited recognition that they have a mental illness" (p. 266).

Creative arts therapies and schizophrenia

For years, creative arts therapies have been used in the treatment of schizophrenia. A review of research on creative arts therapies and schizophrenia conducted by Crawford and Patterson (2007) suggested that the creative arts therapies are effective in treating schizophrenia. "There is some evidence to suggest that arts therapies have differential effects on symptoms of schizophrenia with a greater impact on negative and general symptoms such as feelings of depression, lack of energy, and reduced motivation than on positive symptoms such as hallucinations and delusions" (p. 70). Like most psychotherapies used with schizophrenia, creative arts therapies seem to be effective particularly in addressing the negative symptoms.

One noteworthy study was conducted by Röhricht and Priebe (2006) and used a form of therapy that resembles Developmental Transformations. Their exploratory study compared a group receiving body psychotherapy with a group receiving supportive talk group therapy (CBT). The body psychotherapy portion was performed by a dance movement psychotherapist and included many elements similar to DvT, including a sound and movement circle, mirroring, creative free movement and enactment of various scenarios. The outcomes of this study showed remarkable positive results for their sampling with those in the body psychotherapy group showing a 50% improvement in their negative symptoms and the CBT group showing only a 21% improvement. While this was a very small sampling and there was a higher dropout rate in the CBT group, the results are still noteworthy. In particular, the authors stated that "the effect size was substantial and at least as high as those reported in the literature for antipsychotic medication and CBT" (p. 677). Another important finding of this study was the effect of the dance movement therapy on an individual's attendance. Those in the dance movement groups were much more likely to attend their groups. These patients reported a greater interest in treatment and more enjoyment in the therapeutic process. Greater attendance in therapy then translated to greater potential for positive results. A more recent study conducted by the same team using dance movement therapy but without a control group has also shown similar positive results (Röhricht, Papadopoulos, Holden, Clarke, & Priebe, 2011).

There has been very little research looking at the effects of creative arts therapies on the positive symptoms of schizophrenia. For the most part, researchers have looked at the impact on negative symptoms (Crawford & Patterson, 2007). The positive symptoms have been left to psychopharmacology, a relatively measurable treatment that can address extreme psychotic behavior. It is likely that because these are the aspects of the disorder that are usually associated with the acute phases of schizophrenia, they receive the most initial attention (Yotis, 2006). When an individual is initially brought to the hospital, presenting signs of schizophrenia, it is often with positive symptoms that are potentially placing that individual or others in danger. When encountering bizarre and potentially threatening behavior, clinicians do not have the luxury of doing psychotherapy. Instead, the focus is usually on curtailing the potentially harmful behavior through medication.

Drama therapy and schizophrenia

Researchers and drama therapists have offered various justifications for the use of drama therapy in treating schizophrenia. In their review of research of drama therapy with schizophrenia, Ruddy and Dent-Brown (2007) proposed that drama's ability to act as a container for the various disordered thoughts and emotions associated with schizophrenia makes it particularly effective. They also suggested that drama therapy gives the participants a means of environmental regulation to help distinguish the world of the drama from the world of the group, aiding in their differentiation between reality and fantasy. Ruddy and Dent-Brown also pointed to the drama therapy concept of distancing (Landy, 1996) as a means of allowing an individual's psychological material to be worked with, with an underlying safety net that it is "only a story" (Ruddy & Dent-Brown, 2007).

In *Drama, Psychotherapy and Psychosis: Dramatherapy and psychodrama with people who hear voices*, Casson (2004) looked at the potential of drama therapy to work with individuals experiencing psychosis. In particular, Casson looked at the ability of drama therapy to promote change without the necessity of insight. Casson wrote that traditional therapeutic interventions can often be imposed upon the client, making it less productive. Drama therapy, on the other hand, does not require insight in order to facilitate change. Casson also looked at the ability of drama to allow the individual to look at unacceptable parts of the self. He proposed that "it becomes possible, if not to integrate the split-off parts, at least to establish a relationship with them at sufficient distance, such that the person feels less threatened and more in control, with choices rather than ultimatums" (pp. 241–242).

Emunah (1983) saw drama therapy as a means to assist individuals with schizophrenia in dealing with the possible confusion between reality and fantasy. According to Emunah, dramatic play is a method of "controlling in fantasy impulses which are difficult to control in reality, of assimilation and mastering reality" (p. 78). Emunah looked at drama therapy's ability to engage and involve the group members. Due to the collaboration necessary in a drama therapy group, Emunah stated that drama therapy is particularly effective in working with those clients who are withdrawn and exhibiting some of the negative symptoms of schizophrenia.

Social withdrawal is a common symptom of schizophrenia. Frequently individuals with schizophrenia, due to the negative symptoms of the illness, retreat from interacting with those around them.

> The schizophrenic person retreats from the world because he feels he is not in control of his relationships with others. We have seen how this withdrawal from others is stimulated by the anxieties aroused by his inability to keep inside and outside, self and other, separate and distinct. Thus, the schizophrenic's lack of personal integration is intimately connected to his lack of social integration. The drama therapy group operates toward objectives on both of these levels: (1) to integrate the patient's sense of identity and diminish the boundary confusion; and (2) to integrate him into the group and stimulate mutually satisfying relations with others. (Johnson, 1981, pp. 60–61).

Thus, according to Johnson, the drama therapy group can be an effective tool in working with these socially withdrawn individuals and helping them reengage with society.

Developmental Transformations

Developmental Transformations (DvT) is a form of drama therapy that uses an embodied approach to psychotherapy. Taking inspiration from various sources such as psychoanalysis, object

relations, client centered therapy, dance therapy, existentialism, deconstruction, and Buddhism (Johnson, 2000), DvT engages the client in spontaneous free play. Within DvT, the client and therapist are both involved in the improvisation and work together in a playful, free-flowing manner. There is an extensive history of clinicians using Developmental Transformations in the treatment of individuals with schizophrenia (Forrester & Johnson, 1995; Galway, Hurd, & Johnson, 2003; Johnson, 1984; Schnee, 1996).

Within the *Developmental Transformations Text for Practitioners* (Johnson, 2005), Johnson, the founder of DvT, described the work as a means to deal with the dilemma of being in an instable world full of paradox. He stated that "each of these dilemmas serves as another source of instability in our lives: being mind and a body, being a subject and object, living in a real and imagined world at the same time" (p. 10). When applied to schizophrenia, this description of the instability of being seems to be particularly apropos. Schizophrenia is full of paradox and instability. Individuals with schizophrenia are continually navigating the experience of living in a real and imagined world at the same time. They are also impacted by the paradox of being both a mind and a body, navigating the frequent disconnects between the two.

At its core, Developmental Transformations is an approach that has three basic principles: embodiment, encounter, and transformation (Johnson, 2000, 2005). A Developmental Transformations session takes place in an embodied manner. Both client and therapist are engaged physically in the activity with attention frequently drawn to the body. With therapist and client both in the same space, the experience of human encounter is enhanced. Being placed face to face with the therapist and other group members without props or other objects to bind anxiety, a client is forced to experience the encounter and find ways of coping with the ensuing anxiety. The principle of transformation occurs within a session as the action continually shifts and changes. Within this process new ideas and images arise, transforming, allowing new ideas and experiences to surface, breaking through the client's rigidity and defenses.

Using the three principles of embodiment, encounter and transformation as its framework, illness in DvT is characterized

> . . .as being derived from the fear of the instability of being, specifically instability brought on by being a Body (embodiment), by being in proximity to the Others (encounter), and experiencing the constant change and impermanence of Form (transformation). These fears lead to conditions such as Withdrawal, Clinging, Rigidity, Confusion, Control, Submission, Violence, and Hatred, which cripple the person (Johnson, 2005, pp. 7–8).

DvT then, attempts to work on these conditions by providing a repetitive practice that eventually allows the individual to tolerate the instability of being and to have fewer barriers between them and the world. Through work in DvT, a client is able to encounter the world and others in a more embodied way and to transform along with the world's unpredictable instability.

Developmental Transformations and schizophrenia

Schizophrenia can be seen as a disorder of embodiment, encounter and transformation. Essentially, it is a disease that negatively influences an individual's ability to connect with their own body, to connect with those around them and to transform in a healthy manner. As a drama therapy method that has these three areas as its basic principles, DvT seems uniquely poised to address some of the main aspects of schizophrenia. Within this context, DvT has the ability of addressing the negative and positive symptoms of the illness as well as the individual's overall quality of life. This section will look at the possible applications of DvT to the treatment of schizophrenia.

Negative symptoms

Many of the negative symptoms of schizophrenia can be viewed in terms of affect, motivation and rigidity. The affective flattening associated with schizophrenia can create a disconnect from one's body and a disconnect from those in one's social sphere. Similarly, difficulty in processing affective cues from others can hinder their ability to connect. Avolition, the lack of initiative or motivation in schizophrenia, can cause individuals to feel disconnected from their bodies and those around them. In regards to transformation, many individuals with schizophrenia are locked into rigid patterns of behavior, this rigidity is often due to the negative symptoms of the illness, an unwillingness to change or try new activities and a lack of motivation (Heerey & Gold, 2007).

Although one of the main negative symptoms in schizophrenia is affective flattening (American Psychiatric Association, 2000), research has shown that this does not mean individuals with schizophrenia experience less emotion. Researchers have looked at clients' abilities to experience both positive and negative emotions. In reviewing studies of affect with individuals with schizophrenia, Gruber and Kring (2008) determined that "schizophrenia patients are less outwardly expressive of negative emotions yet report experiencing similar or greater amounts of negative emotion compared with healthy controls across a variety of studies and methods" (p. 520). In a similar review, Cohen and Minor (2008) determined that there is "little evidence that individuals with schizophrenia have deficits in their ability to experience pleasurable emotion states" (p. 7). In fact, it has been demonstrated that individuals with schizophrenia report enjoying positive stimuli as much as healthy individuals (Heerey & Gold, 2007).

Although they are capable of feeling a wide range of emotions, it would appear that these individuals are not often given the opportunity to experience and express a broad range. Within the DvT setting, clients are able to play with a wide variety of settings and explore a wide array of emotions while playing and taking on various roles and situations. The therapist encourages the clients to go to extremes, enhancing the discrepancy and distance and giving them the chance to more fully embody the experience. It might be hypothesized that these clients could then be able to translate their experiences from the group room to the real world. In relation to emotion and drama therapy, Emunah (1983) stated, "[in the group] often clients will recall sensations, emotions, or relationships which they felt were not longer accessible to them. Discovering the capability of portraying a given emotion suggests a potential capacity to experience this emotion again in real life" (p. 79). The DvT group members experience emotion within the group setting and then have the opportunity to bring that experience back into their day-to-day encounters.

Individuals with schizophrenia have a difficult time understanding and recognizing emotion in those they encounter. In particular, when processing facial expression, it seems difficult for the individual with schizophrenia to accurately process negative facial expressions, especially if the person displaying the emotion is unknown to them (Caharel et al., 2007). This difficulty then translates into an unfortunate cycle of events. Falkenberg, Bartels, and Wild (2008) described the ensuing cycle as follows:

> It is possible that patients' reduced ability to recognize and to rate emotions correctly leads to irritation, which would already be enough to make it difficult for them to react appropriately. The additional deficit in their own facial behavior impedes mutual communication even more, as it causes irritation in the

communication partner as well thus augmenting the unfortunate situation (p. 252).

Not only does this deficit impact the individual's experience of their own emotion, it can also interfere with their ability to effectively encounter those around them.

The most common suggestion in addressing this deficit is to include some form of social skills training specifically looking at affect recognition within the treatment of schizophrenia (Shaw, Dong, Lim, Faustman, Pouget, & Alpert, 1999). Falkenberg, Bartels, and Wild (2008) have also said in reference to this population, "It should, however, not be ignored that the patients still have emotional abilities that might be open to external influences or even improvement, e.g. by means of social training" (p. 252). In particular, it has been shown that people with schizophrenia can be taught how to better recognize facial expressions. This is often accomplished through emotion recognition in photos that are shown to the client (Carter & Neufeld, 2007). Instead of using photos or impersonal computer screens, DvT has the ability to achieve the same results in an active, embodied way. Within a DvT group or individual session, various emotions can be played, exaggerated, heightened and identified. This process then becomes part of the group action.

Through the encounter in DvT, focus is placed on the process of noticing, feeling, animating and expressing. This process consists of noticing a difference in the other, feeling an emotional response to the difference, having an animated physical response and then expressing a communicated expression back to the other (Johnson, 2005). It is within this process of communication that individuals with schizophrenia frequently have difficulty. As established previously, these individuals are often not able to effectively notice the emotions of others. It has also been noted that these individuals have difficulty animating and expressing their own emotional experiences. A breakdown in this process, then, makes it difficult to interact with others and to be fully present.

> In the midst of such upsetting interactions, people either withdraw or make errors in noticing, feeling, animating and expressing. The usual tactic for helping people handle these situations more effectively is by providing various structuring devices to help them maintain control and calm. DvT uses a different method, which does not restrict the process of this recursive cycle, but which nevertheless provides a means by which the person can learn. This method is called the *Playspace* (Johnson, 2005, p. 13).

By utilizing the playspace, DvT allows the client to play with the human interaction. Safely contained in the liminal space, mistakes can be made and consequences of poor communication can be experienced and played with. As the therapist maintains a consistent dialogue, commenting on the here and now experience of the client, a meta-commentary is created. This process gives the client immediate feedback on their behavior and on the level of their emotional attunement. They are then given opportunities to make corrections and to modify their behavior in a playful, safe way and thus internalize the process. Thus, through DvT's use of the noticing, feeling, animating, expressing cycle and its constant feedback to the client, it becomes a useful tool in assisting clients with schizophrenia in handling affect.

The negative symptoms of schizophrenia can also been seen in a seeming lack of motivation in individuals with the illness. This can become particularly problematic when attempting to motivate individuals to participate in the therapeutic process. Heerey and Gold (2007) found that individuals with schizophrenia have a hard time translating hedonic value into actual motor behavior. Thus, they have a difficult time looking forward to the future for potential rewards. Instead, Heerey and Gold suggested that "interventions that rely on the physical presence of rewards may thus prove more motivating for patients than those that rely on consequences or deferred rewards" (p. 276). DvT gives clients immediate positive rewards and feedback to the participants. DvT can be fun and entertaining which can be used to motivate clients to participate. As mentioned previously, individuals who were engaged in therapeutic forms that they enjoyed and that had an element of play were more motivated to attend and participate in their treatment thus leading to better treatment outcomes (Röhricht & Priebe, 2006).

Clients with schizophrenia are often characterized as being rigid and inflexible (Schultz & Searleman, 2002). Rigidity could possibly be seen as a result of a client's lack of motivation to change. Without motivation to attempt new behaviors, these individuals stick to the familiar routines. Varying from the norm could also put the individual at risk of making mistakes in attunement. New situations mean new challenges which could be overwhelming to the individual with schizophrenia. This rigidity is also seen with paranoid clients and those with fixed delusions. As a means of warding off confusion brought on by the positive symptoms, clients rigidify their behavior. In this way, clients work to bring the world into some kind of order (Johnson & Quinlan, 1985, p. 505).

Through the constant, shifting nature of DvT, clients are given multiple opportunities to try new actions. According to Emunah (1983), "Rigidity, a common symptom in schizophrenic reactions, may be lessened through weaving in and out of roles and behaviors" (p. 80). Through the free flowing improvisation of DvT, clients weave in and out through various roles and behaviors. A client is allowed to repeat rigid behaviors within the group setting, however, the group leader constantly works to playfully challenge the individual's rigidity.

> DvT emphasizes the continuous approach to the moment of presence, to forming rather than to form, and therefore remains either neutral to "story," "character," and "plot," or may even purposefully attempt to disrupt, deconstruct, or dispel these forms if they appear to be "encrusted" and interfering with the natural flow of ideas and images emerging from the individual (Johnson, 2005, p. 7).

The therapist continually works to enable clients to step out of their comfort zones and attempt something new.

Through its embodied approach and the playful distance created by the playspace, DvT is positioned well to address many of the negative symptoms of schizophrenia. In particular, DvT can give individuals concrete feedback on their ability to emotionally attune to the other and their ability to effectively communicate their emotional experience. DvT can aid in motivating clients to participate in treatment and to be more active in the recovery process. DvT can also address the rigidity associated with schizophrenia by offering continual opportunities and encouragement to try new behaviors.

Positive symptoms

The positive symptoms of schizophrenia can also be seen in the context of embodiment, encounter and transformation. Delusions, hallucinations and thought disorders create situations where individuals cannot trust the information they receive from their physical senses. Psychotic experiences distort the ability of an individual with schizophrenia to fully encounter the other and can potentially have the effect of alienating potential friends and allies. These symptoms also impact an individual's ability to be flexible and transform in a healthy manner to stimuli.

As mentioned previously, there is very little research about using drama therapy and DvT in treating the positive symptoms of schizophrenia. However, some have argued that drama therapists might actually be the best choice in working with delusions

and hallucinations, "Dramatherapists can work without interpreting metaphoric material and so may be more able to work with delusions and voices than other therapists" (Casson, 2004, p. 243). In looking at psychotherapeutic approaches to treating positive symptoms, most notably CBT (Kingdon & Turkington, 1994; Turkington & McKenna, 2003), there are some aspects that can translate well such as calling attention to the symptoms and careful reality testing that can be enhanced through the application of DvT to the treatment process.

Within the playspace of DvT a therapist has more freedom to address and work with psychotic material. Because the playspace is an agreement between the therapist and the client that the action is play and "not real," the therapist can playfully address delusions and images that arise during the course of the session in a safe manner. Clients are then given the opportunity to play with the delusion and images, reworking and potentially reintegrating them.

Although not directly using DvT, this effect was seen by Silverstein (2007) in his work with a client showing positive symptoms. Silverstein used a transitional space that resembled the playspace in working with Jungian archetypes that were similar to the client's psychotic material. This process "allowed for the patient to gradually consider alternative views of his self, past, present, and future and to develop a healthier personal narrative but without conveying that his delusion was a symptom of his illness that needed to be eliminated" (p. 266). By playing with the psychotic imagery and not dismissing it, the client was able to consider alternatives to his delusional beliefs without feeling threatened. Similarly, DvT allows a client to experience a wide variety of alternative views of self. Over time, these alternative views can transform and be integrated into their own personal narrative, replacing older, more dysfunctional beliefs.

Johnson (1981) suggested that within play, the individual with schizophrenia is able to reveal part of their inner self, which is often occupied with fantasy. Once revealed, the individual can then freely explore these aspects of self and actualize them in the presence of others. "In this way, the inner self makes contact with the world, and the individual's fantasies become part of objective existence. . .such experiences can serve to lower the individuals anxiety and help to integrate his disorganized personality" (p. 60). By exploring the fantasy aspects of the psychosis, they become real and actualized in the playspace. Once they are actualized, the client can then play with them, explore them, try on new permutations, and eventually reintegrate them in a more functional and less disorganized manner.

While psychotherapy is not usually a reasonable treatment for extreme initial psychotic episodes (Lehman & Steinwachs, 2003), it can be used to help individuals develop greater perspective and understanding of the positive symptoms of the illness. DvT is uniquely equipped in this manner to facilitate a transformation in the client's relationship with their illness, their body and their relationships with others by allowing for playful exploration as well as reality testing.

Quality of life

When the positive and negative symptoms combine, the overall quality of life can be greatly impacted by schizophrenia. Not only is the illness itself debilitating, but the public response and stigmatization can often compound the negative effects of the illness. Once a diagnosis of schizophrenia is given, many often give up on the potential for an individual to improve their quality of life and find a way to live in a state of recovery. Medication can often take away the positive symptoms of the illness, but then the individual is left with the underlying feelings and experiences, as well as the negative side effects of the medication (Schnee, 1996). DvT offers an embodied way to work with the illness while at the same time enhancing the individual's quality of life through play and empowerment.

Davidson, Shahar, Lawless, Sells, and Tondora (2006) explored the role of play and pleasure in assisting these individuals with the recovery process. They identified several ways in which play assists individuals with schizophrenia

> . . .by providing respite from the illness and its effects and offering the person something to look forward to; as a source of renewing hope and commitment; by imbuing life with a sense of meaning and purpose; as evidence of the ways in which one can contribute to the lives of others and to the broader community, and thus of one's value as a human being; as avenues to rediscovering one's own remaining areas of strength, competence, and health in the midst of persistent dysfunction; and, finally, as a way to reconstruct an effective sense of social agency with which to do battle with the illness and its associated effects and side effects (Davidson et al., 2006, p. 155).

Thus, the ability to play and experience pleasure allows individuals diagnosed with schizophrenia the chance to work on many aspects of their lives.

Through play and exaggeration, many DvT sessions are imbued with humor and delight. As Forrester and Johnson (1995) have observed, "Laughter, relief, equanimity, and connection are often the by-products of this kind of dramatherapy group" (p. 18). These "by-products" of DvT allow the client to experience aspects of humanity not always afforded them due to their diagnosis.

The playspace in DvT also gives clients the opportunity to play out roles that might not otherwise be attributed to them. The stereotypes associated with schizophrenia often leave the client feeling as though they do not have options. Casson (2004) has observed, "Many psychotic people suffer role poverty: loss of roles in life. They benefit from the opportunity in drama to satisfy act hungers and play, in surplus reality, roles that the outer world does not give them opportunity to inhabit" (p. 246). With its improvisation and free transformations, DvT allows a client to play numerous roles outside of those they are usually cast in by the world around them. Instead of being cast as the Sick One, the Outcast, the Crazy Person, or worse, in the playspace the individual can play the Healthy One, the Lover, the Boss, or any other role – their potential is endless. Once they leave the playspace, they will then have the felt experience of playing the roles and could possibly be able to play out aspects of those roles in their own lives and through their encounters with others.

In the same respect, DvT gives clients the chance to imagine and fantasize a future self. Research has shown that it is difficult for individuals with schizophrenia to imagine events in their future (Van der Linden, 2008). DvT encourages the client to imagine their future, to play with their potential and to have an embodied experience of future possibilities. By being able to project into the future, their own autonomy and ability to direct the course of their lives is greatly enhanced.

In looking at the lives of individuals with schizophrenia, then, it is important that an effort is made to enhance the overall quality of their lives. Davidson et al. (2006) stated, "First and foremost, we suggest viewing people with psychiatric disabilities – even if at first only in terms of their potential – as active agents directing their own lives. . .we suggest that neither the person's efforts nor our own as professionals should be limited to reducing symptoms and dysfunction" (p. 160). DvT offers strong tools in empowering the individuals diagnosed with schizophrenia to be active agents directing their own lives.

In the treatment of schizophrenia, a disorder of embodiment, encounter and transformation, DvT has the potential of being a powerful method in working with the many complicated aspects of the illness. DvT can address the negative aspects of the illness,

most notably in the areas of affect, motivation and rigidity as well as the positive symptoms of schizophrenia through the distance established by the playspace. And when it comes to the overall quality of life for an individual with the illness, DvT takes important steps toward reestablishing a sense of empowerment, meaning and play.

Criticisms of Developmental Transformation with schizophrenia

This positive potential notwithstanding, there are some who would criticize DvT in the treatment of schizophrenia. Like critics of drama therapy in general, critics of using DvT with individuals with schizophrenia might point to the potential dangerous flirtation with fantasy and reality. Landy (2008) stated, "Many action psychotherapists have been criticized for being overly stimulating, provocative, cathartic, and infantilizing while working with vulnerable populations. These criticisms have been repeatedly hurled at Moreno and Perls, as well as contemporary drama therapists, like Johnson" (p. 215). However, as was cited previously, it is possible that the very action of going in and out of character – of playing a wide variety of roles and then coming back to reality – can potentially be a means of assisting clients in differentiating between reality and fantasy (Casson, 2004; Emunah, 1983). It is difficult to delineate any boundary when one is standing too far away from the boundary. Landy (2008) continued, "Yet the practice of drama therapy, like that of theater, is about contained expression. Through drama therapy, the demons are released, but within the confines of the playspace. The delusions are expressed, but as characters in a drama with a story to tell" (p. 215). By effectively using the playspace, clients are given the opportunity to explore their relationship to reality and fantasy and to potentially make corrections in their relationship to the two. While there is still much research to be done in this area, preliminary studies have shown that patients are able to clearly distinguish between a fantasy environment in psychotherapy and an environment that is more reality based outside of the therapeutic space (Silverstein, 2007).

As with other forms of psychotherapy with this population, it should be mentioned that DvT treatment is not indicated for individuals who are floridly psychotic. It should be carried out with the support of the client's psychiatrist and other members of the treatment team, and it should be practiced by a therapist who has been appropriately trained in DvT.

Sample DvT session structure

In conducting a DvT session with individuals with schizophrenia, a clear overall structure is important in order to facilitate involvement and to clearly delineate between reality and fantasy. The following example contains the basic structure for a DvT session with individuals with schizophrenia and is based on the guidelines found in Johnson's *Developmental Transformations Text for Practitioners* (2005, pp. 22–23). While there are no sanctioned or required structures for a DvT session, this example provides some concrete ways to guide the action and to optimize the approach for schizophrenia.

After welcoming clients to the group and briefly checking in with members, the leader gives a short "rap." The rap in DvT is "a brief verbal presentation that links the purpose of the group to the clients' situation, from their point of view, then predicting the challenges that will arise, and explicitly asking for their collaboration" (Johnson, 2005, p. 23).

Leader: Welcome to group today. As you know, everyone here is working on various personal goals. Some here have talked about wanting to have relationships and wanting to be able to communicate better with others. That's what we're going to work on here. We're going to spend the next 45 min improvising and acting out various roles and situations. There may be moments when you don't feel like trying something new. In these moments we will work together as a group to explore new options. What we do today will help you with your decision-making and your ability to communicate well with other people. But remember, the most important thing today is to have fun.

After the rap and a short physical warm-up, members are encouraged to stand in a circle. The leader will now assist the group in entering the playspace. Each group has a different means of designating the difference between reality and fantasy and entering the play. Especially when working with schizophrenia, it is important to make sure that the group entrance structure is clear to all participants. This particular group uses the image of a magic curtain.

Leader: (*Throughout the group, the leader consistently models a playful attitude. As the group enters and engages in the playspace, the leader demonstrates how to play, modeling for the group members an enhanced and discrepant form of communication.*) Everyone look up and see if you can see the curtain today. Anyone see it?
A: Yes!
Leader: What color is it?
B: Blue.
Leader: Great! A blue curtain. Now, everyone reach up and grab the curtain. (*Group members reach above their heads.*) Now we're going to bring it down on a "hum" sound. One. Two. Three!
All: (*Together the group pulls down the magic curtain.*) Hmmmmmmmm.
Leader: Alright! Now remember, this is the curtain that separates reality from fantasy. Once we step through this curtain, *anything* is possible. We can do anything – be anything! Are we ready?
All: (*Group members respond affirmatively.*)
Leader: Okay. In front of you there is an opening. Take hold of the curtain and when you are ready, step one foot through. (*Waits for everyone to do so.*) Now the other foot through. (*Again, waiting for each group member to step fully in the playspace. The step forward has brought all group members into closer proximity*). Now let the curtain close behind you. (*Once the curtain closes, the Leader initiates eye contact with each of the members.*) Look who made it to the playspace today. I see Bob. I see Julie. I see Bernice. I see Hector. (*Each member in turn makes eye contact with the leader.*) Alright. Here we are – the playspace – the land of fantasy!

This entrance structure clearly delineates for the group members the difference between reality and fantasy with the curtain representing the border between the two. The leader is constantly checking in with group members to ensure that they are in the playspace by observing their actions and level of discrepancy within their play.

The majority of the group takes place within this playful space. Initially the group begins with a sound and movement exercise, with each group member being given the opportunity to share a sound and movement while the rest of the group mirrors it back to them. The leader helps each member notice the sound and movement offered by the other and encourages them to repeat the action. The leader playfully works with the members to evoke new and unique actions. An emphasis is placed on physicality and being fully embodied while noticing others in the group. As the action progresses, the leader works to playfully increase the physical, emotional and interpersonal demands on the participants. Eventually, images begin to arise from the collective sound and movement and role plays develop. Group members are encouraged to take risks and make offers that impact the flow of the action. While leading the group, the leader uses several interventions to enhance the action and to give the group members feedback (Johnson, 1992, 2005). The DvT tools most applicable to this discussion are Joining, Intensification, Transformation to the here and now, and Diverging (Johnson, 2005).

In Joining, the leader joins the group members in particular actions in order to lend ego strength and give group members

support as they try new and different actions. For example, during the course of the group, the image of a tightrope arises, one group member, Marcus, is reluctant to cross the rope.

Leader: (*Noticing Marcus' hesitation*) It looks pretty far down, doesn't it, Marcus?
Marcus: Yes. Too far down.
Leader: (*Reaching a hand out to Marcus*) How about we cross it together? I promise to help you across to the other side. What do you say?

By joining Marcus on the tightrope, the leader gives him the ability to complete the action in a safe and supported manner.

Intensification is when the leader makes an action bigger or smaller, louder or softer, etc., calling attention to the difference and enhancing the client's awareness and attunement. Intensification enhances focus and the client's ability to feel and experience the emotional and interpersonal content of the situation. As an example, during the group a moment arises where a group member, Denise, in role, expresses frustration with her living situation.

Denise: (*Quietly*) I just want to have my own place.
Leader: (*Encouraging joining*) Everyone repeat what Denise said.
Group: I just want to have my own place.
Leader: Louder!
Group: (*Louder*) I just want to have my own place!
Leader: I can't hear you!
Group: (*Even louder*) I just want to have my own place!
Leader: (*Quietly*) Now whisper it.
Group: (*Whispering*) I just want to have my own place.

By playing with the intensity of the phrase, Denise and the other group members are able to explore different affective levels of the phrase. Moving forward the leader could then instruct the members to all say the phrase to an individual while pointing their fingers, further intensifying the action.

Transformation to the here and now is when the leader provides a running commentary on the action of the group. By using this tool the leader is able to comment on the actual action in the room while still maintaining a playful attitude. The leader calls attention to moments of missatunement and points out moments when the client seems to be more connected. Through this tool the leader is also able to challenge clients on their delusional beliefs, thus, providing immediate feedback on the action of the group. For example, there is a moment when the majority of the group is doing the same action of smiling and waving to one another, however, one member, John, is waving but with no visible display of affect. At this point, the leader might choose to transform to the here and now to give John the feedback.

Leader: (*In a playful, non-judgmental tone*) The group seems to all be smiling and waving at each other – but it looks like John is not smiling like the rest of us – he's doing something different.

The leader could then further transform the moment and facilitate attunement by instructing the rest of the group to mirror John and match his affect expression.

By Diverging, the leader offers occasional discrepant images and actions that are unexpected and require the client to be flexible and find new ways of relating. Enhancing the instability of being forces the client to practice their ability to stay in the moment within the playful atmosphere of the playspace. If the group is demonstrating a repetitive pattern of behavior, the leader might choose to stir things up.

Leader: (*Suddenly pointing to the sky.*) Oh no!! What is that?! Look up there! It's falling right toward us!! What should we do?!

The group then has to respond to this new information and spontaneously adjust to a change in the repetitive pattern.

By using these tools, the leader helps each group member work on their personal goals and areas of weakness. The group members are given the opportunity to make new choices and to behave differently in the playspace than they would in the real world. This provides them with actual embodied experiences in making these choices while encountering the other group members. Having had the experience of making these choices within the playspace, the members can then potentially transfer that experience to their lives outside of the group.

When the group time is over, the leader takes action to close the group. Once again, the leader gives clear directions and follows a familiar structure in order to facilitate the transition from play to reality.

Leader: (*The leader brings the group members back together in a circle.*) Let's bring down the magic box. Everyone reach way up and bring down the magic box. One. Two. Three.
All: (*Group members all reach up and bring down a large imaginary box.*)
Leader: And let's open it up. (*The group takes the lid off the box.*) Now we'll put in any images, ideas, themes that came up while we were here in the playspace. What should we put in?

Group members put in various images from the play. If there are images that the group members do not directly mention, the leader will point them out. Once it seems that there is nothing left to put in, the leader continues.

Leader: Okay, let's put the lid back on. (*The group puts the lid back on.*) And now we'll send it back up. (*The group reaches under the box and collectively raises it up.*) Okay, it is time for us to leave the land of fantasy – to leave the playspace where anything can happen and go back to the real world. Let's take one last look around the room to see who was here today. (*Making eye contact with the various group members.*) Now, feel the curtain behind you. Say good bye to the playspace and take your right foot out. Now take your left foot out and let the curtain close behind you. And now, we will send the magic curtain up. One. Two. Three. Here we are – back in reality.

As the group members leave the group room, the leader observes to make sure all members have fully exited the playspace and re-entered reality.

Conclusion

Clearly, there is much further research to be done in looking at DvT and schizophrenia. However, from these comparisons and limited qualitative data, DvT can be viewed as a potentially strong tool in treating schizophrenia. DvT has the potential of helping an individual with schizophrenia deal with both the positive and negative symptoms of the illness, transforming them from sick patients to individuals surviving with a mental illness. It can also serve as a playful means of enhancing quality of life and aiding recovery. Through the embodied encounter, the DvT playspace can be a transformational space where individuals often relegated to the shadows are given the chance to actively share in the spotlight.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Caharel, S., Bernard, C., Thibaut, F., Haouzir, S., Di Maggio-Clozel, C., Allio, G., et al. (2007). The effects of familiarity and emotional expression on face processing examined by ERPs in patients with schizophrenia. *Schizophrenia Research*, *95*, 186–196.

Carter, J. R., & Neufeld, R. J. (2007). Cognitive processing of facial affect: connectionist model of deviations in schizophrenia. *Journal of Abnormal Psychology*, *116*(2), 290–305.

Casson, J. (2004). *Drama, psychotherapy and psychosis: Dramatherapy and psychodrama with people who hear voices*. New York, NY: Brunner-Routledge.

Cohen, A. S., & Minor, K. S. (2008). Emotional experience in patients with schizophrenia revisited: Meta-analysis of laboratory studies. *Schizophrenia Bulletin*.

Crawford, M. J., & Patterson, S. (2007). Arts therapies for people with schizophrenia: an emerging evidence base. *Evidence Based Mental Health*, *10*, 69–70.

Davidson, L., Shahar, G., Lawless, M. S., Sells, D., & Tondora, J. (2006). Play, pleasure, and other positive life events: Non-specific factors in recovery from mental illness? *Psychiatry*, *69*(2), 151–163.

Emunah, R. (1983). Drama therapy with adult psychiatric patients. *The Arts in Psychotherapy*, *10*(2), 77–84.

Falkenberg, I., Bartels, M., & Wild, B. (2008). Keep Smiling! Facial reactions to emotional stimuli and their relationship to emotional contagion in patients with schizophrenia. *European Archives of Psychiatry and Clinical Neuroscience*, 245–253.

Forrester, A. M., & Johnson, D. R. (1995). The role of dramatherapy in an extremely short-term in-patient psychiatric unit. In A. Gersie (Ed.), *Brief Treatment Approaches to Drama Therapy* (pp. 125–138). London: Routledge.

Galway, K., Hurd, K., & Johnson, D. R. (2003). Developmental transformations in group therapy with homeless people who are mentally ill. In D. J. Wiener, & L. K. Oxford (Eds.), *Action therapy with families and groups using creative arts improvisation in clinical practice* (1st ed., pp. 135–162). Washington, DC: American Psychological Association.

Gruber, J., & Kring, A. (2008). Narrating emotional events in schizophrenia. *Journal of Abnormal Psychology*, *117*(3), 520–533.

Heerey, E., & Gold, J. (2007). Patients with schizophrenia demonstrate dissociation between affective experience and motivated behavior. *Journal of Abnormal Psychology*, *116*(2), 268–278.

Johnson, D. R. (1981). Drama therapy and the schizophrenic condition. In G. Schattner, & R. Courtney (Eds.), *Drama in therapy* (pp. 47–64). New York: Drama Book Specialists.

Johnson, D. R. (1984). The representational of the internal world in catotonic schizophrenia. *Psychiatry*, *47*, 299–314.

Johnson, D. R. (1992). The drama therapist in role. In S. Jennings (Ed.), *Drama therapy: Theory and practice* (pp. 112–136). London: Routledge.

Johnson, D. R. (2000). Developmental transformations: Toward the body as presence. In P. Lewis, & D. R. Johnson (Eds.), *Current approaches in drama therapy* (pp. 87–110). Springlfield, IL: Charles C. Thomas.

Johnson, D. R. (2005). *Developmental transformations: Text for practicioners*. New York: Institutes for the Arts in Psychotherapy.

Johnson, D. R., & Quinlan, D. (1985). Representational boundaries in role portrayals among paranoid and nonparanoid schizophrenic patients. *Journal of Abnormal Psychology*, *94*(4), 498–506.

Kingdon, D. G., & Turkington, D. (1994). *Cognitive-behavioral therapy of schizophrenia*. New York, NY: Guilford Press.

Landy, R. J. (1996). *Essays in drama therapy: The double life*. Bristol, PA: Jessica Kingsley Publishers, Ltd.

Landy, R. J. (2008). *The couch and the stage: Integrating words and action in psychotherapy*. New York: Jason Aronson.

Lehman, A. F., & Steinwachs, D. M. (2003). Evidence-based psychosocial treatment practices in schizophrenia: Lessons from the Patient Outcomes Research Team (PORT) Project. *Journal of American Academy of Psychoanalysis*, *31*, 141–154.

Patterson, T. L., & Leeuwenkamp, O. R. (2008). Adjunctive psychosocial therapies for the treatment of schizophrenia. *Schizophrenia Research*, *100*, 109–119.

Röhricht, F., & Priebe, S. (2006). Effect of body-oriented psychological therapy on negative symptoms in schizophrenia: a randomized controlled trial. *Psychological Medicine*, *36*(5), 669–678.

Röhricht, F., Papadopoulos, N., Holden, S., Clarke, T., & Priebe, S. (2011). Therapeutic processes and clinical outcomes of body psychotherapy in chronic schizophrenia – An open clinical trial. *The Arts in Psychotherapy*, *38*, 196–203.

Ruddy, R., & Dent-Brown, K. (2007). Drama therapy for schizophrenia or schizophrenia-like illnesses. *Cochrane Database of Systematic Reviews*, (1). Art. No. CD005378.

Schnee, G. (1996). Drama therapy with the homeless mentally ill: Treating interpersonal disengagement. *The Arts in Psychotherapy*, *23*, 53–60.

Schultz, P., & Searleman, A. (2002). Rigidity of thought and behavior: 100 years of research. *Genetic, Social & General Psychology Monographs*, *128*(2), 165.

Shaw, R. J., Dong, M., Lim, K., Faustman, W. O., Pouget, E. R., & Alpert, M. (1999). The relationship between affect expression and affect recognition in schizophrenia. *Schizophrenia Research*, *37*(3), 245–250.

Silverstein, S. M. (2007). Integrating jungian and self-psychological perspectives within cognitive-behavior therapy for a young man with a fixed religious delusion. *Clinical Case Studies*, *6*, 263–276.

Turkington, D., & McKenna, P. (2003). Is cognitive-behavioural therapy a worthwhile treatment for psychosis? *The British Journal of Psychiatry*, *182*, 477–479.

Van der Linden, M. (2008). Remembering the past and imagining the future in schizophrenia. *Journal of Abnormal Psychology*, *117*(1), 247–251.

Yotis, L. (2006). A review of dramatherapy research in schizophrenia: methodologies and outcomes. *Psychotherapy Research*, *16*(2), 190–200.