

**CAN YOUR INNER CHILD**

**COME OUT TO PLAY?**

**Towards a Play Deficit Model of Re-Claiming Spontaneous Play  
and Laughter Through Drama~Therapy**

**Sheila Karen Ostroff**

A Research Paper

In The Department Of

The Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements

For the Degree of Masters of Arts

Concordia University

Montréal, Québec, Canada

September 2001

© Sheila Karen Ostroff,

797 Bertrand Circle,

Ville St. Laurent, Montréal, QC. H4M 1W1

(514) 744-3284, [aloha@ostroff.com](mailto:aloha@ostroff.com)



National Library  
of Canada

Acquisitions and  
Bibliographic Services

395 Wellington Street  
Ottawa ON K1A 0N4  
Canada

Bibliothèque nationale  
du Canada

Acquisitions et  
services bibliographiques

395, rue Wellington  
Ottawa ON K1A 0N4  
Canada

*Your file Votre référence*

*Our file Notre référence*

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-82671-6

Canada

## ABSTRACT

### **CAN YOUR INNER CHILD COME OUT TO PLAY? Towards a Play Deficit Model of Re-Claiming Spontaneous Play and Laughter Through Drama~Therapy**

Sheila Karen Ostroff, For the Degree of Masters of Arts  
Creative Art Therapy (Drama~Therapy)  
Concordia University, September 2001

In this paper I explore the use of sensory embodiment and laughter in drama~therapy as a method towards repairing a “play deficit” due to early trauma. I will demonstrate through a case study that the regressive activation and the re-claiming of the inner child within the developmental play space provided by drama~therapy promotes spontaneity and role flexibility. This paper demonstrates why developmental play stages must be experienced to be assimilated and that spontaneity is not something that can ever be intellectualized. A major premise being that regressive play can be healing and that drama play provides a space for the cathartic release of memory and emotion and a place to process it. It is much easier to think creatively around a problem under conditions of play and merriment, than when our mind is filled with a sense of helplessness, worthlessness, powerlessness, and inadequacy.

The drama~therapist is a therapeutic witness and guide who creates a time, place and space for the inner child to feel contained and safe enough to be spontaneous. This unconditional acceptance permits a space for the recreation and experiential rediscovery of the stages of human development. The drama therapist can provide a model focused on increasing role flexibility through mind/body connections. A meta-physical and meta-cognitive framework is made available for the client to reflect and process their current and early play experiences but from an adult perspective.

Drama~therapy is a laughter therapy, that can contribute to mind/body wellness and advance mental health. Because, as we know, he who laughs.....lasts.

## ACKNOWLEDGMENTS

I would like to thank my husband **Neil** and my children **Liz** and **Alex** for their loving support, always. I think I have may have some time now. I would like to thank my parents, my father who took lots of time to read and play with me while I was a developing child and my mother who let him. I would also like to thank all my patient understanding good friends who put up with me.

I would like to express my gratitude to the many people at **Concordia** who have been important to me through all my years there. Thank you, Leo Bissonette from the Special needs department for providing me with wonderful editors. Thank you Christine Nadeau Morel whose door is always open a crack and usually has two minutes for me.

Many thanks to all my drama~therapy friends and my Montreal peer support group, Zeeva, Louise, Leigh, and Susan. My thanks to Christine Novy who imparted to me the benefit of her knowledge, reflections and many new ideas, and Denise Tanguay who is always open minded and most kind. Thank you Pierre Gregoire, for taking the time to listen to me and read my ideas. I would also like to thank Barbara MacKay with whom I experienced the meditative moment in the drama~therapy space.

Most of all, I would like to thank Stephen Snow, playful trickster, Shaman, intuitive wise man and dreamer of dreams that come true. A.K.A. the program director, it was he who introduced me to the laughter and openness of drama~therapy. You helped make so many of my dreams come true. Thank you for your support and flexibility. I admire your ability to see and care for the ideas in others.

# **CAN YOUR INNER CHILD COME OUT TO PLAY?**

## **Towards a Play Deficit Model of Re-Claiming Spontaneous Play and Laughter Through Drama~Therapy**

### **TABLE of CONTENTS**

<b>INTRODUCTION</b>	<b>1</b>	
<b>METHODOLOGY</b>	<b>4</b>	
<b>CHAPTER 1</b>	<b>THE QUESTION OF "PLAY AND SPONTANEITY" IN PSYCHOTHERAPY: AND THE CONCEPT OF THE "INNER CHILD"</b>	<b>9</b>
<b>CHAPTER 2 PART 1</b>	<b>THEORIES OF HUMAN DEVELOPMENTAL AND PLAY AND THE POSSIBILITY OF A "PLAY DEFICIT" IN ADULTS</b>	<b>25</b>
<b>CHAPTER 2 PART 2</b>	<b>THE MAKINGS OF A PLAY DEFICIT: ONE EXAMPLE OF IT'S POSSIBLE FORMATION</b>	<b>35</b>
<b>CHAPTER 3</b>	<b>USING RELAXATION AND LAUGHTER AS AN ANTIDOTE IN DRAMA THERAPY</b>	<b>40</b>
<b>CHAPTER 4</b>	<b>HOW DRAMA~THERAPY WORKS TO RECREATE THE DEVELOPMENTAL PLAY SPACE</b>	<b>52</b>

<b>CHAPTER 5 PART 1 TOWARDS A MODEL OF RE -CLAIMING SPONTANEOUS PLAY AND LAUGHTER THROUGH DRAMA-THERAPY</b>	<b>60</b>
<b>CHAPTER 5 PART 2 CLINICAL PRACTICE, PLAY &amp; IT'S RELEVANCE IN DRAMA-THERAPY TO OVERCOMING A PLAY DEFICIT</b>	<b>69</b>
<b>CONCLUSION</b>	<b>82</b>
<b>REFERENCES</b>	<b>vii</b>

## INTRODUCTION

*The quality and success of parenting is deeply enhanced when parents can realize their own neglected child selves and transform them into compassionate resources for the care of their own children. The way one treats the inner child strongly determines the way one treats the outer child (Abrams).*

### **Can Your Inner Child Come Out To Play?**

In my training as a drama therapist I have come to believe that honouring the child in us and giving that child the freedom to be playful allows us to become more open to ourselves. I also believe that *the inner child* can become actively engaged in drama~therapy through an early developmental sequential framework. British Play therapist Linnet McMahon (1992), defines play as:

A spontaneous active process in which thinking feeling and doing are separated from fear of failure or bad consequences... Risks can be taken because it is just play... The player is freed to be creative. However, an important condition for play to be spontaneous is that it can only take place within a safe, familiar and protected space, providing a time and a place, where the play has a beginning, a middle and an ending, and then one returns to everyday life (p.1).

The drama~therapist is a therapeutic witness and guide who can create a place, and a space in time for the *inner child* to feel contained and safe enough to be spontaneous. This unconditional acceptance permits a space for the recreation and experiential rediscovery of the stages of human development. The drama therapist can provide a model focused on increasing role flexibility through mind/body connections. A meta-physical and meta-cognitive framework is made available for the client to reflect and process their current and early play experiences, but from an adult perspective.

As a drama therapist trying to promote drama~therapy and play to the mental health community, I have experienced a lack of awareness of the benefits by professionals. I have also experienced resistance from some professionals about enlisting adults in this pursuit perhaps because of their own discomfort levels or because of their psychological model of training.

The purpose of this paper is to explain why and how a developmental drama~therapy model promoting play with adults can contribute to a wellness model in mental health. The construct of the *inner child* can be used therapeutically in several ways. I am using it as, the *inner infant*, the *consciously remembered child*, the collective *eternal child*, the *developing child* and the *spontaneous child*, the *emotional child*, the *wounded child* and the *traumatized child*.

I will attempt to explain the *inner child* within a context of different theories of why the regressive activation of the *inner child* could be an valuable approach. Once the *inner child* is found, soothed, played with, and appeased symbolically, the outer adult might be more willing and able to move on with increased flexibility.

This paper will explore a number of questions such as, what is differentiates normal from pathological early child development? Can a **play deficit** result from early trauma caused by an absence of spontaneous play during a critical developmental stage? What is a **play deficit**? How did the idea of the *inner representational child* evolve? How can drama~therapy help with this specific problem?

Through my drama and play work experiences I have become aware of the many reasons for which I believe could be termed **play deficit**. I am therefore proposing a reclaiming / recovery model of drama~therapy using the developmental play frame or space and basing this on the hypothesis that there may possibly exist a **play deficit** in some adult individuals. In child development psychology research and in play therapy there exists a multitude of etiological models that have been proposed to elucidate this concept. (Gil, 1991; James, 1994; Lewis, 1993; James, 1994; McMahon & Linnet, 1992).

This paper explains that developmental play stages must be experienced to be assimilated and that spontaneity cannot be intellectualized. A major premise being that regressive play can be healing.

I will explore the differences in normal and pathological child development. What can early embodiment play and therapeutic games do to re-establish a positive mind/body connection? Drama~therapy and embodiment play provide a space for the cathartic release of memory<sup>1</sup> and emotion and a place to process it.

It is much easier to think creatively around a problem under conditions of play and merriment, than when our mind is filled with a sense of helplessness, worthlessness, powerlessness, and inadequacy. Once the clients have moved past their own inner struggles, they can rediscover that playful *spontaneous inner child*. Drama~therapy is the only therapy with laughter as an integral benefit, and in a drama~therapy group all the emotional experiences are shared with adult playmates. By reintroducing developmental play systematically and sequentially through drama~therapy, a **play deficit** may be helped.

Drama~therapy is a multiple intelligence therapy in that it engages all areas of the person, developmentally. The sensory and experiential nature of the drama play exercises propels a person from embodiment to play to laughter. The therapist/witness creates the space for recalling personal issues.

How can a model of reclaiming the early *inner child* be put into play to find the *inner parent* and reconnect to the self? I will explore the use of embodiment play and laughter in drama~therapy as a method towards reclaiming spontaneity and repairing the **play deficit** that may have resulted in early trauma.

---

<sup>1</sup> This follows a 1996 model by Brucci, in which experience is conceptualized as being encoded at subsymbolic, nonverbal and verbal symbolic levels( in Cortina, 1997, <http://attachmenttherapy.com>).

## METHODOLOGY

As a professional who uses many forms of creative play as tools in my work, I think it is essential to understand the basis for the preconceptions and the prejudices against my work promoting play as a therapy for adults. In order to help defend, debate and dispel the many myths surrounding play, I believe that I must be able to explain and respond theoretically in the language of professionals from other fields. I believe this is a necessary step towards the support of drama~therapy, and creative arts therapies in general. Currently there is no research within the field of drama~therapy to support this conjecture about adult play and **play deficits**, so the basis for my paper at this junction is speculative. The information presented in this paper has been based on many fields including psychiatry, psychotherapy, child development, trauma research, play therapy and drama~therapy.

The orientation of this paper is a construction bridging theory and practice. This investigation is directed towards the importance of understanding the use and design of a developmental drama~therapy play model, used as a retrospective narrative framework with adults who have encountered forms of trauma in their childhoods. This paper will include a construction of a model of drama~therapy that utilizes the concept and actuality of the *inner child* retrospectively and actively in the *here and now*. What are the benefits that can occur when play is reintroduced in a safe therapeutic environment into adulthood through drama~therapy? I hope by the end, this question will be answered. The outline of my paper will be as follows.

### **CHAPTER 1 THE QUESTION OF “ PLAY AND SPONTANEITY “ IN PSYCHOTHERAPY: AND THE CONCEPT OF THE “ INNER CHILD”.**

Who or what is this *inner child*? The *inner child* has also been associated with the terms *true self* and the *creative self*. I will expand on this topic and others that relate to various historical and current views of regression, play, and psychotherapy. I will be using a constructivist approach in exploring a

variety of classical psychiatric concepts of why play is important. Following are some of the issues I be examining such as: The controversies surrounding the use of play and fantasy with adults that may have been given a negative image suffused with a negative pathology. Where are the bones of this belief buried? Why is play for adults so controversial? I will be introducing a historical context to *inner child* which is one of the main subject matters emphasized in this paper. The *inner child* moniker has been used as a motif by many professional psychotherapists, some of whom will be presented in this paper. I will be defining terms used to describe play from many perspectives and introducing both the supporters and the detractors of play.

First, I will look at a Freudian perspective on retrospective childhoods and the neurotic defences of repression and regression. Then, I will present the early Freudian pathological perspective of adult play and the influence of early psychological theory and the unconscious. This is followed by as review of the pathological psychiatric view of play and adult play conceptualized by Freud and adhered to by his followers. I will then bring in a historical and current perspective on Jung and his archetypal concepts of the *eternal child* and the personal *inner child*, and how that *inner child* is brought into therapeutic space. I introduce Joseph Moreno, originator of psychodrama and the first person to use action oriented spontaneous play with adults' ideology. Then Alice Miller and her ideas on the drama of the silenced and forgotten, wounded *inner child* are presented. To continue this constructivist approach, the role of the caretaker in early childhood is made known through Melanie Klein's theories of the importance of the symbolic object and the lost object, Donald Winnicott's ideas on the caretaker and the individual in the phenomenal space and Bowlby and Ainsworth anthropological findings on attachment to the caretaker are offered. Sullivan and Bucci use attachment theories to encode levels and layers of interpersonal understandings.

## **CHAPTER 2 PART 1 THEORIES OF HUMAN DEVELOPMENTAL AND PLAY AND THE POSSIBILITY OF A “PLAY DEFICIT “ IN ADULTS**

### **CHAPTER 2 PART 2 THE MAKINGS OF A PLAY DEFICIT**

In the first part of this chapter, I will be focusing on developmental psychology theory. Development deals with the ways that personality, cognitive ability, and behavior change during a person's life span, concentrating particularly on childhood development. I begin this chapter by introducing the work of three influential developmental psychologists namely, Piaget, Erikson, and Stern; I will then talk about pathological development and its long-term effects on an individual. I will include its impact on brain development and stage development. Part two, raises the possibility of a **play deficit** in adults and how drama~therapy can help. Finally, I will use post-traumatic stress disorder and its effects on an individual and their adaptation to trauma, as an example of what happens in trauma and development and neurodevelopment. I will give an example of how I think a **play deficit** can develop.

### **CHAPTER 3 USING RELAXATION & LAUGHTER AS AN ANTIDOTE IN DRAMA~THERAPY**

In 1955, Victor Frankl, the famous holocaust survivor and psychiatrist thought that *humour should be used as a compliment to regular therapy*. That is also, how I believe the mind and body benefits of Drama~therapy can be seen. Mind & body connections are a new direction currently being followed in many wellness programmes in hospitals and health centres. Due to the length of this paper I will only be focusing on the two introductory aspects of the drama~therapy warm- up experiences, the relaxing sensory and embodiment exercises and the playful fun games. I will do this from the neurophysiological and psychological viewpoints. I will do this by introducing current neurological concept and research studies on stress, relaxation, and laughter as medicine. I will also be expounding on the importance of these two curative aspects for dealing with stress as independent and often unrecognized vital parts in the drama~therapy process. The first part,

presents the neurobiological studies of stress and its impact on the individual physiologically and psychologically. Then explains how somatic relaxation and sensory motor work can play a vital part towards unveiling and healing early trauma by reconnecting the body and the mind. I will examine spontaneous laughter as medicine by linking it to positive outcomes in both physical and mental health.

#### **CHAPTER 4 HOW DRAMA-THERAPY WORKS TO RECREATE THE DEVELOPMENTAL PLAY SPACE.**

Chapter 4 presents how drama-therapy can mirror the early primary care, sensory and attachment experiences through experimenting in a safe trust filled space. I will be presenting some of the sources of drama-therapy, and a few of the developmental drama-therapy continuums that apply within this paper. Drama-therapy is a multi-arts medium that flows through the continuum of human development. Dramatic play can recreate the developmental stages and in so doing shift, cognitive, emotional, or interpersonal abilities by moving through areas that were blocked or skipped, forming and constructing new-found ego strengths. There are many ways to use the drama-therapy continuum but not all can be described in this paper. Drama-therapy is an art and a therapy that uses the physical presence as a medium for realizing ideas and feelings. Most of the drama-therapy models I will be speaking of in this paper are based on the developmental models of several key figures whose theories have advanced the field of drama-therapy, Joseph Moreno, Richard Courtney, Phil Jones, David Read Johnson, Anne Cattnach, Sue Jennings, Penny Lewis and Pam Barranger Dunne, to name only a few.

## CHAPTER 5 TOWARDS A MODEL OF RE-CLAIMING SPONTANEOUS PLAY AND LAUGHTER THROUGH DRAMA~THERAPY

This chapter, presents a model that I have created and used for adult women who were survivors of early childhood trauma or abuse. My clients have been mostly women, had there been a men's group, I am sure the experience would have played out somewhat differently.

The re-claiming of the *inner child* was essential in order to find a more assertive individuated adult. Some adults may have a difficult time with role flexibility or becoming spontaneous. A drama therapist is a professional trained in facilitating and developing playfulness and creativity with adults within a safe containing transitional space, recreating the infants' earliest symbolic experiences to the final dramatic development of role flexibility. In this case model of a developmental drama~therapy play group, for the seven sessions specified, I will be explaining the objectives, rationale, the aim and giving some processing of the group work.

### CONCLUSION

Where can drama~therapy be used to its best advantage. What makes it different from other therapies? I speak about the **play deficit** and how drama~therapy can accommodate the re-experiencing of early play development. I focus on the process and forms of play as they relate to the mind and body therapeutically with adults, adolescents, and children. The medium of drama~therapy has many areas that can be spotlighted but within the limits of this paper I focus on the importance of developmental play space that drama~therapy provides and the opportunity for the re-discovering of spontaneity and flexibility.

## CHAPTER 1 THE QUESTION OF "PLAY AND SPONTANEITY" IN PSYCHOTHERAPY: AND THE CONCEPT OF THE "INNER CHILD"

*In every adult there lurks a child--an eternal child, something that is always becoming,  
is never completed and calls for unceasing care, attention and education.  
That is the part of the human personality and which wants to develop and become whole (C.G. Jung).*

As a professional who uses many forms of creative play as tools in my work, I think it is essential to understand classical and current theories being used in the field of mental health. To understand the basis for preconceptions and the prejudices I may encounter and in order to debate and dispel the many myths surrounding play, I believe that I must be able to explain and respond theoretically in a language understood by professionals in other fields.

The idea of an adult playing and the use of fantasy in therapy have traditionally have been controversial subjects. Is adult regression pathology or is it an activated neurotic defense? Can spontaneous expression and the use of the imaginary be effective for the re-claiming and development of ones self and psyche?

This paper is in support of letting the *inner child* out to play. Where did the idea of an *inner child* originate? Why is activating the spontaneous child in therapy an important therapeutic construct in drama~therapy? This first chapter presents the adult/child in therapy and play from different psychological perspectives by presenting a brief history of its conception and development, it's detractors and proponents. Sigmund Freud, originator of retrospective childhood histories and defense mechanisms, is reviewed. Carl Jung, originator of the *inner child* archetype, defined how the child in therapy should be used and examples will be offered as to how the *inner child* can be facilitated in the creative arts therapies. J. L. Moreno and Alice Miller are mentioned as defenders of the child within the adult.

The trusting environment needed in the primary relationships and necessary for a place to play, will be substantiated through Melanie Klein's theories of symbolic object relations and Donald Winnicott's ideas on the phenomenal play space. Finally, the important constructs of Bowlby, Ainsworth, and Sullivan will be presented to help explain what results from different types of attachment development.

## PLAY IN THE ERA OF NEUROSIS

*"A distinction has not been made between art and neurosis especially since the first is a blessing of humankind and the latter is one of the curses" (Storr).*

### Sigmund Freud

How does the framework of what can be considered normal or healthy behaviour in our current culture such as play apply to the Victorian era of 1837-1901? Psychiatrists at that time, were as Carl Jung said "not interested in what the patients had to say, but rather in how to make diagnosis or how to describe symptoms and to compile statistics...patients were labelled and rubber stamped with a diagnosis...it was Freud who introduced psychology to psychiatry" (Jung, 1961, p.114). However, at the same time it must also be acknowledged that Freud, as an neurologist working in the 1800's, used concepts, definitions and adjectives to describe art, creativity, and play that were conceived and originated from that time and place. In 1924, Sigmund Freud, strongly hypothesised that art, creativity, and playing should be classified as *defence mechanisms of fantasy, regression, and sublimation* and as *pathological*<sup>2</sup> evasions of real life. For example, when comparing a successful writer's activity, to that of a child at play, he wrote, "The creative writer does the same as a child at play. He creates a world of phantasy which he takes very seriously...invests large amounts of emotion – while separating it from reality... as people grow up they cease to play, and they seem to give up the yield of pleasure which they gain from playing" (Freud, in Storr, 1972, p.157). Freud linked together childhood play, dreams, and daydreams as being escapist wish-fulfilling activities designed

---

<sup>2</sup> Pathology being any condition that is not normal and any condition that is a deviation from the normal (*Encarta World English Dictionary, 1999,2000*)

to compensate for an unsatisfying reality. Artists were in his view like children who continued to build castles in the air instead of coping with reality in an adult fashion. Freud attached a negative sign to all imaginative pursuits and implied that if the artist was more adapted to reality there would be no place for creative endeavours... and said that " a happy person never phantasies only a unsatisfied one" (Freud, in Storr, 1972, p.xii).

However, it seems that he did not consider all imaginative work to be negative. Freud states "an artist's joy in creating, in giving his fantasies body, or a scientist in solving problems or discovering truths, has a special quality which we shall certainly one day be able to characterize in metapsychological terms (Freud, in Chasseguet – Smirgel, Grunberger, 1986, p.61). These two views lead us to believe that there existed in Freud an ambivalence towards art and creativity.

Anthony Storr(1993) is a well known writer and practicing psychiatric psychotherapist trained in both psychoanalysis and analytical psychology. His view is that creativity is more bound up with a *dynamic of the normal* than with psychopathology and there is no hard and fast line between mental illness and mental health. That is because he thinks that the agents for change in psychoanalytic process are themselves symbols; "For words are representations of reality rather than reality itself: and yet their judicious selection as Freud well knew, can profoundly alter a man's psychological attitudes" (p.196). Storr believes that Freud found himself compelled to theorize "that artists were close to neurotics but who escaped their fate by sublimating their sexual energy into work. And that the arts were products of sublimation: and derived from primitive and possibly aggressive, instinctive impulses for which they were ultimately substitutes for" (Storr, 1993,p.6). As a result of Freud's theorizing and ruminations, Storr(1973) feels that psychoanalysts often have difficulty discerning the difference between neurotic symptoms, pathological defences or psychological techniques of a positive kind which serves the individual well in relating to the subjective and the outside world, and which constitutes the process of living (1973, p.50). Even so, his daughter and disciple Anna Freud,

later defined sublimation as the displacement of the instinctual aim in conformity with higher social values and that sublimation pertains rather to the study of normal than to that of neurosis (Storr, 1973, p.6).

To add, there exists within the nature of spontaneous play and in all forms of creativity a certain measure of chaos. What can be learned from the chaos is that a form of order can be created. This idea is one that exists always and perpetually in nature and in the nature of the arts.

### **Childhood Memories in the Service of Therapy**

In 1919 when Freud spoke about his theories, there was an ambiguity in his beliefs about the real child, childhood and the fantasy child. In his early psychiatric psychoanalytical work with adults, the child was spoken about but retrospectively. Childhood is always referred to as a site of reminiscence. Freud did not analyze children because "childhood has it's own ways of seeing, thinking, and feeling". He believed that the job of therapy was in the analysis of childhood and that "the essence of psychoanalytic method is to alter something...and when it has succeeded in removing the amnesia which conceals from the adult his knowledge of his childhood " (Hillman, 1990, p.78, 81).

In Freud's view, retrospective reflection was necessary for finding the medical or neurotic causes, but treatment was much more about changing the conscious personal attitude (Jung, 1954,p.21). It was the influence of early childhood histories and the work that could be done with the unconscious that Freud was interested in.

Freud was the first to actualize the child. He gave the child *primacy*, he considered nothing to be more important than those early years of childhood. He the gave the child *a body*, it now had passions, sexual desire, lusts to kill, fear, sacrifice, rejection, hate, love and preoccupations with bodily functions. Freud gave the child *pathology* in the form of repressions, fixations, and suffering(Hillman, p.79). Freud also considered that dwelling continuously on the evils of past childhoods and remain there wallowing in self-pity(from those memories) to be a neurotic tendency.

Kris's term "regression in the service of the ego" has been the only regression generally considered tolerable in psychoanalysis (Hillman, p.85).

### **Carl Gustav Jung**

Carl Jung, who was mentored by Freud eventually parted ways with him over their different beliefs. Jung did however agree with Freud on the matter of retrospection but with his slant, which was that "*the regressive tendency* only means that the patient is seeking himself in his childhood memories... His development is one sided: it left important items of character and personality behind, and thus it ended in failure. That is why he has to go back. A dominating one-sidedness leads to disaster"(Jung, 1954, p.33). " This *inner child* theory is that the child and the childhood are not actual. The child motif is a picture of forgotten things from our past, it represents the pre-conscious childhood aspect of the collective psyche..."(Jung, in Hillman 1990, p.27). We cannot know what children are until we have understood more of the workings of the fantasy child, the archetypal child in the subjective psyche. Jung felt that the *inner child* was a psychological corrector. He claims that,

The child motif represents something that not only existed in the distant past but something that exists now...not just a vestige but a system functioning in the present whose purpose is to compensate or correct, in a meaningful manner, the inevitable one-sidedness and extravagances (Jung, in Hillman 1990, p.81.).

Jung emphasized aspects of *inner child* workings such as, the child in therapy, the child archetype, the developing child, and child - like play for adults. In it, he explored what he called "*the child motif*" and "*the childhood aspect of the collective psyche*"(Hillman, in Abrams, 1990, p.80).

## INNER CHILD AS OUR EMOTIONAL SELF

*"Renewal, divinity, a zest for life, a sense of wonder, hope, the future, discovery, courage, spontaneity, immortality. As such the inner child is a uniting symbol and brings together the separated or disassociated parts of the individual...It is the primordial image of the Self, the very center of our individual being (Abrams).*

The *inner child* concept has taken on many meanings since Carl G. Jung (1940) first conceived it in his writing of The Psychology Of The Child Archetype. Jeremiah Abrams (1990), editor of Reclaiming The Inner Child says that, "The *inner child* is both a developmental actuality and a symbolic possibility... it is the soul of the person, created inside us through the experiment of life, and is the primordial image of the Self, the very center of our individual being ...The child's voice is essential to the process of becoming one [an individual]. Individuation is, the life long process of personality development, it is tied to and circles around the unique identity of the childhood self...the child we have been remains within us ...a container of our personal history and forever symbol of our hopes and creative possibilities" (Abrams, 1990, pp.1-2). The child archetype or "*inner child*" can be found within many manifestations of dreams, art, myth, fairytale story, and literature.

The concept of the *inner child* as an archetypal symbol and Carl Jung's view on regression have been discussed and written by his followers right up to the present day, such as his belief that

"Regression is a genuine attempt to get at something necessary, the universal feelings of childhood innocence, the sense of security of protection, of reciprocal love of faith- a thing that has many names" (Jung, 1954, p.62.). In her book, The Drama of the Gifted Child (1981), Alice Miller's regression work with adults has greatly influenced practitioners with regards to the *forgotten, wounded, traumatised or abused inner child* because she was one of the first contemporary psychoanalysts to look at her own theory base and reject it.

Jung said, "the tendency to engage in regressive activity has the positive function of keeping us to the child and of activating the '*inner child*' " (1954, p.62). This paper based on a developmental drama play therapy model is about encouraging *the inner child* to emerge by

promoting the *inner child* as being both a developmental actuality and a symbolic possibility as Jeremiah Abrams previously suggested. Therapy via the arts invites, attracts, and encourages the participation of the *inner child* in a directed temporary return to a child like state by using forms of creative or expressive engagement. Lucia Capacchione, art therapist and author of Recovery of Your Inner Child works with the *inner child*, *the inner parent*, and the *inner family*. For her the *inner child* is the emotional inner self. A wounded child with memories and voices from the past, closeted in the body symptoms that have been expressed suppressed or repressed in the body. She creates a safe space for her clients to be creative.

### **Joseph Moreno and Spontaneity**

Dr. Joseph Moreno, a Viennese psychiatrist and psychotherapist, and a younger contemporary of Freud, Jung, and Adler, documented the first positive psychological benefits of drama in 1909. He was the innovator of psychodrama<sup>3</sup> action treatment methodology and sociometry, his own theory of personality and inter-personal relationships<sup>4</sup> he based his theories of acknowledging that everyone has the capacity to be a creator. He believed that spontaneity is the fresh ingredient in the creative process, from which the creative act derives (White, 1983).

He is also acknowledged as being a major contributor, and one of the pioneers of group psychotherapy. He saw the family as the place where our most significant learning about ourselves began, it was the matrix of our identity and where spontaneity was fostered or extinguished. He looked to all groups in the individual's world for patterns of behaviour sources of conflicts and overload for resources and for new possibilities.

Moreno moved beyond Freud's intrapsychic focus in his belief that here and now interactions as well as patterns in the family of origin are seen as influencing the individuals' sense of well being and

---

<sup>3</sup> Psychodrama is a method that uses techniques such as role-playing and role reversal as a psychological method.

<sup>4</sup> Sociometry is a method, which measures interpersonal relationships in groups. It is a concrete method of showing all the people in a person's life that have a significant psychological connection. It can be real or fantasy, present, past, or future.

level of functioning (White, 1983). He felt that the goal of therapeutic intervention was to expand the role repertoire, to give relief from overdeveloped existing roles, and to explore a range of new role for new outcomes

Adam Blatner (1997), an internationally well-known psychodramatist, tries to define the meaning of spontaneity, play, and fun. He says spontaneity is elusive because,

“ it involves the quality of the mind, the active opening up which accompanies the thinking of new ideas or the trying something in a new way. It involves thinking afresh, balancing impulse and restraint, and integrating imagination reason and intuition. Spontaneity is the process by which inspiration enters creativity. It is more than mere impulsivity because it requires intention to achieve an aesthetic or constructive effect. Spontaneity may be understood as the opposite of habit, stereotyped thinking neurotic compulsive rituals, or transferences ... In being spontaneous you are open to the present moment is different from the past...and it's fun (p.5).

He says fun does not mean irresponsible frivolity, destructive behaviours or self-indulgent hedonism, which are maladaptive forms of enjoyment (Blatner, 1997, p.6).

### **Alice Miller**

Alice Miller, a classically trained German psychoanalyst wrote about the power of repression and the inadequacy of psychoanalysis that reinforces suppression through its theories; How conventional methods of psychoanalysis block the creativity of patients as well as analysts. She said that it was only through the act of following her impulses in a playful way via spontaneous painting that she was able to find access to her own *inner child*, her true self. She said that in not speaking about childhood wounding and staying silent, does immense damage to the true self<sup>5</sup>, “it causes the child inside to be abused, exploited, and turned to stone... That it is only, when this *inner child* find's it's feelings, can it speak and tell the drama of it's story... If, however we can take the path that was opened up by D. W.

---

<sup>5</sup> Miller's writings are based on the search for the hidden, lost and authentic true self, and idealized, conforming false self (Miller, 1981, p.xvi).

Winnicott the patient will reach a new sense of being really alive and regain his capacity to open up to full experience. Then he will be able to face his repressed conflicts"(Miller, 1981, pp.vii-xvii).

Alice Miller proposed that we need enlightened witnesses in our society to stand up for children assertively, protect them from the adult's misabuse of power, and hear the signals coming from the child inside and children everywhere (1981).

## **THE PLACE WHERE PLAY BEGINS**

### **Melanie Klein**

It was Melanie Klein, one of the pioneers of child psychoanalysis, who discovered that all child's play had symbolic significance which led to the development of her play technique. She proposed that symbol formation is the product of loss and symbolic play allows for the experience of differentiation of internal reality and external reality. She believes that the main task is to understand and interpret the child's fantasies, feelings, anxieties, and experiences expressed by play and symbols. If the play activities are inhibited then they must be overcome. She said that mourning and grief felt by losses are experienced as depression and are intensely painful to the child. Concepts can be used to think of objects<sup>6</sup> in their absence and the fullness of shared meanings becomes more available to the child through language. If depressive pain can be tolerated, the capacities for thinking, linking and abstraction develop, which connect the child all the more effectively with the world through ever more elaborated meaningful relationships. The drive towards reparation is the child's loving and anguished need to restore abused and damaged internal situations, and this is directed towards external objects, which stand for the damaged internal objects. Concepts can be used to think of objects in their absence and the fullness of shared meanings becomes more available to the child through language

---

<sup>6</sup> Klein imagined that mental structures rose out of various internal objects. In the paranoid-schizoid state of being the infants creates the object (the object initially being only the breast). If the infant cries the breast appears. Therefore, all is good, and it is a good object. If the breast does not appear it is then a bad object. The infant internalizes this way of thinking. The relationship associated to the object (part object, caregiver) is split into persecutory and idealized relationships. The ego (the self) is then similarly split (1932).

(Klein, 1932). Klein's emphasis was on the development of the relationship within the therapeutic setting (Waller and Gilroy, 92). She believed that the disturbed child differs essentially from the well adjusted child in that growth was impaired at some level of the process of emotional development (Klein, 1955). Perhaps, there is also a place of impairment in a traumatic situation where a **play deficit** occurs.

### **Donald Winnicott**

Donald Winnicott, Psychotherapist, paediatrician and author makes a significant distinction between the meaning of the noun play and the verbal noun playing in his book Playing & Reality. For him "playing has a place and a time". It is not wishing or thinking, doing things takes time and says playing is doing" (1971, p.41). Donald Winnicott's theories of play, object relations and the phenomenal space<sup>7</sup> have greatly influenced all of the creative arts therapies especially drama~therapy, a therapy of playing and witnessing. Winnicott spoke of the "potential space" as being where we play and that is where outer and inner realities meet. The creative arts therapist attempts to recreate in a therapeutic holding space, that playful intermediate area of experience and experiencing.

As a paediatric psychiatrist working with parents and children, he believed that the study of play in development from very early on, made use of material that had been otherwise neglected in the field. He thought that this may have been the case because the area of play in therapy overlaps that of the therapist and the clients, and there may have be the countertransferential difficulties along with the theoretical reasons for this strong resistance to play. His theories included an emphasize on the importance of the transitional object and the transitional phenomena as "*the intermediate area of*

---

<sup>7</sup> In Winnicott's object relations theory, the object represents the infant's transition from a state of being merged with the mother to a state of being in relation to the mother as something outside and separate His concern was with the first possession (object) and the intermediate area between the subjective and that which is objectively perceived. Transitional objects and transitional phenomena for him were at the basis for initiation of experience. This concept is his basis the trusting environment, a contained phenomenal space, where symbolic play can be used therapeutically (1971).

*experiencing*'. This area of space he has called "the third part of a persons life which inner reality and external life both contribute... a resting place... keeping inner and outer reality separate yet interrelated. This is "the place of illusion" which he says in adult life is inherent in art and religion (1971). It is this " place " that is closely parallels the developmental play space in drama-therapy.

Winnicott (1971) believed that in life, " to control what is outside (external) one has to do things not simply to think or wish it, and doing things takes time... playing is doing. Play is universal and belongs to health" (p. 41). "The intermediate area of experience, unchallenged in its respect of its belonging to internal or external (shared) reality, constitutes the greater part of the infant's experience, and throughout life is retained in the intense experiencing that belongs to the arts and to religion and to imaginative living and to creative scientific work" (Winnicott, p.14).

He felt that the good enough care taker encouraged trust through interactive play experiences<sup>8</sup>. He defined this as a phenomenal space, an intermediate area where playing has a time and a place to become a potential space for a shared reality. Winnicott (1971) stated:

When symbolism is employed the infant is already clearly distinguishing between fantasy and fact, between inner and outer objects, between primary creativity and the basis of the attachment to the mother; is in the non-verbal realm of the interpsychic, intrapsychic, the interpersonal and the symbolic.... Creative playing is allied to dreaming and to living but essentially does not belong to fantasizing...Fantasizing interferes with action and with life in the real or external world... it interferes with dream and with the personal or inner psychic reality, the living core of the individual personality. The Transitional objects and transitional phenomena belong to the realm of illusion, which is at the basis of initiation of experience" (p.31).

He thought spontaneous play is a creative place where the baby must be given this chance to live relatively and use objects to be creative with. If there is no area in which to play or have an experience then there is no link. "The deprived child is restless and unable to play. Failure of dependability or loss of object means to the child a loss of the play area, and the loss of meaningful

---

<sup>8</sup> Much like the transference phenomena in psychotherapy.

symbols"(Winnicott, 1971, pp. 101-102). Drama-therapy opens up a path as suggested by Miller and creates those links referred to by Winnicott within a created developmental play space.

## **ORGANIZED AND DISORGANIZED FORMS OF ATTACHMENT**

### **John Bowlby and Mary Ainsworth**

Winnicott's concept of good-enough mothering which for him, also included fathering, was dependant on the continuity of care and of the caretaker within a facilitating environment (Winnicott, 1981, p.141). Bowlby's theory focused on the complexity of infant's behaviour with its primary caregiver from the beginning of the baby's personal life (Winnicott, 1981, p.142). He paid particular attention to the function attachment behaviour and to various factors that may shape the organization of an individual's attachment system (Fraley, C. & Shaver, P., 1999, p.737). Bowlby termed this a secure base phenomenon. Mary Ainsworth conceptualized the caregiver's responsibilities in the following terms; sensitivity to signals, cooperation vs interference with ongoing behaviour, physical and psychological availability vs. unavailability, and acceptance vs. rejection of the infant's needs (and consequent limits on the caregiver) (Ainsworth, 1982). These ideas led to the classification of three types of attachment namely, secure attachment, resistant attachment, and avoidant attachment. However, with caregivers who are anxious, intrusive, or rejecting, attachment research has shown that two varieties of anxious attachment then develop, the resistant pattern and the avoidant pattern (Cortina, 1997). Bowlby's discovery of these secure and anxious patterns of attachment was originally based on a laboratory procedure using monkeys. Ainsworth's theories on the Strange Situation (SS) evolved from naturalistic observations of mothers from a village in Africa and later in a middle class sample in Baltimore, Maryland (Ainsworth et al., 1978).

The key constructs in Bowlby-Ainsworth attachment theory is that affectional bonds are formed as a result of interactions between child and parent. Emotional life was seen as dependent on the formation, maintenance, disruption, or renewal of attachment relationships. The basis of the

attachment theories proposes that out of the first relationship with the primary caretaker "stems from a set of expectations and assumptions which will influence subsequent relationships - which can not easily be changed" (Parkes, Stevenson - Hinde, Marris, 1991, p.1).

It has been found that many children categorized with disorganized status in the Strange Situation (SS) have parents that abuse them. There is also clear evidence that children with disorganized attachment patterns are at a greater risk for the occurrence of psychopathology in later development (Cortina, 1997). This idea concerned Winnicott as well, because he felt that the richness of the happiness that builds up in health, does not build up in psychiatric ill health (Winnicott, 1981, p.142).

### **Sullivan and Bucci**

In Harry S. Sullivan's (1953) book The Interpersonal Theory of Psychiatry, he espouses that human development can only be understood in a relational context. Sullivan believed that mother's anxiety could be very disruptive to the relationship and development of interpersonal patterns and that caregivers have the capacity to induce severe anxiety in their infants. This has relevance to disorganized-disoriented patterns of attachment. He conceptualized three modes in which experience was encoded, the prototaxic, parataxic and syntaxic modes are early forerunners of cognitive and emotional models that have attempted to conceptualize how intuition and experience at subsymbolic levels influence behaviour. Pototaxic mode was an undifferentiated state in which the infant was incapable of making distinctions between self and others. Parataxic perception of experience (non verbal) are lived moment based on associations, memory of events, rudimentary moments, causal connections in the symbolic and verbal where conclusions are drawn from reasoning and foresight. Syntaxic modes contain rules of logic consensual validation (verbal) generalization of experience beyond immediate context (Sullivan, in Cortina, 1997).

In Bucci's (1996) model of cognitive organization, he says that the mind encodes experience in three modes at the subsymbolic, the nonverbal symbolic and verbal symbolic level. These

In Bucci's (1996) model of cognitive organization, he says that the mind encodes experience in three modes at the subsymbolic, the nonverbal symbolic and verbal symbolic level. These information-processing models are views of the emotional experience and the emotional processing of experience. He says that one can focus on subsymbolic experience by using symbolic imagery, which is the mediating mode of encoding experience. Subsymbolic experience is based on analogies, global, holistic. It has a sense of immediacy to it that can be modality specific (visceral, sensory experienced on a connectionist kinaesthetic) using discrete specific sequential imagery or by processing what the meanings represent<sup>9</sup>(Cortina, 1997). Bucci's view of the therapist's task is to convert disturbing emotional experience that has been encoded at the subsymbolic levels --and remains inaccessible to awareness--into symbolic images and words into narratives.

Infancy, childhood, and adolescence are currently considered as sensitive periods during which attachment behaviour develops normally or deviously according to the experience the individual has with his attachment figures (Greenberg, 1999 p. 472). In proposing my hypothesis, I considered that the combination of early trauma and a lack of a place to feel safe and play spontaneously could be considered as a disruption to normal attachment and psychosocial development. I hypothesised that if this interruption was severe enough and long enough it could possibly lead to a lack of developmental play at critical stages. Moreover, the earlier the disruption occurs perhaps the earlier the **play deficit** is manifest.

Traumatic experience at any age may by-pass codification at symbolic levels, and hence remains sequestered in the form of subsymbolic experience. One of the distinct features of Bucci's model that separates it from Freud's concept of primary process, is that subsymbolic processing is not primitive. Freud considered primary processes as impulse ridden and dominated by wishful

---

<sup>9</sup> What Daniel Stern, 1985, calls RIG's--representation of interactions that become generalized. See chapter 3

processes can compute infinitely more information than serial processing. Most activities like learning to play tennis, sculpting, dancing, or painting, [ drama] are processed at subsymbolic levels. Once the step is mastered, it becomes automatic and is processed "off line" at subsymbolic levels. Subsymbolic is not necessarily unconscious. We can focus on subsymbolic experience by using symbolic imagery, the mediating mode of encoding experience (Bucci, in Cortina, 1997).

Symbols and language have properties of reference-symbols refer to other entities such as signs and signals and generativity-symbols can be combined to form an infinite number of new forms. Emotion and speech develop independently of each other, but become increasingly intertwined during development. There are gains and losses in the transformation of emotion into the symbolic world of language"(Cortina, 1997).

This is very important to creative arts therapists who try to enter into the subsymbolic realm to connect and communicate through the symbolic imagery in areas such as drama, art, dance/movement, and music.

In this chapter, I have attempted to show the origins of the child theme in psychotherapy. In summary, Freud invited the client to sort through their memories of childhood for retrospection and reflection. One aim of his was to detect unconscious pathological defences used in creative pursuits. He considered them mechanisms of repression, regression, and fantasy. Jung encouraged the adult client through the many manifestations of the archetypal eternal child in myth, fairy tales and dreams to realize their authentic selves and experience the spontaneous child in their personal consciousness through creativity. Moreno enjoyed chaos, and used disorder to create order through spontaneity, the play and drama directed by the therapist towards a cathartic moment of enlightenment. Klein attributed feelings of sadness and loss in the mourning of the lost object and stressed the importance of play during childhood. Winnicott proposed that a *good enough* attachment is a relationship formed between a caregiver and a child that meets the needs of both and within this phenomenal space a place to play creatively can be found. Anthropological

studies by Bowlby and Ainsworth demonstrated that loss or threat of loss of the attachment figure was seen as the principal cause in the development of psychopathology. Problems arose when a *good enough* attachment was interrupted by the prolonged emotional or physical unavailability of the attachment figure (James, 1994). Sullivan and Bucci spoke about the disruptions in attachment and where the levels of the encoding are stored from those experiences.

The next chapter will focus on normal development, developmental psychopathology and **play deficits**. Developmental Psychopathology is regarded as being due to a person having suffered or still suffering the consequences of disturbed patterns of attachment, leading them to have followed a deviant pathway of development.

## CHAPTER 2 PART 1 THEORIES OF HUMAN DEVELOPMENTAL AND PLAY AND THE POSSIBILITY OF A "PLAY DEFICIT" IN ADULTS

*The developmental paradigm is one of the most powerful means by which people have attempted to understand themselves (Johnson).*

Human development is so complex. According to German philosopher Feyerabend, "There is only *one* principle that can be defended under *all* stages of human development. It is the principle that: "*anything goes*".<sup>10</sup> It has also been held that personhood is a process through which we try to mark the "stages" of development in this process. Development is believed to continue across a lifetime from infancy through to late adulthood (Freud, 1905; Werner, 1948; Piaget, 1954; Erickson, 1968; Kubler -Ross, 1969; Levinson, 1978). Development theory has been the subject of study in the fields of psychology, psychiatry, education, social work and medicine. Each field has its own unique perspective. Early psychologists have described the development of thought in essentially three stages (Piaget, 1951):

- 1) Sensory motor - thoughts are represented through bodily movements or expressions.
- 2) Symbolic - where things are represented by symbols (visual, sonic, gestural, postural as in mime).
- 3) Reflective-where representation is accomplished through words, language or other abstract symbols.

Jean Piaget, Erik Erickson and Daniel Stern are theorists who have identified set stages of normal psychosocial developmental and their theories are widely used by professionals in the fields of education, psychology and creative arts therapies. I will be presenting views of normal and abnormal development and what happens in childhood when these normal developmental paths have been interfered with through trauma. I will discuss Post Traumatic Stress Disorder (PTSD) and the psychological and physiologically effects stress has on a persons' development. My

---

<sup>10</sup>*Encarta® Book of Quotations* © & (P) 1999,2000 Microsoft Corporation. All rights reserved. Developed for Microsoft by Bloomsbury Publishing Plc.

hypothesis of a **play deficit** in adulthood links into these concepts, so I will show how a trauma or neglect occurring during a critical stage of a child's development could have lead to missed phases of spontaneous play. I propose to show in this chapter that a failure to provide a safe place to play, nurturant, sensitive and available supportive caregiving, or environmental or medical trauma in early childhood, could also have contributed to the existence of possible **play deficit** in adults. My proposed **play deficit** intervention for adults, applies drama~therapy as a regressive model recreating normal play development in a therapeutic space.

### **Normal Psychosocial Development**

Theoretically, the outcomes in an individual's life combine to produce a psychosocial history that could be used to explain events in the person's life and to describe the person's point of reference to life events and can possibly be based on a combination of five organizational concepts (Newman & Newman, 1984):

- Stages of development.
- Developmental tasks.
- The psychosocial crisis.
- The central process for resolving the psychosocial crisis.
- Coping mechanisms.

For a long time, it was an accepted practice that adult models were the guides used to assess children. The contemporary mind/body approach examines developmental and psychiatric disturbances in childhood directly. These disturbances are currently considered "a result of complex interactions over the course of development between the biology and brain maturation and the multidimensional nature of experience" (Mash & Dozois, 1996, p.5). It has been determined that children and adolescents actually suffer from emotional disorders at as high or higher rates than adults (one in four) (Ingersoll, 1995). It is now known that depression in childhood is very common,

and if untreated, it has far reaching consequences that can influence every aspect of a child's growth and development. The field of developmental psychopathology has emerged as the study of adjustment, maladjustment and adaptation over the course of development that is the life span ( Mash & Barkley, 1996). From a developmental psychopathological viewpoint, a breakdown in the formation of a secure parent – child attachment relationship creates a core disturbance in the ability of the abused [traumatised] children to form future healthy relationships (Wekerle & Wolfe, 1996). Studies assert that early play experiences that are witnessed by a caretaker in a safe trusting environment promote secure attachments through affect attunement (Stern, 1985). A parent's failure to provide nurturant, sensitive and available supportive caregiving may be a fundamental feature across all forms of maltreatment and it may be a link to future developmental problems or reoccurring violence across generations. There is also a growing body of evidence that suggests that exposure to violence or trauma alters the developing brain by altering normal neurodevelopmental processes (Wekerle & Wolfe, 1996).

### **Jean Piaget's Constructive Development**

The Swiss psychologist, Jean Piaget, was the first person to study development through the play of children. His researches in developmental psychology and genetic epistemology had one unique goal, to establish how knowledge grows. Piaget focused on the constructive nature of cognitive and intellectual development which is that children did not just absorb information but instead used their developing mental structures and reasoning capacities for building personal interpretations of concepts.

He recognized that a child's view of the world was not a copy or a reflection of an adult view of life. Children's logic and modes of thinking are initially entirely different from those of adults. Each child creates his own views based on their ability within their reality at a given point in time. A child's view to understanding his world goes through developmental transformations along with their play (Piaget,

1962). He realized that development was a bottom-up process. That tactile and kinaesthetic sensations guide early attachment behaviour as well as help regulate the infant's behaviour and physiology. Infants and very small children explore the world through these systems, building the neural networks that are the foundation for later cognitive development (Piaget, 1952). According to Piaget (1962), the stages of schematic play must be experienced to be assimilated. In other words, play cannot be intellectualized because it is experiential.

The activities of very young children are often dominated by sensorimotor (Piaget, 1952) and emotional systems (Schore, 1994). Piaget found that children needed to use play to explore and learn about the world. Some of Piaget's ideas have been vigorously challenged. The current fashion views knowledge as an intrinsic property of the brain. However, experiments have demonstrated that newborn infants already have some of the knowledge that Piaget believed children constructed<sup>11</sup>.

### **Erik Erikson's Epigenetic Theory on Development**

Erikson believed that childhood is very important in personality development. However, he believed that Freud misjudged some important dimensions of human development. Freud said that our personality is shaped by the age of five, Erikson felt that personality continued to develop beyond five years of age. Erikson's developmental theory sees a person's lifelong development as a long series of developmental crises (Leick & Davidson-Neilsen, 1996). For Erikson all of the developmental stages are present at birth, but unfold according to an innate plan, with each stage building on the preceding stages, and paving the way for subsequent stages. Each stage is characterized by a psychosocial crisis, which is based on physiological development, but also on demands put on the individual by parents and/or society. Ideally, the crisis in each stage should be resolved by the ego in that stage, in order for development to proceed correctly. Trust vs. Mistrust -- birth to one year. Autonomy vs. Shame & Doubt -- two and three years, Initiative vs. Guilt -- ages four and five, Industry

---

<sup>11</sup> See Stern.

vs. Inferiority –from six years to puberty, Identity vs. Role Confusion – adolescence, Intimacy vs. Isolation -- young adulthood, Generativity vs. Stagnation -- mid adulthood, Integrity vs. Despair -- late adulthood.

Erikson believed that development is primarily qualitative because changes are stage- like, but also quantitative as one's identity becomes stronger and one's convictions solidify. He believed that nature determines the sequence of the stages and sets the limits within which nurture operates. However, all must pass through one stage before entering the next in the stated order. The outcome of one stage is not permanent, but can be altered by later experiences. Everyone has a mixture of the traits attained at each stage, but personality development is considered successful if the individual has more of the "good" traits than the "bad" traits (Erikson, 1963). Erikson (1963) theorizes that

The success of these phases determines the attachment possibilities with others and how flexible they will be in determining the relationships with others in finding 'the optimal distance'. If they have for a variety of reasons not been successful in these early phases, they will become too rigid in their relationships {and other areas of their lives}" (p.9).

This undermining of basic trust is a large part of what many believe that makes problems in living. Without basic trust, attachment is hindered. The first two stages of his developmental theory correspond to Bowlby's attachment period, first three years of the child's development (Erikson, 1963, p.8). To resolve a feeling of basic trust and overcome basic mistrust is considered by Erikson to be the basis for hope. Criticisms of his theories surround the fact that he undertook no statistical research to substantiate his theories, and his research was based solely on boys. Trying to test his theories in order to validate them has been regarded as difficult.

## Daniel Stern and Early Infant Development

Daniel Stern's (1985) theories of infant development presented in his book, The Interpersonal World Of The Infant: A View From Psychoanalysis And Developmental Psychology introduces a very early perspective suggesting that many senses of the self may exist in preverbal forms at birth (if not before). He conceived that:

Infants develop socially through their sensory modalities immediately upon birth or soon thereafter. In Winnicott's language, *'this is the intermediate area of experience, unchallenged in respect to its belonging to inner or external (shared) reality, and constitutes the greater part of the infant's experience'* (Stern, 1985, p.31).

Stern considers himself both a psychoanalyst and a developmentalist. He says that "even though the nature of the self may elude the behavioural scientists, the sense of self-stands as an important subjective reality... How we experience ourselves in relation to others provides a basic organizing perspective for all interpersonal events" (1985, p.6).

Stern formulated through observation that for infants a pattern of awareness is a form of organization. It is the organizing subjective experience of whatever "it" is that will later be verbally referred to as the "self". This organizing subjective experience is the pre-verbal, existential counterpart of the objectifiable, self reflective, verbalized self and there are senses of the self that if impaired can lead to madness or social deficiency (Stern, 1985). Following are the senses of the self make up the foundation of the subjective experience of social development, normal and abnormal.

- **The sense of agency** without which there can be paralysis, the sense of non-ownership of self-action, and the experience of loss of control to external agents.
- **The sense of physical cohesion** without which there can be fragmentation of bodily experience, depersonalization, out of body experiences, derealization.

- **The sense of continuity** without which there can be temporal disassociation, fugue states, and amnesias, not "going on being".<sup>12</sup>
- **The sense of affectivity** without which there can be dissociated states.
- **The sense of a subjective self** that can achieve intersubjectivity with another without which there can be cosmic loneliness or, at the other extreme, psychic transparency.
- **The sense of creating organization** without which there can be psychic chaos.
- **The sense of transmitting meaning** without which there can be exclusion from the culture, little socialization, and no validation of personal knowledge.

Daniel Stern is also well known for his groundbreaking research on parent attunement and affect attunement, what he calls the sense of the subjective self. It is located within the realm of parental *mirroring* and *empathetic responsiveness*. The social attunement dialogue is accomplished during the first six to nine months of a baby's life. It not based strictly on imitation, there must be an intersubjectivity about affect: reading the feeling state from overt behaviour, perform a similar corresponding but not imitative response, and the corresponding response must be read as a response to the original action. Each encounter should provide a theme and variation, which can include for example visual, audio, oral and movement. The affect attunement performance occurs at around 9 months and matches and intensifies within the encounter providing feelings with behaviours. It refers to internal states to a quality of feeling. "Imitation renders form, attunement renders feeling...they occupy two ends of the spectrum" (Stern, 1985, p.142).

### HUMAN DEVELOPMENT AND THE ADULT PLAYING

*"Play is too often regarded in our society as childish, sinful or shameful and therefore unacceptable. It is not, true it is child like, but it should not be prohibited to the adult. For the working adult play permits a periodical stepping out from those forms of defined limitations which are his social reality"(Erikson).*

Children have used many forms of play to enable them to master events or situations by actively bringing it about rather than being a passive and helpless spectator (Millar, 1972, p. 29). Erik Erikson

---

<sup>12</sup> Winnicott's term.

has called play "the royal road to the understanding of the infantile ego's efforts at synthesis" (Erikson, 1963, p. 209). He understood a major function of the ego to be its attempt to synchronize the bodily and the social processes of the self. The ego has a need to master the various areas of life in which the individual finds his self, his body, and his social role wanting and needing to achieve. He alleged that to be a purpose of play, to "hallucinate ego mastery and yet also practice it in intermediate reality between phantasy and actuality" (Erikson, 1963, p.212). That is also one of the rationales of drama-therapy play.

J. L. Moreno understood the purpose of play well. He said he conceived and created his Theatre of Spontaneity, having observed children's play in Viennese city parks and by watching these children act out dramas that represented their individual experiences. It was in this therapeutic theatre that he applied impromptu playing with his adult patients (Blatner & Blatner, 1997). This is one essential reason why drama-therapy is useful intervention for adults.

### **Adaptations to Trauma and Neurodevelopment**

It has been stated earlier that the developing brain organizes and internalizes new information in a user-dependent fashion and that developmental experiences determine the organizational and functional status of the mature brain. It has been determined through thorough research and experience that there are neurophysiological responses and various adaptive mental and physical responses to trauma, including hyperarousal and dissociation. These symptoms have been documented in many studies (Gil, 1996, p.18). The more a child is in a state of hyperarousal or dissociation, the more likely they are to have neuropsychiatric symptoms following trauma. The acute adaptive states, when they persist, can become maladaptive traits (Perry, R. Pollard, Toi. et al., 2001b). Resilience is a word that is often heard being used for children, but Vigilante says that there is a misunderstanding of what resilience is. She considers that the expressions '*children are resilient*',

or 'they'll get over it', or 'they didn't even know what was happening', to be a pervasive, destructive outlook perpetuated by caretaking adults. To judge a child's reactions of *unattached, nonreactive* behaviours as *not being effected*, rather than a *surrender response* position exacerbates the potential negative impact of trauma. She declares that "Children are not resilient, children are malleable". In the process of 'getting over it', elements of their true emotional, behavioural, cognitive and social potential are diminished – some percentage of capacity is lost, a piece of the child is lost forever (Vigilante, in Dozier, Stovall, & Albus, 1999, p. 664). Childhood trauma has a profound impact on the emotional, behavioural, cognitive, social, and physical functioning of children. Following are a few of the terminologies derived from a developmental perspective describing this childhood pathology.

**1. Developmental Interference:**

This is an existing classification used for explaining whatever disturbs the typical unfolding of development, particularly gross environmental deprivations or demands which are not commensurate with the child's immature ego capacity to comply or cope with them (Nagera, in Mendell, 1983 p.320). This term has been applied in circumstances involving children that have been affected in a divorce, an experience of severe stress, abuse, a death, or a non-bereavement loss of any kind.

**2. Adaption Failure:**

This is another idiom that has been used for defining this type of child psychopathology. It is a failure to adapt from which may result in a deviation from age appropriate norms, exaggerations or diminishment of normal developmental progress (Mash & Dozois, 1996, p.22).

**3. The Child Sexual Abuse Accommodation Syndrome:**

This a model concerning accommodation of victimization and child sexual abuse which identifies five stages of maladaptive accommodations. It suggests that trauma is accommodated through distorted cognition and maladaptive emotional functioning. Further research through retrospective studies suggested that early traumatic experiences may lead to lifelong psychological and physiological changes, although data from prospective studies are not available to demonstrate their specific nature. It is suggested "a developmental framework can provide an

approach towards accommodating changes in children's responses with maturation....[It is] another important consideration in theory construction (Clark & Miller, 1998, pp.18-19).

Persistent fear and the neurophysiological adaptations to this fear can also alter the development of a child's brain, resulting in changes in physiological, emotional, behavioural, cognitive, and social functioning. The core principles of neurodevelopment provide important clues about the mechanisms underlying the observed functional changes in children exposed to violence. The brain develops functions and capacities that reflect the patterned repetitive experiences of childhood. This is true for a host of functions associated with violent behaviours. The capacity to moderate frustration, impulsivity, aggression, and violent behaviour is age-related. With a set of sufficient motor, sensory, emotional, cognitive and social experiences during infancy and childhood, the mature brain develops, in a use-dependent fashion a mature, humane capacity to tolerate frustration, contain impulsivity and channel aggressive urges. Exposure to violence activates a set of threat-responses in the child's developing brain in turn, excess activation of the neural systems involved in the threat responses can alter the developing brain. Finally, these alterations may manifest as functional changes in emotional, behavioural, and cognitive functioning (Perry, 2001).

I question here what transpires with those children and adolescents growing into adulthood. Could a **play deficit** occur from the lack of secure play environment, actual or perceived? Could skipped or forgotten developmental stages or phases of spontaneous play due to emotional, situational, environmental, medical or traumatic occurrences create some type of **play deficit**? I am suggesting that an *inner child* approach using the developmental play space in drama-therapy may be a good therapeutic model. Perhaps some missing areas of play development could be reclaimed, re-created, re-membered, re-connected, re-developed, re-embodied, re-enacted or re-framed?

## CHAPTER 2 PART 2 THE MAKINGS OF A PLAY DEFICIT:

### ONE EXAMPLE OF IT'S POSSIBLE FORMATION

*"A better understanding of childhood disorders may provide the basis for designing interventions that are more effective and prevention programs" (Mash & Dozois).*

#### POST TRAUMATIC STRESS DISORDER

Traditional psychotherapy addresses the cognitive and emotional elements of trauma, but lacks techniques that work directly with the physiological elements, despite the fact that trauma profoundly affects the body and many symptoms of traumatized individuals are somatically based. Altered relationships among cognitive, emotional, and sensorimotor (body) levels of information processing are also found to be implicated in trauma symptoms (Perry, 2001).

The field of developmental study accords major attention to children and adolescents but has potential implications for reconceptualizing adulthoods as well. There is growing realization through research that many childhood problems have lifelong consequences for the child and the society, and most adult disorders are rooted in early childhood conditions or experiences. Perhaps, a better understanding of the narratives within the childhood traumas could lead to the development of more effective adult interventions. Re-claiming *inner child* narratives to repair a **play deficit** using the developmental play space provided by drama~therapy, could be considered an effective intervention. In trying to better understand childhood traumas, I will apply this reasoning to Post Traumatic Stress Disorder and relate it to the population of adolescent mothers, with whom I am presently working. In a later chapter, I will be using an example of a drama~ therapy group consisting of five abused adult women, who may have had Post Traumatic Stress Disorder (PTSD) in their childhoods.

While working with the population of adolescent mothers I noticed signs of this as hyperarousal and disassociations during moments of play. I believe that could also have interfered occasionally while playing with their children, unconsciously turning it into difficult activity for them, a task to be avoided. The capacity to play with one's child is considered a critical function in parenting and attunement. To enjoy, have fun, to create a safe space for to play creatively with their children is an important factor in the forming of parental bonds. I think PTSD may be one cause. There is a lot of information available about Post Traumatic Stress Disorder. Not all can be given here, but I will offer a brief summary of the definition of symptoms and recommendations from authorities on the subject.

The definition of Post-Traumatic Stress Disorder (PTSD) according to The National Center for Post Traumatic Stress Disorder is that a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as natural disasters, terrorist incidents, severe accidents, and serious medical procedures. The traumatic events most often associated with PTSD differ for men and women. For men it may include rape, combat exposure, childhood neglect, and childhood physical abuse. For women they may include rape, sexual molestation, physical attack, being threatened with a weapon and childhood physical abuse. The individuals who are most likely to develop PTSD are those who:

1. Experience greater stressor magnitude and intensity, unpredictability, uncontrollability, sexual (as opposed to nonsexual) victimization, real or perceived responsibility, and betrayal.
2. Have prior vulnerability factors such as genetics, early age of onset and longer-lasting childhood trauma, lack of functional social support, and concurrent stressful life events.
3. Report greater perceived threat or danger, suffering or being upset, terror, and horror or fear.
4. Have a social environment which produces shame, guilt, stigmatization, or self-hatred.

PTSD is marked by clear biological changes as well as psychological symptoms. PTSD is associated with a number of distinctive neurobiological and physiological changes and brain

structures that are involved in the processing, integration of memory and in coordinating the body's fear response. Psychophysiological alterations associated with PTSD include hyperarousal of the sympathetic nervous system, increased sensitivity of the startle reflex, and sleep abnormalities. People who suffer from PTSD often relive the experience through nightmares and flashbacks, they have difficulty sleeping and feel detached or estranged. These symptoms can be severe enough and last long enough to significantly impair the person's daily life (James, 1994).

People with PTSD tend to have abnormal levels of key hormones involved in response to stress. Neurohormonal changes seen in PTSD are distinct from, and actually opposite to, those seen in major depression. Also, the distinctive profile associated with PTSD is seen in individuals who have both PTSD and depression. It frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition and other problems of physical and mental health. The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting ([www.ncptsd.org](http://www.ncptsd.org)).<sup>13</sup>

### THE PLAY DEFICIT : AN EXAMPLE

I would like to offer, using statistics and research, how I think a **play deficit** can occur with the population of adolescent mothers.

- Experience of repeated intergenerational patterns of neglect or abuse.
- Repeating intergenerational patterns of neglect.
- Their own adolescent stage of development.
- The absence of a caretaker or a father who played with them.
- The lack of a safe play to play.
- Disturbances that occurred during their early childhoods.

---

<sup>13</sup> I have found nothing that relates to adult play.

I will use few research statistics on neglect and child abuse to show the effects of trauma. This information explains why the developmental play space model of drama~therapy would be good intervention for adolescent mothers. A study of 673 mothers that assessed the levels of parental monitoring of their children found that unmarried mothers were twice as likely to be in the lowest level of parental monitoring compared to married mothers (Chilcoat, Breslau, and Anthony, 1996). Most have not experienced the watchful caretaker. Daughters of single parents are 53 percent more likely to marry as teenagers, 111 percent more likely to have children as teenagers, 164 percent more likely to have a premarital birth, and 92 percent more likely to dissolve their own marriages. Furthermore, an analysis of child abuse cases in a nationally representative sample of 42 US counties found that children from single parent families are more likely to be victims of physical and sexual abuse than children who live with both biological parents. Compared to their peers living with both parents, children in single parent homes had:

A 77% greater risk of being physically abused

An 87% greater risk of being harmed by physical neglect

A 165% greater risk of experiencing notable physical neglect

A 74% greater risk of suffering from emotional neglect

An 80% greater risk of suffering serious injury as a result of abuse overall

A 120% greater risk of being endangered by some type of child abuse(Sedlak & Broadhurst, 1996,

[www.leaderu.com/fatherfacts/consequences.1989](http://www.leaderu.com/fatherfacts/consequences.1989)).

Many have been abused by the only caretakers they knew. In a San Francisco study of 930 adult women, about 1 in 6 women with a stepfather as a principal figure during childhood was sexually abused by him, compared with 1 in 40 who lived with her biological father was sexually abused by him (Russell, 1996). A study of over 50,000 cases of child abuse found:

28% lived with two biological parents compared to 68% nationally

44% lived with only their biological mothers compared to 25% nationally

5% lived with only their biological fathers compared to 3% nationally

18% lived with a biological parent and that parent's cohabiting partner compared to 9% nationally (Malkin & Lamb, 1994).

I think these numbers show that many of these children have not had many safe spontaneous play experiences or safe places to play. As I have shown in the previous chapters if they could not feel safe, could there be a safe place to play? Who was there to witness or contain their play experiences? "A study of 75 families with infants found that fathers spend about 45% of time alone with their infants in play, whereas mothers spend only 15-20% of time alone with their infants engaged in play" (Yarrow, et al 1984). With so much single parenting, they most likely will not have a father around to play with them. It also caused me to wonder how many of my clients have had reliable fathers, stepfathers, or mother's boyfriends to play safely with.

The act of playing with their children is problematical for many of the clients referred to me. It is oppositional to their stage of adolescent development but for some it brings nightmares and upsetting memories that they tried to repress and forget. I have endeavoured to show why these adolescent single mothers must relearn how to play with their children. Without some form of therapeutic intervention, their cycle of abuse and neglect will continue with their own children. I am hoping to do a study on this population because I believe it is an ideal population for a drama-therapy using the therapeutic container as a developmental play space. With all these psychological, neurological, and developmental roadblocks, to learn how to play with ones own child must be overcome with a therapy such as drama-therapy which uses play as the method of intervention.

## CHAPTER 3 USING RELAXATION AND LAUGHTER AS AN ANTIDOTE IN DRAMA~THERAPY

*"As a medical scientist, it is gratifying and fulfilling to continue to discover objective scientific data to support beliefs that many have held intuitively for centuries.' A Merry Heart Doeth Good like a Medicine" (Berk).*

Some neurophysiologists have demonstrated that creative arts, prayer, laughter, and healing all stem from the same source in the body, and are associated with similar brain wave patterns. The physiological impact in the body from these activities are believed to be closely related as to how they make people feel (American Cancer Society, 2000). Appreciation of the humour in jokes and cartoons seems to be related primarily to the ventromedial frontal lobe, an area that shows relatively little activity in patients with major depression and in which lesions may destroy the person's sense of humour. Can creative drama~therapy and playful games be used in the same manner that humour therapy is, such as in a wellness treatment to promote the mind and body balance necessary for good mental health? Alternatively, should the adult who plays still be considered abnormal and pathological? Mind/body therapies are beginning to establish a scientific evidence base and their approaches are currently being integrated into mainstream medicine. Relaxation-response therapy consistently produces measurable, predictable and reproducible physiological changes when specific mental instructions are followed. These physiologic changes occur independently of any belief.

In this chapter, I will focus on the neurobiological wellness aspect of drama~therapy and how it can be used to treat pathology at a biochemical level. In addition, I will advocate the method of drama~therapy using the developmental play space as a treatment for adults with **play deficit**. What sets drama~therapy apart from the creative arts is the intentional ritualized incorporation of

the kinaesthetic activities in warm ups through sensory-motor & playful group exercises.<sup>14</sup> These types of exercises are essential to for repairing the **play deficit**. The psychotherapeutic use of movement in drama~therapy furthers the mental and physical integration of a person. As a complementary therapy, it can be used to promote healing, a sense of freedom or well-being, an outlet for expression and a means of communicating and integrating feelings. J. L. Moreno emphasized that psychodrama was a science of action basing these beliefs on the fact that the individual is most fully alive when in action. Action engages energy and memories stored in the body, including pre-verbal experiences (White, 1983). I will establish how some drama~therapy methods can use these mind/body connections to heal.

Art therapist Linda Chapman employs in her work a mind/body intervention that activates kinaesthetic movement through a scribble, the subsequent drawing and telling of a story leads to symptom reduction. Drama~therapy in effect activates all parts of the person. The interdisciplinary foundation of the play and drama continuum contains within it all that is vital for the full human experience. As a drama therapist, I use all variations of developmental play for adults because I believe it promotes, through regression, a balanced redevelopment of the individual. In other words playing with the *inner child*, repairing the **play deficit** can help to further a stronger outer adult. In this chapter, I will show how drama~therapy validates these benefits physiologically and reconfirms these results psychologically.

I will show the neurobiology of stress and its effects on the body and mind. However, for this topic I am only able to briefly touch on the immense topic of somatic psychotherapy and how abuse affects the body on a biological and parataxic subsymbolic level. I will then be taking this psychological and physiological concept and proactively applying it to laughter, relaxation, and group therapies. Sensory and embodiment exercises can be used to help relieve hypervigilance, arousal and anxiety, which can

---

<sup>14</sup> See Chapter 4.

be characteristic of PTSD. Offering a therapeutically safe and protected place such as the developmental drama play space in which clients can become aware of different ways to de-stress with a knowledgeable observing therapist is a relevant intervention when dealing with and overcoming trauma. Playful exercises are designed to activate spontaneity and laughter. I will be suggesting how laughter is a logical intervention for depression, anxiety, stress, abuse and cancer as treatment. Also, being part of a drama-therapy group and having group support has been proven both neurobiologically and psychologically to be helpful. Psychodramatist Jacob Moreno (White, 1983) claimed that groups also influence an individual's sense of well being and level of functioning.

### **Drama~Therapy as a Mind and Body Approach**

A mind and body philosophy of treatment is an open-minded approach that concentrates on each individual in an overall and caring manner. It must be considered as *an extension ... not a substitution* for traditional therapy. These types of interventions have the potential to produce the most meaningful results because the outcomes are based on the needs of individuals. The focus is on treating the whole person. The practitioners and health care professional that believe in this viewpoint are dedicated to helping people harness their inner healing resources. Bernie Siegel, M.D., is one of the most persuasive advocates of complementary and alternative medicine particularly mind-body healing. He encourages healing and personal growth through "carefrontation" a variety of holistic techniques for empowerment and self-awareness that includes the use of dreams, drawings and images. He has focused on humanizing medical care and education and teaching other health care professionals about the mind-body connection. He said it began with a positive workshop about how to deal with cancer. He said Elizabeth Kubler-Ross helped him by introducing him to the writings of Carl Jung and to the unconscious and the world of drawing (Siegel, 1986). From that he began to understand that there are many issues related to treatment and

survival that he hadn't been considering, such as helping people to *live*, helping them to *make choices*, *empowering them* (Siegel, 1986). I think that using the developmental play space found in drama~therapy has not previously been seriously contemplated as an adult treatment for early abuse or depression.

## **RELAXATION, MEDITATION, VISUALIZATION, LAUGHTER AND THE IMMUNE SYSTEM**

### **Stress and It's Damaging Outcomes**

Research reported in the mid-1990's demonstrated a significant relationship between chronic depression, anxiety, anger and/or stress and heart disease (Mind/Body Health, 1996a, 1996c, 1997). Stress hormones suppress the immune system, increase the number of platelets (which can cause obstructions in arteries), and raise blood pressure. It is known that during stressful periods the adrenal gland releases corticosteroids of which prolonged secretion may induce depression (Fry 1992). Studies published from 1996 to 1998 indicated that chronically depressed individuals were 70% more likely to have a heart attack when compared with their non-depressed counterparts (Mind/Body Health, 1996b). Individuals who were depressed incurred medical expenses that were twofold the cost of individuals who were not depressed (Mind/Body Health, 1996b). Chronically angry individuals were found to have an increased risk of heart attack and death. It has also been recently established that future health outcomes are enhanced by "the glass that's half full" as opposed to "the glass that's half empty". Researchers concluded that it was not the specific situation that was stressful, but it was the *meaning* of the situation to the individual that determined the amount of stress experienced by each individual (Mind/Body Health, 1996a, 1996c, 1997, Hope Health Letter, 1998). In the **play deficit** model of drama~therapy, narrative of experiences can be reviewed and reframed from an adult perspective within a therapeutic process.

## Mediation, Guided Imagery and Visualization as Therapy

Just as individuals are capable of sustaining a stress reaction, we also have the ability to put our bodies into a state of deep relaxation. Dr. Herbert Benson of Harvard University has named this a "the relaxation response". This is a state of being where all the physiological events in the stress reaction are reversed, the pulse reduces speed, blood pressure falls, breathing slows and muscles relax. In a developmental play space, relaxation techniques can be introduced cautiously at the beginning of each session.

Presently, there are many ways to reduce stress in the body that fall under the heading of relaxation techniques that are available from several disciplines. The concept of imagery and visualization as a therapeutic technique is centuries old. Imagery and visualization are different in that the latter is seeing in the mind where imagery may use all the senses. Those therapies that use fantasy to encourage, solve problems, or evoke a heightened awareness and consciousness use imagery. Guided imagery and visualization is a defined imagery. It can be any thought that denotes a sensory quality. These sensory qualities include visual, aural, tactile, olfactory, proprioceptive, and kinaesthetic (American Cancer Society, 2000). The use of the imaginal is found in early developmental play (Stern, 1985). When we apply this framework to the **play deficit**, this method will activate the *inner infant* at a place of early trust formation within the individual.

Mental images can have either a direct or an indirect effect on one's health. Although it cannot cure disease, imagery is an important technique that helps the mind influence the body in positive ways. Being able to create mental images is a strong mind/body force in reducing pain and reducing symptoms associated with illness. This is often achieved by using images that reduce sympathetic nervous system arousal and in general enhance relaxation. "End state" imagery is where clients imagine themselves in a state of being where they have perfect health or have achieved their goals. One goal might be, for example, reducing nausea or headaches, or being

able to relax more to fight stress or hyperarousal. Like other mind/body methods, imagery and visualization have been shown in careful studies to promote relaxation, and it reduces stress, as do other mind-body techniques. Along with relaxation come many health benefits (American Cancer Society, 2000).

Through PET (Positive Emission Tomography) scan studies of the brain there is evidence that imagining an experience stimulates the same part of the brain activated by the actual experience. One study, showed that meditation was very helpful for those who suffer chronically from mild depression. In another controlled study, 76 mildly depressed subjects improved significantly within six weeks of learning to meditate. The control group, which did not meditate, improved only slightly. Research suggests that imagery can be either a remedy for feelings of helplessness or a method of provoking a desired physical effect. A small study showed that visualization could alter brain wave patterns leading to relaxation and improved mood states (American Cancer Society, 2000).

### **Somatic and Sensorimotor Activation through Embodiment as Therapy**

Traditional psychotherapy addresses only the cognitive and emotional elements of trauma, but lacks the techniques that work directly with the physiological elements. This has been the customary form of therapy despite the fact that trauma profoundly affects the body and many symptoms of traumatized individuals are somatically based. Altered relationships among cognitive, emotional, and sensorimotor (body) levels of information processing are also found to be implicated in trauma symptoms (Ogden & Minton, 2000).

In the **play deficit** drama-therapy model (as described later in chapter 5) somatic and sensorimotor activation are combined with embodiment techniques and then monitored by process work. They are then integrated using a developmental play format. Somatic psychotherapy is a method of therapy that integrates sensorimotor processing with cognitive and emotional processing for the treatment of trauma. Unassimilated somatic responses evoked in trauma, involving both

arousal and defensive responses, are shown to contribute to many post trauma symptoms. By using the body (rather than cognition or emotion) as a primary entry point in processing trauma, sensorimotor psychotherapy directly treats the effects of trauma on the body, which in turn facilitates emotional and cognitive processing. This method has been especially beneficial for clinicians working with dissociation, emotional reactivity, or flat affect, frozen states or hyperarousal and other PTSD symptoms.

When working with the *inner child*, body, emotions, and memories of early trauma which were repressed or forgotten can also surface. Also crucial to this approach is that the therapist regulates clients' dysregulated states as they cultivate clients' self-awareness of inner body sensations. It is also felt that sensorimotor processing alone is insufficient, the integration of all three levels of processing, sensorimotor, emotional, and cognitive is essential for recovery to occur (Ogden & Minton, 2000).

### **Laughter as a Humorous Therapy**

There is a fundamental body of medical evidence that shows laughter's positive effects on the immune system. From a scientific perspective, humour has been explicitly shown to reverse the biological effects of stress. It is unlikely that any single pharmacologic agent can match the therapeutic effects of laughter. Laughter appears to reduce levels of certain stress hormones and reduce growth hormones.

Laughter provides a safety valve that shuts off the flow of stress hormones and the fight-or-flight compounds that come into action in times of stress, rage, or hostility. Blood pressure is lowered and there is an increase in vascular blood flow and an increase in oxygenation of the blood, which further assists healing (Bittman, 2000).

Research into the physiological effects of laughter have found that laughter induces a number of physiologic effects similar to those induced by narcotics and anxiolytics, without the threat of addiction

or adverse reaction. A good, hard belly laugh causes a brief rise in pulse and blood pressure followed by a reduction in pulse and blood pressure lasting an hour or more (Fry 1992). Laughter lowers levels of corticosteroids. It also reduces other catecholemines, improves arterial oxygen levels, and enhances endorphin production (Berk 1989). There are beneficial effect of humour on lymphocyte function and IgA secretion (Dillon 1985). In an extensive series of research studies performed by Berk (1989) the physiological response produced by mirthful laughter was shown to be opposite to that observed in classical stress, supporting the conclusion that mirthful laughter is a eustress state, a state that produces healthy or positive emotions. Laughter appears to tell the immune system to "turn it up a notch". This data clearly demonstrated that watching a one-hour comical video promoted results which indicate that, after exposure to humour, there is a general increase in activity within the immune system, including:

- An increase in gamma interferon, which tells various components of the immune system to "turn on".
- Having diminished levels of cortisol and stress hormones. These hormones are the ones that are responsible for triggering elevated blood pressure, heart rate, and a host of other stress-related responses.
- An increase in activated T cells (T lymphocytes) these natural killer cell (one of the body's most powerful natural defences against viruses and cancer) attack viral infected cells and some types of cancer and tumour cells.
- Increased immunoglobulin productions that can help fight infections. Increased Cytokine Gamma Interferon production is known to regulate the body's ability to turn up the volume of its natural immune responses.
- An increase in the antibody IgA (immunoglobulin A), which fights upper respiratory tract insults and infections.
- An increase in IgB, the immunoglobulin B is produced in the greatest quantity in body.
- An increase in Complement 3, which helps antibodies to pierce dysfunctional or infected cells.

The results of the study supported other research indicating that with humour, there is a general decrease in the stress hormones that constrict the blood vessels and suppress immune activity.

For example, levels of epinephrine were lower in the study group both in anticipation of humour and after exposure to humour. Epinephrine levels remained down throughout the experiment. In addition, dopamine levels (as measured by dopac) were also decreased. Dopamine is involved in the "fight or flight response" and is associated with elevated blood pressure.

The increase in both substances IgB, as well as Complement 3, was not only present while subjects watched a humour video, there was also a lingering effect that continued to show increased levels the next day (Berk, 1989). This promising area of neurobiological research and drama~therapy research is in need of further and more precise investigation.

### PSYCHOLOGICAL BENEFITS OF LAUGHTER

*A very little consideration will show us clearly that the sense of humour is always born of a sense of proportion, both in the inner and outer world (C.G. Jung).*

#### The Laughter Treatment

Laughter is one of the results and benefits that accompany the playful *inner child* in drama~therapy when working with the **play deficit**. Laughter unites people and social support has been shown to improve mental and physical health. Movies like *Patch Adams* have highlighted the difficulties involved with bringing laughter to the forefront of the medical health industry but they have also dramatized how play helped the individuals cope.

Victor Frankl, a German professor of psychiatry and neurology, instigated a way to survive the Nazi death camps. He came up with a theory of therapy to use as a *compliment* to what was being practiced. He was trained in psychoanalysis and was invited by Freud to present his ideas. His work as an existential psychiatry has been recognized internationally.

His theory is based on *the human spirit, and the will to meaning, man's will to meaning and the freedom of man's will*. In 1955, he authored a book called The Doctor And The Soul: From Psychotherapy to Logotherapy. Dr. Frankl said that man lives in three dimensions namely the somatic, the mental and the spiritual. "The spiritual human dimension cannot be ignored because

that is what makes us human"(Frankl, p. xxx). Frankl spoke of many things but I will be referring to his concept of paradoxical intention.

The patient is encouraged to do or wish to happen the very thing he fears...encouraging the patient to do or wish to happen the very thing he fears engenders an inversion of intention. The pathogenic fear is replaced by a paradoxical wish. By the same token the winds is taken out of the sails of anticipation"(Frankl, 1969, p102).

Frankl believed that paradoxical intention should always be formulated in as humorous a manner as possible. His opinion was that,

Humans are the only animals capable of laughter. Humour allows a man to create perspective, to put a distance between himself and whatever may confront him...humour allows a man to detach himself from himself and therefore to attain the fullest possible control over himself (Frankl, 1969, p.108).

To make use of the human capacity for self-detachment is what paradoxical intention basically achieves (Frankl, 1969, p.108). How does drama~therapy fit into this concept of paradoxical intention? Firstly, the art of drama use the exact same principle of self-detachment. Secondly, drama~therapy is the only therapy besides humour therapy where fun and laughter is an integral part of the therapeutic work. How can someone laugh and cry at the same time? It is paradoxical. The more one laughs the less one cries. It is also biological. For hundreds of years, it has been acknowledged that "Laughter is the best Medicine". One of those hidden resources people have is the human ability to laugh. The more one plays, the more they laugh, and the more they feel like laughing. It really worked. Laughing makes us feel good. Positive emotional states are as beneficial to emotional health and mood as any antidepressant.

The psychological benefits of humour can be considered as amazing, laughing invokes feelings of happiness and joy, laughing lifts us up out of our whirlpool of problems. Under conditions of delight, playfulness, and laughter, it is much easier to think creatively and become more flexible around a problem than when we are filled with feelings of helplessness, a sense of worthlessness, and ideations of inadequacy. There is a cathartic (cleansing) release after a bout of laughter. Shared laughter also

promotes bonding and unity within a group. Not afraid of being put-down, people will share their opinions. Laughter also opens the door to more real and risky communication, this then enables people to talk about uncomfortable issues or concerns.

Patty Wooten, founder of Jest for the Health of It agrees. She said, "humour is flowing, involving basic characteristics of the individual and expressed in the body, emotions, and spirit. The experience of laughter momentarily banishes feelings of anger and fear and provides moments of feeling carefree, light hearted and hopeful". She states:

We are less likely to succumb to feelings of depression and helplessness if we are able to laugh at what is troubling us... Laughter provides an opportunity for the release of those uncomfortable emotions which, if held inside, may create biochemical changes that are harmful to the body (Wooten, 1996, p 49).

Norman Cousins(1979) noted the therapeutic effects of humour and laughter during his treatment for *ankylosing spoendylitis*. It sparked his theory that negative emotions had a negative impact on health. He theorized that the opposite was also true, in that positive emotions would have positive physiological effect. This is similar, in logic, to the paradoxical effect of Frankl. Anecdotal evidence has long supported the proposition that distressing emotions and humour cannot *occupy* the same psychological space (Sultanoff, 1997). Depressed individuals report that when they laugh their depression dissolves. Individuals who tend to be anxious frequently report that experiencing humour is a way to better cope and reduce anxiety.

Scientists today believe that, even though humour cannot cure disease, it has profound physical and psychological benefits. As with so many mind/body situations, humour provides relief from worry. In so doing, it relaxes the individual and reduces stress. Endorphins are released. The entire process is helpful, and it can enhance the quality of life (American Cancer Society, 2000).

To obtain greater acceptance by the medical communities, alternative interventions need to be scientifically tested in controlled trials. Such research is underway at centres around North America

funded through the National Center for Complementary and Alternative Medicine of NIH. Alternative therapies will gain more acceptance by the medical community if research demonstrating their effectiveness is conclusive. Indeed, once the evidence is in place, such therapies will no longer be considered alternative but akin to mind/ body medicine, it will become an integral feature of accepted medicine (Benson, 1996). This chapter demonstrates the depth that drama-therapy can reach in order to repair. It can be meditative and relaxing, it can be playful and fun, and it is as insightful as it is flexible. It connects the body to the mind, and the mind to the spirit by offering a therapy as old as the human race itself.

## CHAPTER 4 HOW DRAMA~THERAPY WORKS TO RECREATE THE DEVELOPMENTAL PLAY SPACE

*It is in this gap between art and life, in a sort of timeless space, that we can experiment with ways of being which can help and heal both the individual and the group (Cattanach).*

### Drama~Therapy

The therapeutic use of drama has its roots in early healing rituals uniting mind, body, and spirit (Grainger, 1995, p.11). Drama~therapy has evolved from several disciplines. These include anthropology (ritual and healing); from psychology evolved psychotherapy, play therapy, psychodrama, psychoanalysis, and developmental psychology; from sociology, we get group interaction; theatre brings into play performance theory, theatre history, developmental and educational drama (Landy, 1994). Most of the drama~therapy models referred to this paper follow a humanistic doctrine, a philosophy that stresses an individual's dignity, worth and capacity for self-realization through reason (Merriam-Webster, 1996).

In this chapter I will review the work of several key figures whose foundational theories have advanced the field of drama~therapy. Developmental drama~therapy can be explained using several frameworks. By using a multi-sensory approach, drama~therapy can integrate a wide range of different therapeutic arts processes. A variety of ways of being and situations can be experienced, experimented with and explored through dramatic methods, forms, and fictions.

What can drama~therapy do to help repair a **play deficit**? A developmental drama~therapy format creates a phenomenal space (a time and place) by shifting the adult client temporarily back into the experiential process of play and joining them as a sympathetic therapeutic witness. My belief is that by using a planned system of regressive developmental play exercises and focussing initially on *inner child*, the *judgemental inner parent* or judging ego is also made visible. The therapy work can

eventually be advanced into *the here and now* by ultimately moving the focus onto the symbolic inner parent and a reconstructed outer adult self.

## KEY FIGURES IN THE DEVELOPMENT OF DRAMA-THERAPY

### Adam Blatner

In trying to explain some of Moreno's ideology psychodramatist Adam Blatner wrote,

He reintroduced growth through play, with emphasis on spontaneity, creativity, action, self-disclosure, risk taking in "encounter", importance of the present moment [his term was 'the here and now'] the significance of touch and non-verbal communication, the cultivation of imagination and intuition, the value of humour and the depth of drama (Blatner, 1996, p.xii).

The ideology of Moreno is what sets psychodrama and drama-therapy apart from other forms of therapy. Psychodrama was invented by Jacob Moreno and combines dramatic techniques with psychotherapeutic principles. The stories focus on the experiences of one group member at a time. Through a selected group member called a protagonist, a piece of their reality is shared. The group then explores their issues with them, helping to lead them into a cathartic experience that allows more empathy and insight into their own life stories. The utilization of psychodrama is just one technique employed in drama-therapy which uses fictitious stories, embodiment, projection and role-play in it's various methods of working. Drama-therapy makes healthy group influences such as laughter and creative play accessible through different exercises. The use of these warm up games is integral to the formation of interpersonal relationships created through the dramatic medium. The games are purposely fun, easy, and non-threatening and promote humour, laughter, energy, spontaneity, playfulness and creativity. This process is considered appropriate for all ages. Brian Way, a developmental drama advocate believes that "There is not a child born anywhere in the world, in any physical or intellectual circumstance or condition who cannot do drama" (Brian Way, 1967).

## Richard Courtney

In 1974, drama educator Richard Courtney wrote Play, Drama, and Thought. At the time, it was considered to be a seminal paper on drama development. In it, he examined the various disciplines of play, psychoanalysis, psychodrama, sociology, social anthropology, and theatre. In combining all these disciplines, he concluded that:

Developmental drama<sup>15</sup> is the basic way in which the human being learns - and is thus the most effective method for all forms of education.... when the child at play uses imaginative thought and dramatic action to make choices... they are relating the inner world to the environment (Landy, 1994, p.65).

## Robert Landy

Drama therapist Robert Landy (1994) describes his concept of drama~therapy as incorporating

The aims of many things: education and recreation because it is about learning, renewing and re- creating... it also incorporates the aims of theatre artists, psychoanalysts, developmental psychologists and sociologists...

However, certain basic models provide a comparative spectrum of approaches (pp. 16-17).

According to Robert Landy, when a psychic imbalance occurs that cannot be resolved through everyday means and it impedes ordinary functioning, a form of therapy is needed to restore balance. He says, " In the *role model*, the personality is conceived as a system of independent roles which come into being in three ways...biologically... through social interaction...through action. The first instance views people as role recipients, the second as role takers and the third as role players... (Landy, 1985, p.101). He believes by using drama~therapy balance is restored to the self by means of working through the role (Landy, 1985). The basis of it is the more roles one is able to play the better one should be able to deal with a variety of [social] circumstances, balance affect and cognition, and spend time in a variety of roles (Landy, 1990, p.226). " Roles are the containers of all the thoughts and feelings we have about ourselves in our social and imaginary worlds. When those thoughts and feelings are given a dramatic form and safely played out, one has the potential of seeing oneself

---

<sup>15</sup> Developmental Drama is a phase that both Courtney and Way brought into popular use.

clearly" (Landy, 1990, p-230). This is the idea behind the *inner child* work where the invoked *inner child* can take form and speak out.

### **DEVELOPMENTALLY ORIENTED DRAMA~THERAPY**

A psychodynamic drama~therapy model has been used by both Renee Emmunah (1994) in her five-stage theory and David Read Johnson (1982) in his developmental approach.

#### **Renee Emmunah**

Renee Emmunah (1994) uses sequential phases in her method of drama~therapy. She says that sensory play, drama play and drama games dominate the early sessions because a burden is released when permission is given to play. Pretending provides a unique experience of liberty and exoneration. Her first phase procedure includes creative dramatics, improvisations, playful interactive exercises, and structured theatre games. Many games are physically or socially interactive and the intrapersonal and interpersonal skills that are developed promote self-confidence, self-esteem, trust, and cohesion.

#### **David Read Johnson**

David Read Johnson (1982), a drama therapist and clinical psychologist feels that drama~therapy can be considered a psychodynamic therapy. He has developed a developmental continuum model derived from and based on psychoanalytic theory, developmental psychology, and object relations theory and self-psychology. Like other creative arts therapies, it uses the application of a creative medium towards psychotherapy. According to Johnson (1982),

Where as other paradigms suggest human dysfunction is due to something missing or out of balance, requiring things to be put right, the developmental perspective sees human disorder as a blockage or halt in development. The drama therapist with a developmental approach works with process and sequences and it covers the whole of the lifespan, not just childhood events. The approach works with processes and sequences.... Accordingly for each stage of sensory-motor, symbolic, and reflective.... The development paradigm has relevance to the process encountered in drama~therapy.... Developmental psychologists explore life stages, the mechanisms of and

processes of human development, and the theories of Erikson and Piaget describe the connections that are most often used by the dramatherapist (pp. 29-31).

Treatment involves assessment, by finding out where in the developmental sequence that person has stopped themselves and then starting the journey again with the therapist as a companion and a guide. This is also the organizing principle behind the reclaiming of *inner child* work and the reparation model for a **play deficit**. When Johnson refers to his developmental model of drama-therapy he says, "It involves the representation and the recreation of human experience...it is in the reliving of that moment of becoming that lies at the heart of the human condition"(1982 p.185). In the **play deficit** model the *inner child* can "come out to play" in slow developmental increments.

### **Pam Barranger-Dunne**

Pam Barranger-Dunne (1988) is also a clinical psychologist and drama therapist. She uses the humanistic approach in her model of drama-therapy because she believes it respects each individual's reality. She says,

It helps the client to commit to action that corresponds to their value systems. It works in the here and now. It helps the client to take positive responsibility for their lives. It gives them unconditional positive regard. It frees a person to develop a constructive and confident image of self worth. The drama therapist offers a sacred space that is a safe, relaxed, creative, and trusting environment. This is formed by accepting the client unconditionally and combines many techniques to create a dynamic interactive situation that is highly stimulating for creative engagement... (This philosophy) also provides a place for self-discipline, concentration and it encourages choices (p.p.139 -140).

The client learns to explore areas of their imagination generating ideas and taking risks. It promotes a feeling of control and empowerment for the individual because they possess ownership of their experiences. These skills are necessary for autonomy and self-determination. The drama therapist helps individuals to get in touch with their feelings and practice the dramatic medium in order to

express themselves, trust in their instincts, and become more spontaneous and flexible in a variety of roles and situations.

### Sensory/Embodiment Play

#### Phil Jones

Phil Jones (1996) contends that drama~therapy makes use of many things, these include the content of the dramatic activities, the process of creating enactment, and the relationships formed within the therapeutic work. "A connection is formed between the client's inner world, problematic situation or life experience and the activity in the drama~therapy session" (p.4). When drama therapist Phil Jones (1996) speaks of drama, he says:

Drama and theatre are ways of actively participating in the world and are not merely an imitation of it...and... that within drama there is a powerful potential for healing.... the drama itself is the therapy... the drama does not serve the therapy... the drama contains the process (p.p. 1-4).

Drama~therapy uses sensory embodiment play work as a systematic way to begin with all ages. Generally, embodiment/ body awareness is a pre-verbal exploration of the sensory world: breathing; smelling; touching; hearing and seeing. "Embodiment is used to gain knowledge. Knowledge is gained, not through detachment, but by and through the body in action, with actual, practical, and bodily involvement"(Jones, 1996, p.113).

Jones has identified what he calls the play-drama continuum. He categorizes this continuum into five key aspects of development. The first phase is sensorimotor- this is where the client discovers their body and their body parts and becomes involved with an important other (usually a parent). It involves activity with objects, sound and movement, locomotion and physical relationships. The second phase is imitative play where emphasis is on the development of imitation using face and body and object usage. This entails the imitation and repletion of sound, gesture, facial expressions, and objects. Pretend play is the third phase it is considered by Jones to be where representational

and make believe play begin. It comprises of: objects representing other objects, the wearing of clothing to represent people, the use of the body to represent objects, the use of symbolic toys and pretend events that are acted out. In Dramatic play the fourth phase, the fantasy is sustained and portrayals of others are enacted. This play involves mastering fine and gross motor control, interacting, recognizing and acknowledging others while using objects, using the body to pretend or create a different reality, using props in made up situations and make believe play, creating a make belief situation through a sequence of scenes and playing out different identities. Drama, the final fifth phase of Jones's developmental drama-play continuum involves sustained dramatic activity and consciousness of the audience. There is an acting out of make believe situations as the self or another in a sequence of events that is sustained for more than 5 minutes (p.p. 184-195). These five stages can be used for a deficit assessment, choosing appropriate interventions and for monitoring the therapeutic process.

### **Anne Cattanach and Sue Jennings**

Sue Jennings and Anne Cattanach are drama therapists who have also used a developmental continuum model in their approach to drama~therapy. Anne Cattanach says that, "the theme of this developmental model is the working and re-working of the life stages and changes with individuals and groups"(p.28). Sue Jennings (1994) depicts her developmental drama~therapy paradigm as evolving through three stages; embodiment play, projective and role-play (p.3). She asserts that, "Knowledge is not an object but a process... a relationship with a dramatic dynamic" (Jennings, p.34). She describes her developmental paradigm as EPR. These letters represent the dramatic processes of Embodiment, Projection, and Role (pp.30,101). Ann Cattanach has also similarly, said, "a really exciting session of dramatic exploration will contain elements of body awareness (embodiment), projected play and role-taking (role-play)"(Cattanach, 1994, p.31).

## Penny Lewis

Penny Lewis (1993) is a Jungian drama/dance therapist who uses sensory play as a foundation in the creation of a transitional space within her transpersonal transformational drama-therapy work. She considers her work to be in the shamanic tradition. She uses her techniques to move into the imaginary realm and uncover unconscious symbolic material. She is much attuned to the sensory and uses what she calls *somatic counter transference* to describe the physical body sensations or images that she says she receives from unconscious minds of her clients (p. 23). Penny Lewis's method is to begin with an early sensory/symbolic stage that is "preverbal, unverballed and unverbalisable" (p.25) such as breathing, authentic movement, and sound. The drama-therapy developmental model uses sensory exercises fundamentally. It is where therapy begins. It includes all of the body and senses through different exercises; sensory motor perceptions like breathing, light, sight, touch, sound, taste and smell through experimentation with these bodily experiences using guided imagery visualization, and relaxation exercises. The re-creation of these experiences is simple, engaging, non-threatening, age appropriate and grounding. Sensory embodiment work recreates the early learning developmental process involved with the discovery of the world, as suggested by Daniel Stern and the many sub-symbolic, nonverbal levels of coding within interpersonal and interpersonal learning, theorized by Sullivan and Bucci. A developmental play sequence provides a framework for exploration and at the same time, through the principle of generalization, connects to all the stages of cognitive, emotional, or interpersonal abilities. Fundamental developmental stages not experienced due to neglect, trauma, environment, a disability, loss, or death all creating a **play deficit**, can be re-experienced using drama-therapy in a therapeutically protected place. The developmental play space is familiarly connected to Winnicott's ideas of the creative phenomenal space and the place where trust developments. Having a therapeutic witness evokes an attachment figure, a caretaker to encourage and to securing a foundation of self-esteem. I will be more specific in the use of embodiment within this model in the next chapter.

## CHAPTER 5 PART 1 TOWARDS A MODEL OF RE -CLAIMING SPONTANEOUS PLAY AND LAUGHTER THROUGH DRAMA~THERAPY

*"As the material is made immediate and physical through enactment it combines the knowledge that is gained at the same time through the sensory and emotional feelings which can then be reflected on abstractly" (Courtney).*

Drama can be experienced as a continuum starting within the body itself, progressing through to ritual into games of all varieties, transitioning to role-play and then on to theatre. In drama~therapy, the client explores and processes material physically and bodily in the present while pondering on its meaning at the same time. The main point of this paper has been to suggest that a model of *drama~therapy* using the developmental play space can be fostered in the event of a **play deficit**. By starting with the fundamental foundations of infant and child development, a variety of drama methods can be structured towards a re-integration and re-claiming of the spontaneous self. Although all the developmental play stages are critical for this type of investigation, due to the restrictive length of this paper I have generally focused on the early embodiment and play stages. In the following chapter I will attempt to explain and define the developmental play phases that this drama~therapy model might generally progress through. A drama~therapy format is usually consistent, organized and sequential. Within the structure of the drama work, a repeatable routine is created and maintained.

I will describe a workshop that I created for adult women who had experienced early abuse, rape and incest as an example of how repair of a **play deficit** can be accomplished.

### DRAMA~THERAPY AND DEVELOPMENTAL PLAY

A drama therapist working with adults can use play regressively enacted through the developmental play stages. Sensory play and drama games are sequentially and systematically employed in a directed manner to promote fun, trust and interpersonal skills between participants. In an attempt to restore the blocked trust process, trust in the therapist is promoted through the introduction of safety: via a contained environment; a structured routine, and a respect for the clients needs.

Early proto-drama, sensory play and games are used to re-create the transitional phenomena in a contained drama~therapy space. Here an individual once giving themselves permission to play can begin to process, re-experience and re-learn awareness of their body, their memories and their organizational concepts of their world, at their own pace.

What is stressed in the process is the importance of relationships and connections between the body, emotion, action, identity, change, and drama. Drama~therapy involves the way the self is realized, by and through the body. A drama therapist also uses the embodiment of touch, sight, sound, taste, and smell to promote sensory awareness; as well as sensory-motor movements and narcissistic play, sensory and physical play. Through embodiment the person encounters their difficulties and issues in *the here and now*<sup>16</sup>.

*The here and now* is a term used in drama~therapy that represents the immediate present. In drama~therapy, the client explores and processes material physically and bodily in *the here and now* and can reflect on it at the same time. "As the material is made immediate and physical through enactment it combines the knowledge that is gained at the same time through the sensory and emotional feelings which can then be reflected on abstractly" (Courtney, in Jones, 1996, p.113). The client is guided in the learning of drama skills through the experiencing the many forms of drama play from embodiment to role. This drama play provides the framework for personal development that may or may not have been available in their childhoods. An example of this that would apply would be how mirroring and affect attunement<sup>17</sup> are integrated into drama games as imitation but they also form interpersonal empathic connections.

---

<sup>16</sup> The term *the here and now* was created by Moreno and is also used in drama~therapy to represent the immediate present. It can be incorporated into the drama play in many ways.

<sup>17</sup> See Stern, Chapter 2.

## WORKING WITH A PLAY DEFICIT IN DRAMA~ THERAPY

There are many levels of trauma-related group psychotherapies, with different degrees of emphasis on stabilization, memory retrieval, bonding, negotiation of interpersonal differences, and support. To a varying degree, the purpose of all trauma related groups is to 1) stabilize psychological and physiological reactions to the trauma, 2) explore and validate perceptions and emotions. 3) retrieve memories. 4) understand the effects of past experience on current affects and behaviours and 5) learn new ways of coping with interpersonal stress (van der Kolk, 1992).

Drama~therapy is a contained therapy that uses different methods to activate all the senses, intelligences and abilities of the person in *the here and now*. At the same time it must be recognized how early childhood histories and *inner child* emotions can be retrieved in the here and now through those same methods. This is because sometimes in preverbal or early childhood the defences of sublimation, repression and regression resides in the body which are awakened due to the incorporation of bodywork and kinaesthetic movement in the beginning of the therapy work.

Sensorimotor work is a method that integrates sensorimotor processing with cognitive and emotional processing in the treatment of trauma. It has been realized that sensorimotor processing alone is insufficient; the integration of all three levels of processing – sensorimotor, emotional and cognitive – is essential for recovery to occur. When the client learns to self-regulate their arousal through sensorimotor processing, they may be able to more accurately distinguish between cognitive and affective reactions that are merely symptomatic of such dysregulated arousal and those cognitive-emotional contents that are genuine issues that need to be worked through (Ogden & Minton, 2000).

In this hypothetical **play deficit** model, to reach the *vulnerable inner child* and reclaim and re-integrate the *spontaneous inner child*, a *developmental drama play* is used. The drama therapist must assess and focus on resolving missing or deficit play areas by following the drama continuum.

To help repair the **play deficit**, the drama therapist constructs a sequential play process that can parallel development at the client's pace. This is the journey of healing and self-discovery. The *inner child* is welcomed into a safe therapeutic space through sensory activation, playful games, improvised and dramatic role-play, and ritual techniques. The *developmental drama play* is used to support the *playful inner child* in an attempt to encourage and promote risk taking behaviours and role flexibility in the play space. The adult client is temporarily recreated as a spontaneous childlike individual in a time and space in *the here and now*. The clients are witnessed and carefully monitored re-experiencing missed or traumatised developmental stages of childhood. The client is then able to subsequently examine and sift the damaging influences of early childhood histories through the containment of drama. Metaphor and symbol work can be used in the exploration of their personal histories and their unconscious forgotten memories. A drama framework consisting of personal symbols, metaphors or stories can be developed (see later example). Having a drama therapist to facilitate the play process and reintegrate negative or absent experiences into a more mature realization constitutes a powerful and important form of therapy.

### **Early Embodiment and Sensory Play**

Social scientists have suggested that the self selects personae in different situations and arrives at a sense of identity through bodily expression and expression in relationship to others (as suggested by Stern). Any game or exercise can be used to create playful regressive experiences and sensory play and warm-up exercise is where drama begins.

Sensory play can recreate the developmental process involved with the discovery of the world. Using a developmental approach beginning with breathing and the sensory activities eases the anxiety as well. Knowledge is gained by and through the body in action, actual, practical and bodily involvement- not through detachment. Through embodiment the person encounters their issues in the present, referred to in drama-therapy as the '*here and now*'. Using this method awareness the person

explores material physically and bodily in the present and can pause taking that moment in time for reflection. As the material is made immediate and physical through enactment it combines the knowledge that is gained at the same time through the sensory and emotional feelings which can then be reflected on abstractly. It can be used for relaxation, focusing and stress relief with methods similar to yoga-based animal movements, or breathing exercises such as pretending to blow up a balloon or imagining the use of invisible objects in invisible places with invisible characters (Orlick, 1996, pp. 50-169).

Early learning and knowledge begins with sensory experiences, so sensory play focuses on the sensory perceptions of breathing, light, sight, touch, sound, taste and smell. Exercises are simple, engaging, non-threatening, easily mastered, age appropriate and grounding. Techniques promoting sensory integration are introduced to reproduce an early environment. Some I have used include directed yoga breathing and listening to the sounds of the body and the environment. Some active imagery and relaxation exercises that I have included incorporated visualizing charkas colours while listening to music and growing from a seed into a tree.

### **Drama Warm-Ups and Games**

Warm-Ups And Games promote playfulness, spontaneity, improvisation, flexibility, laughter, and friendship. The drama-therapy containment space is like entering into an out of the ordinary place where drama and play skills are developed. By using games and spontaneous play the client's creative thinking is stimulated and broadened. When being playful, a person enters an "as if" state that has a special relationship to time, space, joy, everyday rules, and boundaries. Warm-up games are used as the foundation of action and integrative therapies because they begin with a development of the body and use all the early forms of play (0-2 years). The developmental play sequences incorporated into drama-therapy warm ups provide a framework for exploration. Creativity and the development of trust are interconnected within the play space. The trust building begins to construct a

more secure foundation where risk taking can be initiated. This new base enables clients to become more flexible in their inner and outer worlds. The drama warm-up games are purposely fun, easy, and non-threatening and used to promote: humour, laughter, vivacity, spontaneity, playfulness and creativity. Cognitive, emotional, and interpersonal abilities are activated within these developmental stages. While The client players move through the blocked or forgotten areas of development, they are also re-constructing and fortifying ego strengths that are needed to deal with their everyday, here and now lives.

### **Projection**

Projection in drama~therapy can occur in numerous ways. Robert Landy speaks of how aspects of a person can be projected onto objects such as dolls, toys, puppets, masks, and shields. A client can create a prop to use as a metaphor or a symbol for whatever issue they are trying to resolve. Landy believes this entails a movement into the fictional, imaginative realm where the focus of attention is upon the persona or role, rather than the person and the person inhabits the paradox of *me and not-me*. Projection allows for space and distance, and the problems and difficulties become a few steps removed and not so close to home (Landy, 1994, p.149). Jennings (1992) believes "the greater the dramatic distance we create, the greater the range of therapeutic choices"(p.110). For Phil Jones (1996) projection in drama~therapy is "The process by which clients project aspects of themselves or their experience into theatrical or dramatic materials or into enactment, and thereby externalize inner conflicts"(p.266).

### **Role- Play**

Role work involves exploration and experimentation with *the self and the other*.

In dramatized or enacted play, [one] can develop a range of roles and appropriate behaviours. Individuals can play out past fears, rehearse current strategies and anticipate new events through the various forms of play ... they can

learn about outcomes of choices and rehearse life skills; they can project into the future and test reality, surplus reality and dreams. This is where the self-healing takes place (Jennings, 1994, p.5).

It is believed that a wide repertory of roles and skills are essential in order to function with flexibility as an individual and as a part of a larger social system. Role taking was a term coined by sociologist G. H. Mead who in 1934 defined it as a complex dramatic process of internalizing qualities of the role model (Landy, 1994, p.82). The therapeutic processes used in role taking are imitation, identification, projection, transference and role-playing. In order not to be trapped in a single role, the drama~therapy space is a place to practice, test out, fine-tune or try on different behaviours in play or in drama, different role behaviours.

Drama~therapy as a developer of roles promotes role flexibility. Through various methods and techniques of dramatic role-play, many identities can be developed and promoted. The experience may inspire a person to change, resolve things, or to realize consequences of their behaviours. Role-playing is meta-cognitive therapy in that a person has an opportunity to experiment with different personalities, subjectively experiencing through those characters thoughts and actions.

### **Ritual**

As a person passes through stages and changes in their life journey, dramatic ritual has been at each point of important transitions. In the history of humanity, ritual has formed a part of the religious and spiritual practice within all belief systems in ceremony and celebration. Dramatic rituals can be used to communicate things that cannot be conveyed through language alone. A ritualized framework grounds the drama~therapy experience in that it provides a containing opening and closing ceremony with a clear beginning, middle and ending. Renee Emmunah (1984) applies dramatic ritual in the fifth phase of her dramatic development to provide a framework of the treatment and prepare for closure. She asserts that dramatic ritual enables us to:

- Find insight into challenges and events and to reframe them as achievements and gains.
- Register, reflect on, and acknowledge the group or client as they move forward into the future.
- Facilitate, review, evaluate, give feedback, and experience accomplishments.
- Deeply express in a meaningful way, the sadness and joy felt in the completion of the intimate group journey through co-created structure.

## **CHAPTER 2 PART 2 CLINICAL PRACTICE, PLAY & IT'S RELEVANCE IN DRAMA~THERAPY TO OVERCOMING A PLAY DEFICIT**

In this chapter I will present a case model of a drama~therapy group using the developmental play space. This is an abbreviation of a short-term model that I used to assist an adult group. For ethical reasons I feel restricted to stay within tight boundaries because there is no authorization for research or publication. Therefore, I am obligated to provide only very brief description about clients and their processes. I will give one instance for each week.

### Description of the Agency

The agency where this group was given is a non-profit organisation created in the early 1990's by a suburban community within a large municipality. This centre is administered by a board of directors of participating members (users) and citizens. The centre encourages creative expression by offering new and alternative services in mental health. There are numerous therapists and various professionals participating and it is a training centre for advanced students. The weekly groups that are available consist of art therapy, dance/movement therapy, drama~therapy, music therapy, groups for incest and sexual abuse, discussion groups for each gender, meditation, relaxation, storytelling and poetry workshops plus individual counselling.

The member clients are citizens of the community and neighbouring communities who are between the ages of 18 and 65. This agency was created for individuals experiencing mental

health problems or who wish to improve their psychological and emotional well-being. The agency is not a drop in center, no referrals are required, materials and services are free and no records are kept but registration as a member and group registration is required.

### Psychological Considerations

The population of this agency fall into different categories. There are clients with various forms of mental illness or abuse, and groups have been created to specifically address their specific populations, for example groups for those with schizophrenia, depression, anxiety, sexual abuse and incest, etc...

## **CREATIVE ASSERTIVENESS THROUGH PLAY AND DRAMATIC ROLE**

### **GROUP STRUCTURE AND MODEL**

Description- Act out your ideas and emotions by wearing a different hat or standing in someone else's socks (shoes are left at the door). The focus of this workshop was on experimentation of different images of ourselves through the creation of character roles.

Discover new ways of seeing yourself and the work through the techniques of drama: such as games, movement, sound improvisation and scene work. Drama-therapy is safe, playful, and adventurous and can open up a universe of possibilities. Participants will expand their self-awareness, self-expression, flexibility, and especially their self- assertiveness.

### The Story Of The Group And Their Themes Per Session

This story of the group journey is also the story of my journey into an unknown territory of sexual abuse, rape, and incest. All the group members were all survivors of some forms of abuse. I had no idea that this would be the group story line when I promoted a drama-therapy assertiveness group. They said they wanted to be more assertive, but it became clear that they actually needed to assert some personal power over their early childhood traumas.

The group comprised five members, women with different traumatic backgrounds. Two clients were child incest survivors that had been raped the men in their families. Two other clients had been raped when they were older; one as a teenager who, due to cultural taboos of the time had put to put her child up for adoption, and the other was ostracized from her ethnic community; additionally she had suffered early trauma resulting from numerous surgeries as a young child. The last group member had been diagnosed with a mental illness and was a partner in an abusive relationship. I consider this group to be one comprised of early trauma survivors.

I observed how it affected their ability to play and it was here that I first formulated the idea of a **play deficit** and a drama-therapy group using **development play**. It was also in this group that I first heard the phrase "*can I really give myself permission to play*". What I thought would be so simple was simply not. It was here that I discovered their need to re-claim themselves. I discovered that a thing as basic as a chosen name could disempower if the name retained a connection to an abuser. It was in this group that I found embodiment exercises to re-claim their bodies, warm up games for them to re-experience play and their childhoods and ways to assert themselves. I would like to say that although I thought I was to be their therapist guide, they led me.

Each exercise was chosen for a reason. It was based on a creative expressive model structured on a metaphor of a formation of a tree. I felt what was first needed was to touch base at a deep level before they could even begin to move into spontaneous play. First roots are created for a sense of safety and security and to begin creating a trust in the developmental drama play space, the therapist, and the group. This necessitated using developmental and sensory work leading to embodiment and symbolic play. The work entails movement, contact, exploration of the senses and the early self. The client becomes more in touch with their bodies and the environment as in early childhood development. This is the place of the *early infant and vulnerable inner child*.

The next part of tree to grow is the trunk; it develops in a contained direction, it becomes a place of transition and formation. Drama~therapy is conducted in a safely contained play space maintained through structure and rules. A client must feel safe when inviting the *spontaneous inner child* to come out and play and to take risks. Where there is permission to play there must also be boundaries to contain the chaos. The developmental play space is a place of fun, games and play but it is also a time for mastery, flexibility, skill building and problem solving.

The tree branching off in many directions is the start of independent work and the final step towards closure. There are many ideas, tastes and possibilities to try out in a protected place so the play space became a container for stories, symbols and metaphor. It is a time to express new aspects, role-play and psychodramatic techniques are used. By temporarily adopting other roles, the *emotional inner child* can learn something new through a change of identity and patterns. This is the place to create their own *inner parent* and identify personal strengths.

### CREATIVE ASSERTIVENESS THROUGH PLAY AND DRAMATIC ROLE

#### Overall Aims For Dramatherapy Group: The Sensory Bodywork

In the first group session I observed that my clients seemed to be disconnected from their bodies, their emotions, and their feelings. I determined that early sensory, embodiment, and movement work that entailed experiencing the body was the place to begin. A drama~therapy developmental framework has mind/body connection as an objective within its treatment. A different sense of the self is highlighted each week focusing on sight, sound, taste, feel, smell, and intuition. Embodiment work also includes relaxation, meditation, and guided imagery.

The naming and validating of feelings by making them cognitive and concrete would be extremely important in the first 3-4 sessions of the therapy work. I will be giving some rationale and aims for each session, a full example of two sessions, session # 1 and session # 4 and a highlight each week from an exercise that I used.

### The Weekly Ritual Assessments:

Each week an opening ritual was chosen as place to begin the thoughts to feelings to body connections.

- Kinetic Haiku Check In- This is a nonverbal kinaesthetic check using words and coloured scribbles in either order. The words are chosen to express thoughts or feeling. The colours and scribble are chosen to express moods and emotional states. They are shown and sometimes performed individually or with the group for added empathy. By doing this each I was able to become aware of how they were feeling emotionally.
- Throwing Out The Garbage- The individual begin by disgorging their difficult or stressful times from that week in the center of the room. After their dumped what was bothering them they improvised throwing it into the garbage and leaving the crap outside the room. By doing that each week we created a safe contained place to begin and I knew what had happened to them that week.
- Relaxation Exercises & Guided Imagery- Each week there was a meditative time, a witnessed space that was theirs. A place of restfulness was created for them alone. It was time to put the their noise and their inner voices of judgement and shame aside and to breath. It was used as a way to get more connected with their bodies.
- Mirroring and Movement -By using group mirroring exercises I was attempting to create trust and bonds through empathy. Being seen and being responded to meets early interpersonal needs. Each week a different member led an exercise, this was done to promote confidence in their abilities to lead brought about by being heard and listened to.

### Closure

- Pulse- This exercise is performed by squeezing the hand of the person next to you in a random rhythm. The holding of hands, touching and squeezing is an early intimate gesture. The use of a heartbeat is primal and subsymbolic, plus there are many association that are connected to a heartbeat. It also activates the *inner infant* and child. This is also an exercise that promotes a positive touch experience but in a non-threatening fun context. I used it as a way to introduce a positive touching to individuals who have more often received bad touching from family members or strangers. Touch, the body, and personal boundaries are issues with abuse victims.

- Treasure box- At the end of each session something from the experience in the group that day was publicly or privately commemorated by each person and saved in the treasure box. It was a way for me to identify what had benefited clients and it gave me a direction to go in for the next session.

The rationale for the first 3-4 sessions was in the re-establishment of mind/body connections. Naming the experience and concretizing the preverbal and nonverbal experiences will be a critical phase in the attempted reparation of the **play deficit** and in the retrieval of the *wounded inner child*. The session aims are building trust in the developmental drama play space and learning about the other people in the group.

What follows below is a listing of all eight sessions with some process work. I will give more details in the first, the third and the last including exercises, and an examples of the processing that occurred in the developmental play space and relate it to the **play deficit** or the *inner child* work discussed in this paper.

### **Session # 1 Root Work: Reclaiming The Abandoned Inner New Born**

**Objective & Rationale:** We will be meeting each other, discuss what we will be doing and setting up a format based on the needs of the group. I think sensory and movement work is so important here. When out of touch with the emotions and the feelings in the body, there needs to be contact on the sensory level to before the move into spontaneity and play.

**The Aim:** What are the plans are for the session.

- To meet group and assess needs
- Meditation & relaxation.
- Sensory and physical nonverbal exercises
- Improvisations that take up a lot of space.
- Self affirmation exercises.
- Meditation to ground their bodies before we begin.

1. **Introduction** - Discussion about what drama-therapy is it and what their needs are.
2. **Greeting & Naming games** - Tell me the story of your name.
3. **Personal Goals for therapeutic work** – Discussion.
4. **Creation of Contract and Group Norms** - Place of safety, respect towards others, timeliness, commitment to group, talk about themselves and their interests, confidentiality, etc.... What can we do to make the group work?
5. **Sensory Warm Up** - Movement to music, Snappy sounds, developmentally getting the body to move by beginning with the extremities (fingers & toes) and finishing with the trunks
6. **Physical warm up** - Stretching body parts, Moving around the room, how much space can you take up, how little, how does it feel? Moving around the room, how much space can you take up, how little, how does it feel?
7. **Games** - Moving/ Freeze Statues - Moving in different moods using body language, Act as if you are happy, confident, scared.
8. **Processing group experience** – Group Discussion and processing.
9. **Closure** - Ritual Pulse; accompanied by a word or a phrase.

#### Treasure box.

During this session, I discovered my group's anger and how they feared it's enormity. They had repressed it and carried it for so long they became afraid of exploding so they disconnected from it. They had signed up for this group to be able to control it. The most distinctive feature of this session was the hatred one particular had towards her own name. Names are bestowed at birth by those who are supposed care for us and love us. This client was named after her father by her father who was also her abuser. She wanted to legally change her name. She was not able to walk with pride because felt she had nothing to be proud of, she had no familiarity with that emotion and did not deserve to be proud of anything. Her goal in the joining the group was to find courage and stop being afraid. Each week she took a new name, as an act of empowerment. I think the act of choosing of a new name for herself as part of the process of re-parenting the *wounded inner child*.

## Session # 2 Reclaiming The Inner Infant

**Objective & Rationale:** To create a sense of grounding (roots) through sensory activities. To promote spontaneous play, sensory exploration play and experimental play in a safe space. Self affirmation exercises, relaxation, meditation somatically grounds group members and solidly puts them in their bodies as we begin the group. Very early developmental games are important here to rebuild and reclaim their identities.

**The Aim:** (similar to session one)

- Meditation, guided imagery & relaxation.
- Sensory and physical nonverbal exercises.
- Mirroring and movements.
- Improvisations where they can take up a lot of space.
- Self-affirmation exercises.
- Relaxation meditation to ground the body before beginning.
- To begin to create trust and cohesion.
- Meditation & relaxation.

One of the group members, when commenting on one of the games revealed how she doesn't recall playing as a child or having any fun. Along with the loss of recall was the accompanying loss of sensory play memories. She spoke about the shame of her early abuse and concluded that she wanted things to change; she wanted to play and she wanted to laugh. She experimented and interacted with the props like toys. She began healing her deficit by playing, creating, interacting and mastering all that was made available to her. It seemed that the group wanted to play and reconnect to their *inner child* as they were rebuilding themselves. Not remembering a childhood could be a PTSD reaction to the trauma experienced in childhood or perhaps there was not a safe place to play. I think early trauma from sexual abuse could result in repression making it difficult to recall early play because of the accompanying memories. A **play deficit** in adulthood would be a result. Root work was needed to activate the sensory play and identify the areas of lost of memory.

Consequently, when working with a **play deficit**, the embodiment of the sensory and the developmental games are so important in recapturing their *spontaneous inner child*.

### **Session # 3 Reclaiming The Vulnerable Inner Child**

**Objective & Rationale:** The session was set up to promote sensory/sound work. Familiarity with each member by name and introduce some improvisational technique through role-play, transformational games and scene work. Due to a severe lack of play in childhood, setting up a play space to experience fun and spontaneity as a goal. Laughter is the results from playful warm up games. It was important to stay with the clients and introduce the drama at the developmental pace of the slowest member. In order to begin encouraging flexibility, drama exercises and situations are chosen carefully to sustain alternative thinking.

#### **The Aim:**

- To activate sensory play through sound and music.
- Name games are used to create a familiarity with each member and to create and affirm identity.<sup>18</sup>
- improvisational performances are initiated through transformational games, role play, and scene work.
- To continue to create confidence and grounding in sensory activities and play.
- To work on personnel issues.
- To create a cohesive and supportive environment .
- To allow participants safe space for fun .
- To allow a space for sensory integration and begin the process of play.

The seemingly toughest member of the group made known how she could not close her eyes. She spoke about her anger, whether she would ever be at peace and stop her private of self-mutilation and self-abuse. She revealed her Jekyll and Hyde existence, a professor by day an exotic dancer in the shadow of the night, mirroring the split in her self, neither in touch. She read us a piece of her writings: "behind a walls feeling like she wants to join in but being afraid to... wanting a hug but being afraid to ask...crying inside...wanting to heal her *inner child* and let her come out and play".

---

<sup>18</sup> I think a sense identity is an important theme especially for survivors of incest.

### **Session # 4 Reclaiming The Inner Playful Spontaneous Child**

**Objective & Rationale:** Playing for success. I am trying to set up a play space for my clients to experience some fun and spontaneity which is very lacking. I want to be able to set up situations that promote alternative thinking and flexibility. I wanted to energize my clients and get them in touch with their bodies and their sexuality in a fun way. I wanted to increase self confidence and assertiveness through dramatic play and to keep the safe therapeutic developmental play space. I used play, transformational exercise and the beginnings of role play

**The Aim:**

- Music, movement and dance.
- Creative mind/body/spirit connections.
- Termination in 4 weeks..
- To work on personnel issues through the metaphor
- To create a cohesive and supportive environment.
- To allow participants safe space for fun.
- To allow a space to begin the process of play.

**Opening ritual - How was your week?**

**Haiku with words -** Quick colour / movement drawing add words or vice versa.

**Body movements –** Re-enact the week & say the words and with movement mirror each other's week.

**Warm up games-- With movement and sounds-** start with shaking off the words that bugged you this week into your own pile; shake it out of your hair, get it off your back, spit it out, throw it away, kick it out. Then pick it up and dump it into a garbage pile. Swish it out off, let it escape into the air, into the cracks in the walls and the window and the ground, let the particle dissolve into the universe.

**Name game -** Up to 5 balls were thrown around using all the names in the group.

**Balloons -** Keep adding balloons, a second and a third then all try to keep all the balloons up in the air at the same time.

**Make a movement / group mirrors -** Each person gets a turn, add a sound to the movement, we mirror each person's sound.

**Music and group / body movements -** (prop; silky cloth, music: percussion, middle eastern belly dancing music). Group follows each other snaking around the room following the lead of the other the leader then moves to the back of the group.

**Transformational stick exercise** - Through the fantasy and imagination the balloon transforms changing shape as it goes round the circle (flexibility is beginning to be established).

**Sharing** -Talk about one assertive thing done in the week; group mood: a volunteer goes out of the room, the group decides on a mood, attitude or behaviour, the volunteer has to guess it. the volunteer asks them to perform an action with it; walk, talk, or pretend to eat.

**Role-play** - I CAN DO IT / NO YOU CANT ) repeat lines moving into action, movement

**Ritual closure** - Treasure box. What would you like to keep that you got from this experience today?

The element of fun was there but so was the movement and the cohesiveness. They were able to enjoy themselves and get caught up in the spontaneity. Being able to say **YES I CAN / NO YOU CANT** was a powerful experience in which each person found something profound. The exercise provided assertiveness and stimulated spontaneity. There was a huge cathartic release with these words. They wanted to do it repeatedly I think because by saying it again and again they began to believe YES I CAN. It seemed to be a form of mastery similar to early development found in repetitive play. They said they were going to feel those words all week. One client said she remembered everyone in her life who had said she couldn't say NO YOU CANT to and felt like choking her partner in the exercise. She said she wanted to yell, scream and stamp her feet. She said she would if we did it with her we wouldn't laugh at her. We all yelled, screamed and stamped our feet. They felt like they were standing up to their tormentors.

In returning to the idea of the *inner child*, I felt there were two types of children in the room. The independent tantrum-throwing two-year-old and the assertive, storming, adolescent, both searching for identity and individuation.<sup>19</sup> As children of trauma and abuse, perhaps they couldn't find a safe place to act out. The repeating of **YES I CAN / NO YOU CAN'T** is also a rehearsal for living. Lastly, being able to say yes or no is critical in the attainment of boundaries, something these individual were

---

<sup>19</sup> Individuation is the act of making separate: the act or process of making somebody or something separate and distinct from others. a process of psychological development: in Jungian psychology, the process of the development of the self, achieved by resolving the conflicts arising at life's transitional stages, in particular the transition from adolescence to adulthood. Jung believed this process could not be completed until middle age. (Encarta World English Dictionary, 1999,2000)

not able to enforce or were unaware of. It is what keeps a person safe and what will help them to parent themselves. They must be able to stand up for themselves without fear of their anger overwhelming their logic because it is easy to misinterpret a person's intentions when there is so much anger.

### **Session # 5 Reclaiming The Abandoned Inner Child**

**Objective & Rationale:** Facing the destructive *inner parent* and reclaiming lost power. Role-playing for assertiveness, camaraderie and to increase self confidence and assertiveness through dramatic rehearsal, and to witness small changes.

**The Aim:**

- Assertiveness through Sound / Movement.
- To work on personal issues.
- To create a cohesive and supportive environment.
- To allow participants safe space for fun.
- To allow a space for sensory integration and begin the process of play.
- To begin to work in the imaginary, transformational and body language & role
- To be able to empower themselves through body language, voice and action.
- To create a therapeutic play space, create group support, and work on drama skills.

I did an exercise using music, movement, dance and fabric. Each person had a chance to lead the dance. I wanted them to get in touch with their bodies as girls and enjoy them as a part of their feminine selves not based on sex. We played "dress-up", the client who had been raped took a white veil. She said that she had never been a bride, and wanted to see what it felt like under a white veil. This was a chance for the group to express themselves as little girls in "dress-up" roles. Role-playing is part of the late stage of childhood development. It is used as a way of promoting role flexibility and identity. It supports independence from parental authority, helps with sex

orientation, and increases the movement from childhood into adulthood, helping to claiming of one's power and strength.

### **Session # 6 Reclaiming The Emotional Inner Child**

**Rationale:** to create a safe therapeutic space allowing the *injured inner child* to reveal it's hurt, pain and shame surrounded by the empathy of others.

**The Aim:**

- To hold, to contain, and to further process what has occurred in the previous sessions.
- To speak about next weeks termination of the group, loss and detachment.
- To find the *inner parent* and welcome their outer adult.
- To work therapeutically in *the here and now*.

I used the physical exercise of a tug of war using rope pulling for their needs. I gave the group a few examples such as "I want it you can't have it", "I don't need you", "I don't want you", "I need you", "stay, go". Or something in their own words. It was an energizing experience, they each had something in their personal life in the *here and now* that was important enough to fight for. They said this session strengthened them. The eventual termination of a group brought up feelings of loss and abandonment. They needed to speak about what playing meant to them. It was the first time they felt that they had truly gotten in touch with, and let out, that *inner child*. All the members in this group have had previous therapy but they said this group was the first time since their mostly forgotten childhoods that they had been allowed to play.

### **Session# 7 Termination: Recovering and Role Playing the Adult**

**Objective & Rationale:** To create a shield of assertiveness and strength and role-play that person, pick a name.

To discuss loss and mourning goodbye, about the group, about how endings and goodbyes have affected them in their lives and how have they coped.

**The Aim:**

- To find success with assertiveness through play.

- To create cohesiveness within a playful framework.
- To continue empowerment performances.
- To create a transitional object of strength.
- To close the group.

#### **Termination / Closure Ritual - Creating A Shield Of Assertiveness & Strength**

- Create a shield in any shape.
- Write words on the shields
- Draw personal symbols on the shield, cut out colours, paste anything onto the shield.
- Choose an animal or character of strength to represent you.
- To write a note to each other after each performance. This note will be added inside the shield for support and comfort.

**Role-play** - walk about the circle, as your character holding your shield. Voice boldly the words written on the outside of the shield.

**Closure** - Each person in the group writes a private note to each other.

One person put her heart on the outside of her shield, she was the one who had twenty medical surgeries before the age of ten. She chose a jaguar to represent herself. One person's shield was in the shape of a heart, she chose a singing bird as her totem because she said their heart was their strength. Another's animal was a lion; she put a blade as a symbol on the inside of the shield (she was the one who wanted to stop being afraid). The women knew what they wanted and needed to do in order to let go of the group. They each chose the totems they needed to amplify their strengths and help them symbolically in their daily struggles. There were many tears at the end of this inspirational group story. Saying goodbye was a difficult experience. Two members did not show. I think their attachment to the group made it too difficult to continue until the end and say goodbye.

The journey of this group was one of growth and development. Each week the phenomenal transitional play space, the encouraging caretaker leader, the group members, and all the creative

group exercises combined to create the supported positive transformation necessary to repair a **play deficit**. My case example demonstrated that these women who didn't remember playing re-experienced the early developmental growth and the spontaneous play in the drama therapy. I hope I was able to briefly show how this led them to individuate from the young *inner child* to a more assertive adult.

Having a quiet space just to breath and listen was paramount to the experience. This was the only place that these women had to let down their defences and fears and just laugh. Developmental drama-therapy play is powerful, especially when working with the *inner child* in rehabilitating a **play deficit**.

## CONCLUSION “the way of the child”

### Review

One of the greatest strengths of drama~therapy is that it incorporates several psychological theories. From this, the drama therapists can create their own format within a ritualized structure by freely selecting from one or more parts of the drama~therapy continuum in accordance with the needs of the group or an individual. I have chosen a model of drama~therapy that promotes a developmental play space for adults. The theme of this paper was to invite the *inner child* to be a playful companion in this safe, therapeutically contained play space. To bring the *inner child* into play and letting it recover and reveal the past, reclaim a childhood and reconstruct a new narrative using the perception of an adult.

In the first chapter, the concept of the child and the *inner child* in psychotherapy was explored. In chapter two the early stages of normal, pathological and neurodevelopment of the individual were look considered. I explored the possibility of trauma and its later effect on the adult through a **play deficit**. I used the description of Post Trauma Stress Disorder and an example of adolescent mothers to demonstrate how a **play deficit** could evolve. In chapter three, I focused on the process of play and forms of play as they related to the mind and the body therapeutically with adults, adolescents, and children. In chapter four, I presented drama~therapy and some of its sources. I focused generally and within the limits of this paper on the importance of developmental play within drama~therapy and its application for re-discovering spontaneity. In chapter five, I showed how drama~therapy follows a developmental systems framework as a basis for understanding and monitoring the developmental processes. A case study of drama~therapy was then used to show how re-experiencing developmental play milestones through adult playgroup can be accomplished. The reported group mirrored the early primary care, sensory and attachment experiences learned through experimenting developmentally in a safe, trust-filled space. I explained its' aims and results.

## Recommendations

Presently the **play deficit** concept I proposed in this paper is quite speculative since there is no quantitative research within the field of drama~therapy to support this its assumptions. I intend to continue this research with the adolescent mothers that I am presently working with.

This model of drama~therapy, which uses the developmental play space shown in this paper as an intervention for abused adults, could be used to benefit many different groups and populations with difficult early development but not necessarily as a result of trauma. For instance: adults who were homeless, in lock up or in multiple foster care placements; adults whose parents were divorced when they were children; adults who were medical patients as children; adults who have experienced a loss or have suffered through the death of a loved one, adults with ADHD who had multiple difficulties in childhood; and, adults who are depressed, anxious, and who have become inflexible. This is To name a few.

This paper has shown in one way how and where drama~therapy can be used to its best advantage. I hope to promote drama~therapy as a laughter therapy that, in turn, promotes a mind/body wellness on multiple levels. I think its time has come, because as we now know, for so many reasons.

Those Who Laugh....Will Last.

## REFERENCES

- Abrams, J. (Ed.). (1990). Reclaiming your inner child. New York: Putnam Books.
- An overview for psychiatric professionals of complementary and alternative medicine (cam) in the treatment of depression [On – line], Available: [www.jps.net/wsd/cam](http://www.jps.net/wsd/cam).
- Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). Patterns of attachment. Hillsdale, NJ.: Lawrence Erlbaum and Associates.
- Ainsworth, M. (1982) Attachment and other affectional bonds across the life cycle: Retrospect and prospect. In C. M. Parkes & J. Stevenson-Hinde, (Eds.). The place of attachment in human behaviour. (pp. 33-51). New York: Basic Books.
- Bannister, A. (1986). Dramatherapy and psychodrama with children. Dramatherapy, 18 No. 2, Summer.
- Barranger-Dunne, P. (1992). The narrative therapist and the arts. Los Angeles: Drama-therapy Institute of Los Angeles.
- Barranger-Dunne, P. (1988). Media in drama therapy: An exercise handbook. Los Angeles: Drama-therapy Institute of Los Angeles.
- Bedard-Bidwell, B. & Sippel, M. (1997). Hand in hand: A practical application of art and play therapy. London: Thames River Publishing.
- Berk, L. (1989). Eustress of mirthful laughter modifies natural killer cell activity. Clinical Research, 37, 115 [On – line], Available: [www.jps.net/wsd/cam](http://www.jps.net/wsd/cam)
- Benson, H. (1996). Timeless healing: The power and biology of belief. New York: Scribner Press.
- Benson, H. The importance of the placebo effect, or "remembered wellness," in alternative therapies. [On – line], Available: [www.rmf.harvard.edu/publications/forum/v19n6/article5/body](http://www.rmf.harvard.edu/publications/forum/v19n6/article5/body).

- Billler, H. (1993). Father and families: Paternal factors in child development. Auburn House, Westport, Connecticut. [On – line], Available: [www.leaderu.com/fatherfacts/consequences](http://www.leaderu.com/fatherfacts/consequences).
- Bittman, B. (1998, 1999, 2000). [On- line], Available: Wellness Reproductions & Publishing, Inc. Available e-mail: [info@wellness-resources.com](mailto:info@wellness-resources.com).
- Blatner, A. & Blatner, A. (1997). The art of play: Helping adults redeem imagination and spontaneity. New York: Brunner Mazel Inc.
- Bowlby, J. (1969/82). Attachment & loss. Vol. 1: Attachment. New York: Basic Books.
- Bowlby, J. (1973). Attachment & loss. Vol. 2: Separation. New York: The Hogarth Press.
- Bowlby, J. (1980). Attachment & loss. Vol. 3: Loss. New York: The Hogarth Press.
- Bowlby, J. (1988). A secure base. New York: Basic Books.
- Bradshaw, J. (1992). Home coming: Reclaiming and championing your inner child. New York: Bantam Books.
- Bruner, K. (2000). Group play therapy with adults. The Arts In Psychotherapy. Vol. 27, pp. 333-338.
- Bucci, W. (1997). Psychoanalysis and cognitive science: A multiple code theory. New York: The Guilford Press.
- Capacchione, L. (1991). Recovery of your inner child. New York: Simon & Schuster.
- Carlson, E. (1997). Trauma assessments: A clinician's guide. New York: Guildford Press.
- Case, C. & Dalley, T. (1992). The handbook of art therapy. New York: Routledge.
- Cattanach, A. (1995). Drama and play with young children. The Arts in Psychotherapy. Vol. 22 # 3 pp. 223-228.
- Cattanach, A. (1994). The developmental model of drama-therapy. In S. Jennings, (Ed.). (1995). The handbook of dramatherapy. New York: Routledge. (pp. 28-40).

- Cassidy, J. & Shaver, P. (Eds.). (1999). Handbook of attachment. New York: The Guildford Press.
- Chapman, L. (2000, October). Psychological reaction to trauma. Paper presented at Convergence Conference, Concordia University, Montreal, Quebec, Canada.
- Chasseguet-Smirgel, J. & Grunberger, B. (1986). Freud or Reich? (C. Pajaczkowska, Trans.). London: Free Association Books. (Original work published 1976).
- Chilcoat, H., Breslau, N. & Anthony, J. (1996). Potential barriers to parent monitoring: social disadvantage, marital status, and maternal psychiatric disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 35 : pp.1673-1682.
- Clark, D. & Miller, T. (1998). Stress response and adaption in children: theoretical models. In T. Miller, (Ed). Children of trauma: Stressful life events and their effect on children and adolescents. (pp. 3-28). Madison, Connecticut, International Universities Press.
- Coppolillo, H. (1991). The use of play in psychodynamic psychotherapy. In M. Lewis, (Ed.), Textbook of child and adolescent psychiatry. (pp. 805-811). Williams: Wilkins Press.
- Cortina, M. (1999), Causality, adaptation and meaning. a perspective from attachment. Theory and Research. Psychoanalytic Dialogues. 9:557-596.
- Cortina, M. ( 1997). Sullivan's contributions to understanding personality development in light of attachment theory and contemporary cognitive models of the mind. Evergreen Consultants in Human Behavior, Co [On – line], Available: <http://attachmenttherapy.com>.
- Cousins, N. (1989). Head first – The biology of hope. New York: Dutton.
- Cousins, N. (1979). Anatomy of an illness. New York: Norton.
- Dillon, K. & Baker, K. (1985). Positive emotional states and enhancement of the immune system. International Journal of Psychiatric Medicine, 5, 13-18.

Dozier, M., Stovall, C., & Albus, K., (1999) Attachment and psychopathology in adulthood. In J. Cassidy & P. Shaver, (Eds.), Handbook of Attachment. (pp. 497-519.). New York: The Guildford Press.

Emmunah, R. (1994). Acting for real: Drama-therapy process, technique, and performance. New York: Brunner/ Mazel Inc.

Encarta world english dictionary ( CD-ROM ) ( 2000), Microsoft Corporation: Developed by Bloomsbury Publishing .

Erikson, E. H. (1964). Insight and responsibility. New York: W.W. Norton & Comp.

Estes, C. (1992). Women who run with the wolves. New York: Ballantine Books.

Frankl, V. (1955). The doctor and the Soul: From Psychotherapy to Logotherapy. Vintage Books: New York.

Frankl, V. (1969). The will to meaning: Foundations and applications of logotherapy. A Plume Book: New York.

Freud, A. (1964). The psychoanalytical treatment of children. New York: Schocken Books.

Freud, S. Collected papers, Vol. II. London: Hogarth, (1924, 1925). p.177.

Freud, S. (1959). Creative writers and daydreaming. London: The Hogarth Press and The Institute of Psychoanalysis, Standard Edition, Vol. IX, p.144.

Freud, S.(1918). The history of infantile neurosis, Collected papers, Vol. III, London: Hogarth (1924,1925), pp. 577-578.

Fromm, E. (1980). Greatness and limitations of Freud's thought. New York: Meridian Books.

Fry, W. (1992). The physiologic effects of humour, mirth, and laughter. Journal of the American Medical Association, 267 (13), 1857-8.

Greenberg, M. (1999). Attachment and Psychopathology in Child hood. In J. Cassidy & P. Shaver, (Eds.), Handbook of Attachment. (pp. 469-498). New York: The Guildford Press.

- Gil, E. (1996). Treating abused adolescents. New York: Guilford Press.
- Gil, E. (1991). The healing power of play: Working with abused children. New York: Guilford Press.
- Grainger, R. (1995). The glass of heaven: The faith of the dramatherapist. London: Jessica Kingsley Publishers.
- Gomes-Schwartz, B. Horowitz, J. et al. Child sexual abuse victims and their treatment. U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, U.S. Government Printing Office, Washington, DC, 1988. [On – line], Available: [www.leaderu.com/fatherfacts/consequences](http://www.leaderu.com/fatherfacts/consequences).
- Hillman, J. (1990). Abandoning the child. In J. Abrams, (Ed.). Reclaiming your inner child. (pp. 77-97). New York: Putnam Books.
- Irwin, E. (1988). Arts therapy & healing. The Arts in Psychotherapy. Vol. 15 #4 pp. 293-296, 307-308.
- Isaacs, S. (1948). The nature and function of phantasy. The International Journal of Psycho-Analysis Vol. xxix part 2.
- James, B. (1994). Handbook for treatment of attachment-trauma problems in children. New York: The Free Press.
- Jennings, S. (Ed.). (1992b). The handbook of dramatherapy. New York: Routledge.
- Jennings, S. (Ed.). (1994). Dramatherapy: Theory and practice 2. London, Routledge.
- Jones, P. (1996). Drama as therapy: Theatre as living. London: Routledge.
- Johnson, D. (1982). Developmental approaches in drama~therapy . The Arts in Psychotherapy. Vol. 9, 982:183-189.
- Jung, C. G. ( 1954). The practice of psychotherapy. Vol. 16, Princeton, N.J. Bollingen.
- Jung, C. G. (1961). Memories, Dreams , Reflections. New York: Vintage Books.

- Klein, M. (1955). Psychoanalytic play technique. American Journal of Orthopsychiatry, 25:223-237.
- Klein, M. (1932). The Psychoanalysis of Children. London: Hogarth Press and Institute of Psychoanalysis.
- Lewis, P. (1993). Creative transformations: The healing power of the arts. Willamette, Illinois: Chirdon Publishing.
- Landy, R. J. (1994). Drama therapy: Concepts, theories and practices. (2Ed.). Springfield, Illinois: Charles C. Thomas Publishers.
- Landy, R. J. (1993). Persona and performance: The meaning of drama, therapy and everyday life. London: Jessica Kingsley Publishers.
- Landy, R.J. (1990). The concept of role in drama-therapy. The Arts in Psychotherapy, 18, pp. 223-230.
- Laughter and Our Health [On – line], Available: [www.thinkquest.org/library/lib/site\\_sum\\_outside](http://www.thinkquest.org/library/lib/site_sum_outside)
- Malchiodi, C. (1997). Breaking the silence: Art therapy with children from violent homes. New York: Bruner Mazel Inc.
- Mann, S. (1996). Metaphor, symbol and the healing process in drama-therapy. Dramatherapy, Vol. 18 No. 2 Summer.
- Mash, E. & Barkley, R. (Eds.). (1996). Child psychopathology. New York: Guilford Press.
- Mash, E. & Dozois, D. (1996). Child Psychopathology: A developmental-systems perspective. In E. Mash & R. Barkley, (Eds.). Child psychopathology (pp. 3-62). New York: Guilford Press.
- McMahon, C. (1992). (Ed.). The Handbook of Play Therapy. London, Routledge.
- McNiff, S. (1992). Art as medicine: Creating a therapy of the imagination. London: Shambhala.
- Merriam-Webster Dictionary, (1996). [CD - Rom] Zane Publishing, Inc.

- Mendell, A. (1983) Play therapy with children of divorced parents. in C. Schaefer & K. O'Connor, (Eds.). Handbook of play therapy. ( pp. 320-354). New York: John Wiley & Sons.
- Miller, A. (1986). Thou shalt not be aware: Society's betrayal of the child. New York: Meridian Books.
- Miller, A. (1981). The drama of the gifted child. New York: Basic Books.
- Miller, T. (Ed). (1998). Children of trauma: Stressful life events and their effect on children and adolescent. Madison, Connecticut: International Universities Press.
- Millar, S. (1968). The psychology of play. London: Penguin Books.
- Mills, J. & Crowley, R. (1986). Therapeutic metaphors for children and the child within. New York: Brunner/ Mazel Inc.
- Mind/Body Health. (1996a). Healthy anger: Let It out or keep it in. Vol. 5 (2), p. 1.
- Mind/Body Health. (1996b). Depression and health care: The high cost of saving. Vol. 5 (2), p. 7.
- Mind/Body Health. (1996c). Hostility depression and heart disease. Vol. 5 (3), p. 1-2.
- Mind/Body Health. (1997). Cost of anxiety. Vol. 6 (1), p. 7.
- Newman, B. M. & P. R. (1984). Development through life: A psychosocial approach. Homewood, Il: The Dorsey Press.
- Ogden, P. & Minton, K. (2000) Sensorimotor psychotherapy: One method for processing traumatic memory. Traumatology, 6(3), article 3 October. [On – line], Available: [www.ncptsd.org](http://www.ncptsd.org).
- Orlick, T (1996). Feeling great: teaching children to excel at living. Carp, Ontario: Creative Bound.
- Parkes, Collin. & Stevenson-Hinde, J. et al. (Eds.). (1991). Attachment across the life cycle. Routledge: London.

Perry, B. D., Pollard, R. Toi L., et al. (2001). Childhood trauma, the neurobiology of adaptation and use - dependent development of the brain: How states become traits. Washington, D.C.:

American Psychiatric Press, Inc.

Piaget, J. (1954). The construction of reality in the child. New York: Ballantine Books.

Piaget, J. (1962). Play, dreams and imitation in childhood. New York: The Norton Library.

Piaget, J. (1973). The child & reality: Problems of genetic psychology. New York: Penguin Books.

Pipher, M. (1997). Reviving Ophelia: Saving the lives of adolescent girls. New York: Putnam.

Rogers, N. (1993). The creative connection: Expressive arts as healing. Palo Alto, California: Science & Behaviour Books.

Rubin, J. (Ed). (1987). Approaches to art therapy. New York: Brunner / Mazel Inc.

Russell, D. "The Prevalence and Seriousness of Incestuous Abuse: Stepfathers vs. Biological Fathers," *Child Abuse and Neglect* 8 (1984). 15-22, In D. Popenoe, Life without father, The Free Press: New York, (1996, 68). [On - line], Available: [www.leaderu.com/fatherfacts/consequences](http://www.leaderu.com/fatherfacts/consequences).

Sedlak, A. & Broadhurst, D. The third national incidence study of child abuse and neglect: final report, U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, Washington: DC. September (1996). [On - line], Available: [www.leaderu.com/fatherfacts/consequences](http://www.leaderu.com/fatherfacts/consequences).

Schaefer, C. & O'Connor, K. (Eds.). (1983). Handbook of play therapy. New York: John Wiley & Sons.

Schutz, W. (1967). Joy. New York: Grove Press.

Siegel, B. (1986). Love, medicine and miracles. New York: Harper.

Siegel, B. (1989). Peace, love and healing. New York: Harper.

Siegel, B. (1986). Love, medicine and miracles. New York: Harper.

Siegel, B. (1989). Peace, love and healing. New York: Harper.

Sobel, D. and Omstein, R. (1997). Anxiety after a heart attack Consumer Reports On Health.  
Vol. 9 (4), p. 41.

Stern, D. (1985). The interpersonal world of the infant: A view from psychoanalysis and developmental psychology. New York: Basic Books.

Storr, A. (1972). The dynamics of creation. New York: Ballantine Books.

Stress and heart disease. (1998). Hope and Health Newsletter. Vol. 18 (4).

Sultanoff, Steve. (1997). Survival of the witty-est; Creating resilience through humor,  
Therapeutic Humour, Vol. 11 (5), p. 1.

Sullivan, H, S. (1940), Conceptions of modern psychiatry. New York: W.W. Norton & Company.

Sullivan, H, S. (1953). The interpersonal theory of psychiatry. New York: W. W. Norton.

van der Kolk, B.A. (1992). Group psychotherapy with post traumatic stress disorders. In H. Kaplan & B. Sadock (Eds.). Comprehensive group psychotherapy (pp. 550-560). Williams & Wilkins.

Wekerle, C. & Wolfe, D. (1996). Child maltreatment. In E. Mash & R. Barkley, (Eds.). Child psychopathology. ( pp. 492-540). New York: Guilford Press.

Warren, B. (1984). Using the creative arts in therapy: A practical application. New York: Routledge.

Way, B. (1967). Development through drama. New Jersey: Humanities Press.

Whelan, R. Broken homes and battered children: A study of the relationship between child abuse and family type, Family Education Trust, London, (1993). [On – line], Available: [www.leaderu.com/fatherfacts/consequences](http://www.leaderu.com/fatherfacts/consequences).

- Winnicott, D. W. (1987). Psychoanalytic explorations. London: Karnac Books.
- Winnicott, D. W. (1971). Playing & reality. Harmondsworth, Middlesex: Penguin.
- Williams, R. & Williams, V. (1993). Anger kills. New York: Harper Perennial.
- Wooten, P. (1996). Humour: An antidote for stress. Holistic Nursing Practice, 10(2), 49-56.
- Wooten, P. (1994). Heart, Humour, and Healing. Mt. Shasta, CA: Commune-A-Key.
- Yarrow, L., MacTurk, R., Vietze, P., et al., (1984). Developmental course of parental stimulation and its relationship to mastery motivation during infancy, Developmental Psychology, 20: 492-503.