

An Exploration of Four Approaches to  
Countertransference in Drama Therapy

Leena Philipose

A Research Paper

in

The Department

of

Art Education and the Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements  
For the Degree of Master of Arts  
Concordia University  
Montréal, Québec, Canada

August, 2003

©Leena Philipose, 2003

National Library  
of Canada

Acquisitions and  
Bibliographic Services

395 Wellington Street  
Ottawa ON K1A 0N4  
Canada

Bibliothèque nationale  
du Canada

Acquisitons et  
services bibliographiques

395, rue Wellington  
Ottawa ON K1A 0N4  
Canada

*Your file    Votre référence*

*ISBN: 0-612-83940-0*

*Our file    Notre référence*

*ISBN: 0-612-83940-0*

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.

**Canada**

## **ABSTRACT**

### **An exploration of four approaches to dealing with countertransference in drama therapy:**

*A study of four models*

**Leena Philipose**

This paper explores four drama therapy models in respect to their treatment of countertransference. This paper is in several sections. The first section traces the origin of the term ‘countertransference’ to Freud, and follows the development of this term until present day. The second section consists of four subsections, which each detail the contribution of one drama therapist towards our understanding and appreciation of countertransference. Each subsection provides background information about the theorist/drama therapist, details the theoretical model s/he has developed including his/her view of countertransference, presents excerpts from an interview with each theorist, and finally gives specific examples from published literature of how these drama therapists work with counter - transference. This paper ends with a chart that cross-references all four models.

*~~A special thank you to Robert Landy, Eleanor Irwin, Penny Lewis, and Greta Schnee for graciously allowing me to interview them for this project.— Also, my advisor, Sherry Diamond, has been amazing throughout this process – always very timely and full of great advice. ~~*

## Table of Contents

<b>Introduction.....</b>	<b>1</b>
<b>Chapter One</b>	
<b>The concept, origins, and prevailing views of countertransference.....</b>	<b>3</b>
<b>Chapter Two</b>	
<b>Four models of drama therapy, four approaches to countertransference.....</b>	<b>18</b>
<u>i) Eleanor Irwin's Psychodynamic Drama Therapy</u>	
Background Information about Theorist.....	18
The Impetus for this Model.....	19
Influences.....	19
Brief Summary of the Drama Therapy Model.....	20
Goals of Therapy.....	21
Basic Concepts.....	21
Individual vs. Group.....	22
Populations Served.....	23
Role of Countertransference.....	23
Interview.....	23
Case Vignettes.....	26
<u>ii) Robert Landy's Role Model</u>	
Background Information about Theorist.....	28
The Impetus for This Model.....	29
Influences.....	30

Brief Summary of the Drama Therapy Model.....	31
Goals of Therapy.....	32
Basic Concepts.....	32
Individual vs. Group.....	34
Populations Served.....	35
Role of Countertransference.....	36
Interview.....	36
Case Vignettes.....	38

### iii) Penny Lewis' Developmental Themes Approach

Background Information about Theorist.....	42
The Impetus for this Model.....	43
Influences.....	43
Brief Summary of the Drama Therapy Model.....	44
Goals of Therapy.....	44
Basic Concepts.....	44
Individual vs. Group.....	45
Populations Served.....	46
Role of Countertransference.....	46
Interview.....	47
Case Vignettes.....	50

#### v) David Johnson's Developmental Transformations Model

Background Information about Theorist.....	54
The Impetus for this Model.....	55
Influences.....	55
Brief Summary of the Drama Therapy Model.....	57
Goals of Therapy.....	57
Basic Concepts.....	58
Individual vs. Group.....	59
Populations Served.....	60
Role of Countertransference.....	60
Interview (with Greta Schnee).....	62
Case Vignettes.....	63

### **Chapter 3**

<b>Comparison and Cross-Referencing between Models.....</b>	<b>67</b>
---	-----------

<b>Conclusion.....</b>	<b>72</b>
------------------------	-----------

<b>Bibliography.....</b>	<b>74</b>
--------------------------	-----------

## **Introduction**

Countertransference is generally described as the therapists' "living response' to the totality of the patient's emotional state at any given moment" (Bean, 1992, p.348). This response can include thoughts, feelings, fantasies, images, altered states of consciousness, acting out, acting in, and bodily experiences in the therapist, such as feeling heat, feeling cold, and having headaches, uterine contractions, rashes, and earaches. Holmqvist and Armelium (1996) have suggested that countertransference has three distinct strands:

"...feelings that are primarily attributable to the therapist's habitual reactions toward patients; feelings that are responses to patients' characteristic ways of evoking reactions in others; and feelings that are unique to a specific patient-therapist dyad" (Brody, Farber, 1996, p.372).

The importance of understanding these countertransference feelings is paramount:

"With greater awareness of the motivating forces behind one's own thoughts, feelings, and behaviours, the therapist is less likely to distort the therapeutic relationship" (Yalom, 1995, p.44).

Racker holds the position that therapists are only truly able to be objective towards their clients if they undergo self-analysis .

(Therapists must...) "make their own countertransference reactions and subjectivity the object of continuous conscious observation and comprehension" (Dosamantes and Alperson, 1992, p.212).

Theorists have long suggested that inexperienced therapists tend to perceive countertransference as a hindrance to treatment and in comparison to more experienced colleagues, tend not to appreciate its therapeutic value (Book et al. in Brody and Fairber, 1996, p.372). Farber and Heifetz (1981) found that inexperienced therapists were



more likely to acknowledge feeling personally depleted by the work than more experienced therapists (Brody and Fairber, 1996, p.373).

In a letter to the editor of the American Journal of Psychiatry in November of 1988, Nancy Morrison, M.D., addresses the problem of not understanding and managing countertransference feelings in her psychiatric day center. She writes:

... “the countertransference that is generated in close work with these patients [people with schizophrenia] presents a major challenge, often expressed as a desire to distance from the patient even to the point of discharge. Unidentified and unresolved, this countertransference may well be a reason why these patients are seldom treated in intensive psychotherapy” (American Journal of Psychiatry, Nov. 1988, p.1489-1490).

Though widely acknowledged in the psychoanalytic literature, there exists little material about countertransference in the drama therapy arena. This paper addresses this lack by delving into the ways countertransference is approached by four acclaimed drama therapy theorists. All four scholars are extremely qualified individuals, having each attained registered drama therapist, board certified trainer, and doctor of philosophy status. They have each written extensively about the feelings that arise within them due to the therapeutic process. Accordingly, I have decided to use their work to help me illuminate the importance of countertransference in the field of drama therapy. I hope to contribute to the drama therapy literature in a way that helps drama therapists recognize and manage the informative and inevitable feelings that are evoked within them as a result of client-therapist interaction.

# **CHAPTER ONE**

## **THE CONCEPT, ORIGINS, AND PREVAILING VIEWS OF**

### **COUNTERTRANSFERENCE**

Before countertransference was a recognized phenomenon, it was seen as a problem to the therapist, often causing so much discomfort that continued therapy was deemed impossible. Such a situation arose in the early 1900's when Joseph Breur, in his studies of histrionic personality, abandoned the treatment of his very seductive female client Anna O. He did this because he could no longer contain his guilt over the disturbing idea that he was the object of his client's lustful desires, which was made clear to him when he became aware that she was inventing a pregnancy to suit her desired wishes (Moore & Fine, 1990). Breur was so troubled by his intense emotional response to her that he immediately booked a romantic get-a-way to Venice with his wife (Jones, 1953 in Jacoby, 1990). Countertransference was first noted in academic circles by Sigmund Freud. He included commentary on it in his treatise 'The Future Prospects of Psychoanalytic Therapy' published in 1910:

“We have become aware of the ‘counter-transference,’ which arises in him [the analyst] as a result of the patient's influence on his unconscious feeling, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it” (Freud, 1910, p. 144-145 in Blum and Goodman, 1995, p.122).

Hence, Freud's initial view of countertransference was negative; he considered it a barrier to effective therapy that could prevent the therapist from objectively feeling for the client.

Freud developed the concepts of transference and countertransference to better understand the psychoanalyst/analysand rapport (Sarles, 1994). His initial thinking on

countertransference was that it involved a therapist's reaction in direct response to a client transference, of which the interpretation and working through he deemed to be "the sine qua non of analytic treatment" (p.67). Freud believed that the patient's past experiences reactivated associated thoughts, feelings, and object-representations. He believed that it was this phenomena that the patient transferred onto the therapist. Freud also concluded that usually clients' transferences were the result of "early unconscious libidinal impulses" (Ibid). There has been dissent about this Freudian idea, and many psychologists prefer to link the thoughts and feelings transferred onto the therapist not to clients' early sexual issues, but to clients' early patterns of interpersonal interaction (Alexander, 1982, Fromm-Reichman, 1959).

Freud enumerated the tasks of the therapist as doublefold: to interpret the client, and to control his/her own feelings:

(The therapist) "...has constantly to perform a double task during the analysis: on the one hand, he must observe the patient, scrutinize what he relates, and construct his unconscious from his information and his behaviour; on the other hand, he must at the same time consistently control his own attitude towards the patient, and when necessary correct it: this is the mastery of the *counter-transference*" (Freud in Bergman, Hartman, 1976, p.97).

This view has remained fairly consistent in present day psychoanalysis. For instance, Jacoby (1994) writes about the danger of not recognizing transference or countertransference:

"An analyst, for example, who is not conscious enough of his own need for power may unconsciously enjoy the dependence of certain patients; he may then, in a subtle manner, cut short their attempts at becoming more independent or he may feel hurt if they succeed in increasing their autonomy" (Jacoby, 1990, p.223-224).

Jacoby also points out that the therapist can always justify behaving in a possessive manner by saying that his actions are to the benefit of the therapeutic process

(Jacoby, 1990). A therapist might also fail to recognize his feelings by masking his own emotional needs behind professional jargon (e.g. acting out, resistance towards the unconscious, etc.)(Ibid).

Anna Freud, daughter of Sigmund Freud and the founder of the school of ego psychology, felt it was possible to eliminate much of the countertransferential feelings of anger and disappointment that characterized the relationships between the early psychoanalysts and their analysands. She felt this negative countertransference could be avoided by psychoanalysts realizing that therapy can still be effective even if the analysand doesn't wish to free-associate immediately. She emphasized that patients were still communicating to the analysts in a state of resistance, and the analyst might be able to glean as much information from the resistances as from the free-associations (Bergman, Hartman, 1976).

Documentation indicates that by 1913, Sigmund Freud determined that countertransference was not necessarily simply an impediment to the therapy, but could also be a very useful tool for understanding the psychotherapy client. He recognized that:

“everyone possesses in his own unconscious an instrument with which he can interpret the utterances of the unconscious in other people” (Freud, 1913, p.320 in Blum, Goodman, 1995, p.122).

Freud conceded that the only manner in which the therapist could fully understand his/her own unconscious conflicts would be to undergo analysis him/herself. In his 1910 treatise he publicized his views on the topic. He noted the emergence of numerous psychoanalysts and theorized that “no psycho-analyst goes further than his own complexes and internal resistances permit” (Freud, 1910, p.144 in Blum and Goodman, 1995, p.122). He suggested that psychotherapists scrutinize their own neurotic conflicts to

effectively administer therapy. Freud's views about the analyst needing analysis were so well-accepted that they continue as a mainstay of psychoanalysis even today. For instance, Jacoby emphasizes that therapists must be thoroughly analyzed so they can understand the minutiae of their anxieties and unacknowledged desires. Armed with this understanding, they will be prepared to recognize and deal with inevitable countertransference, which he calls "the greatest obstacle to a fruitful analysis" (Jacoby, 1990, p.233)

Though there was never any dissent about the analyst needing analysis, Carl Jung voiced his disapproval about other aspects of Freud's theory. He believed that Freud was short-sighted by concentrating his attention on therapist countertransference and ignoring client countertransference. Jung made his views known in his publication 'Problems of Modern Psychotherapy':

"By no device can the treatment be anything but the product from mutual influence, in which the whole being of the doctor as well as that of his patient plays its part" (Jung 1929a, para. 163).

Jung also believed that Freud didn't recognize the vast treasure of information a therapist could glean from transference. Jung felt that transference was not only indicative of a particular individual's state of mind, but it could also reveal truths about society (Sarles, 1994). Jung also questioned Freud's belief that countertransference was best kept safely hidden from the client. Jung suggested that clients could gain insight into their intrapsychic conflicts by being exposed to the countertransferences evoked in their therapists.

Freud, in turn, felt like as an authority figure he gained insight about Jung's internal struggles by developing strong countertransferential feelings towards him. These

feelings originated from Jung's particularly stormy relationship with his father, a rigid religious authoritarian who valued belief over the search for truth. Jung, at the other extreme, disapproved of the idea of faith, even in the realm of religion. He preferred to acquire his religious beliefs by hard objective science. Jung may have had a negative transference towards Freud because the latter reminded him of his rigid and dogmatic, god-fearing father. Jung describes a meeting with Freud and feeling as though a father-figure were talking:

"I can still recall vividly how Freud said to me, 'My dear Jung, promise me never to abandon the sexual theory. That is the most essential thing of all. You see, we must make a *dogma* out of it, an unshakable bulwark'. He said this to me in the tone of a father saying 'and promise me this one thing, my dear son: that you will go to church every Sunday'" (Jung, 1961, p.149 in Alexander, 1982, p.1013).

Jung's irritation with Freud's instructive and authoritarian manner may have resulted from Jung's past experiences, when he felt similarly denigrated by his father. Jung had already rejected his father, citing an overly controlling demeanor as the reason, and because of the similarity he found between Freud and his father, he likely wished to separate from Freud as well (Alexander, 1982). Freud, on his part, experienced disturbing countertransference paternal feelings. Alexander (1982) speculates as to the reason why Freud was so deeply disturbed by the countertransference evoked in him by Jung:

"Freud at this time was experiencing the concomitants of the father role in the Oedipal drama, which he manifested by a Mosaic [likeness of Moses] attitude toward the flock in the interest of preserving the law, and as the archetypal Oedipal father, Freud unconsciously feared what he projected out in his descriptions of the development of civilization—annihilation by the sons" (Alexander, 1982, p.1013).

Being projected as a father figure was terrifying for Freud since the paternal role evoked unwanted memories within him. Freud was reminded of the death wish towards

his father he had discovered inside of himself during self-analysis. This unconscious death wish held considerable weight especially as it occurred shortly after his father's passing. Freud feared others who might have this wish (Freud, 1900/1958; Grinstein, 1968). Perhaps because Freud's countertransferential identification as the Oedipal father involved his fear of annihilation by the sons, he is recorded to have expressed at least three times to Jung that Jung coveted an unconscious death wish towards him (Alexander, 1982).

In the late 1930's, Freud's idea of the blank screen analyst, one who offers him/herself as a transferential object for the client, began to be seriously questioned because it was noted that it is futile for the analyst to try to hide him/herself completely from the client; there is always something that can leak information, such as the way the office furniture is arranged, character traits of the therapist, or the manner in which the therapist proceeds (Blum and Goodman, 1995). Psychoanalysts began to contemplate a more complex model of countertransference and transference that distinguished positive and negative forms in terms of successful treatment. For instance, they theorized that clients could be aided in treatment if their problems were similar to the repressed conflicts of the therapist. In this case, when the therapist felt a countertransference reaction, s/he would be able to relate to the client's difficulty and therefore achieve a deeper understanding of the client (Ibid).

In 1950, at a time when the British were taking a strong interest in the idea of countertransference, Annie Reich from the British School of Psychoanalysts, expanded the concept to include "the effects of the analyst's own unconscious needs and conflicts on his understanding or technique" (Reich, 1951, p.26 in Blum and Goodman, 1995,

p.123). She observed that the analyst might derive unconscious meaning from the activity of analyzing. Hence, she reasoned that resulting therapeutic interventions represent a form of countertransference (Blum, Goodman, 1995, p.123).

Furthering the definition of countertransference, Irving Alexander, clinical psychologist at Duke University in North Carolina, describes a subtle form:

(Countertransference can also be)“...what the therapist unknowingly engenders in the patient by what he or she does or says or is, regardless of whether it has transference implications for the patient” (Alexander, 1982, p.1018).

Yet other theorists define countertransference as a phenomenon inseparable from transference. One such person is Richard Sarles, Professor of Psychiatry and Pediatrics, University of Maryland School of Medicine.

“Transference-countertransference exists within the therapeutic alliance and accounts for, at least in theory, (1) the working, or (2) nonworking, relationship of the patient and therapist in the therapeutic alliance, and in theory the resistance encountered in this working, or nonworking relationship” (Sarles, 1994, p.66).

Still other mental health professionals underscore the bi-directional nature of these terms; that transferential/countertransferential feelings can stem from either the therapist or the client. Examples of these theorists include Harold Blum, Clinical Professor of Psychiatry at the Psychoanalytic Institute, New York Medical Center, and Executive Director of the Sigmund Freud Archives, and Warren Goodman, Professor of Psychiatry at Cornell University Medical College, Albert Einstein College of Medicine and New York University Medical Center:

“Much can be learned from the patient’s transference reaction to the analyst’s countertransference. If the analyst is sleepy, it will provoke in any given patient his own particular transference reactions; these vary widely and can include overt anger, withholding of associations, denial, and so forth” (Blum, Goodman, 1995, p.127).



Other theorists explored the idea of transference/countertransference as it was identified by Freud. For instance, prevailing views from the 1930's overtly discourage the demonstration of emotional reactions by the therapist, expressing that doing so would present a hindrance to good therapy. These views praised the idea of the therapist mirroring the emotions and conflicts of the patient precisely and carefully so s/he is able to gain insight into the conflict origins, and the futility of endless repetition (English & Pearson, 1937 in Blum, Goodman, 1995).

Melanie Klein, a self-described 'Freudian', agreed with Freud's definition of countertransference, but she also chose to expand it to further her understanding of the client-therapist relationship. She explored Freud's idea that it was impossible to construct a new relationship without the emergence of past behaviours and emotions (Klein, 1948, in Sarles, 1994), ultimately coining the term 'projective identification', defined as:

“a client projecting unwanted aspects of the self onto the therapist and then succeeding in inducing in the analyst corresponding affective reactions” (Blum, Goodman, 1995, p.124).

Arnold Modell (1980), a Boston psychoanalyst, gives much credence to Klein's idea, pointing out that a therapist may be able to feel that which the patient cannot feel. For instance, a narcissistic client may be especially liable to disown negative aspects of the self, such as guilt, anxiety, and depression, and project them onto the therapist. Hence, examination of these countertransference reactions can give tremendous insight about the nature of the disowned parts of the self. Modell notes the case example of a colleague who continually experienced a very denigrating, contemptuous manner from the client. This resulted in her sense of self-worth lowering considerably. Finally, this

therapist directly asked the client about the possible reason for his behaviour. The client promptly told her that previously the therapist had made him feel ashamed. With this information, the therapist was able to detach from her sense of personal attack and concentrate on working through feelings of shame with the client.

Some theorists stress the importance of not fearing the countertransference. Fenichel (1940) expressed that the possibility that the analyst might be overly cautious and try to stop the onset of any feelings toward the client, might result in the analyst not permitting him/herself to show any natural human emotions. Fenichel warns that the analyst risks feeling like “a special being not permitted to be human” (Fenichel, 1940, in Blum and Goodman, 1990, p.123).

In the late 1960's Racker made many contributions to the study of countertransference. For example, he categorized countertransference reactions as either direct or indirect and concordant or complementary. He said that when a therapist felt countertransference because of the client transference, it was called ‘direct’. If the therapist felt countertransference feelings towards a colleague or supervisor, he called it ‘indirect’. Hence, one could concurrently experience both a direct countertransference to a client and an indirect countertransference to a supervisor. When a therapist identified with a client's thoughts and feelings Racker called it ‘concordant’. He called countertransference ‘complementary’ when the therapist identified with the client's infantile object relations. For instance, the client might demonstrate a transference fantasy where the therapist represents a desired object of love, such as a teacher, a parent, or sibling (Racker, 1968, in Blum and Goodman, 1990).

Garfield (1995) has divided emotional affects from countertransference reactions into three categories: the perceptual, the contextual, and the representational. An emotional countertransference response is 'perceptual' when the therapist sees, touches, tastes, or hears something that isn't there. For example, a therapist might have an illusion that s/he is being paged over the loudspeaker in the hospital; s/he might feel a group of muscles constrict and tense when they are usually relaxed; s/he might also see patients' eyes enlarge or fingers extend. These distortions/illusions occur when the therapist absorbs the emotional affect of the client and dramatizes it in the form of an idiosyncratic perceptual illusion. Garfield gives the hypothetical example of strong countertransferential feelings induced in a therapist with an art background and manifested by seeing a schizophrenic patient's face distorted like a Picasso.

When a therapist experiences 'contextual affect' s/he absorbs the patient's affect only to internalize it and feel trapped in the same unbearable situation.

Clients can also trigger 'representational affect', which happens when the therapist's unconscious reacts to client's affect by daydreaming. Garfield points out that the theme of the daydream may be highly instructive as per the issues of the client (Garfield, 1995).

Beres and Arlow (1974) describe the emergence of an unconscious fantasy in the therapist, in response to the report of a patient's dream:

"Without the benefit of associations to the dream and before the process of intuition could become operative, the therapist had grasped the meaning of the patient's dream and responded with his own version of the identical unconscious fantasy. There was a sudden awareness on the therapist's part that his inner experience, which seemed so personal and idiosyncratic, was in effect a commentary on the patient's material. The correct interpretation had come into the therapist's mind in the form of a fantasy. It then required a set of cognitive

operations for him to be able to translate this fantasy into an interpretation” (pp. 38-39 in Garfield, 1995, p.66).

Otto Kernberg (1976) remarked on intense countertransference reactions with borderline patients. He explored this particular phenomenon and expressed his bewilderment: “How are we to understand that the borderline patient is able to induce such a complex reaction in the therapist?” (p.180 in Garfield, 1995, p.64). Kernberg speculates that the answer must lie in the interplay of emotion that goes on when the therapist tries to empathize with the patient. Kernberg states that the therapist’s efforts at empathizing with the borderline client are matched by the latter’s ability to provoke in the former “primitive emotional reactions”(Ibid). He theorizes:

“This temporary ‘dipping into’ his own depth is reinforced by the patient’s nonverbal behaviour-particularly by those aspects of it that, in more or less subtle ways, imply an effort to exert control over the therapist, to impose on him the role assigned to the self or to an object-image within the patient’s activated transference” (Ibid).

Schultz and Glickauf-Hughes describe various transferential reactions in the narcissistic patient that can in turn provoke strong countertransference reactions. Twinning is one such example. In this type of transference, the client sees a clone of him/herself in the therapist. S/he may be unconsciously choosing a therapist who looks like him/her, who practises the same religion, is a member of the same political party, or who has the same sexual preferences etc. Then the client focuses on these similarities within the therapy work. S/he may feel like s/he has finally found someone who validates his/her existence by being so alike. Hence, his/her sense of self-worth is likely to escalate.

This could also be very dangerous, because both therapist and client may feel like they know more about each other than they actually do. Accordingly, they may misunderstand each other since too many assumptions are made (Karterucci, 1990, in Schultz and Glickauf-Hughes, 1995).

The same authors also describe mirroring, negative, and idealizing transference/countertransference reactions. Mirroring involves a patient treating the therapist as an extended part of him/herself. This could result in extremely strong countertransference reactions from those therapists who never had the chance to individuate as children and are at the point in their lives where they are trying to do so. Negative transferences are easily personalized since we are all vulnerable to criticism. Finell believes that therapists' feelings of impotence, hopelessness, and fear of treatment failure often result from the challenge of treating clients who refuse to accord their therapists any value and who often seek revenge against them (Finell, 1987). Finell equivocated the frustration and self-blame she experienced with these clients with the remembrance of her wishes to please her parents:

“My countertransference involved an unrealistic hope that if I worked hard enough, either through correct interpretations, empathic understanding, or self-knowledge and work on my countertransference, I could succeed in the end. My refusal to accept defeat kept me from processing the enormity and totality of the client's plan to defeat me, until he actually terminated” (p.512).

Idealizing transferences involve the client being in constant awe of the therapist and agreeing with every interpretation. Often these transferences are not caught, because the therapist simply smiles and believes that the therapy is working. However, responding as the loved person instead of recognizing the transference of the client means that the therapist is missing a key issue. For instance, the therapist may be failing to realize that

simply feeling smug about the amount of love a client freely gives may be harmful to the therapy if indeed the expressed love acts as a shield of resistance that protects the client from delving into profound issues (Stein, 1981 in Celena, 1995).

In her 2001 doctoral dissertation, Beate Charlotte Freideberg explored the psychotherapist's experience with countertransference. She concluded that countertransference feelings towards a patient stem from that patient demonstrating 'problematic behaviours' and demanding that the therapist 'fix' them without conceding to play a part in the healing process him/herself. Inability to solve the patient's problems may lead to hopeless and disturbing countertransferential thoughts and feelings. These unpleasant reactions may also be due to a recognition that the client's behaviour issues mirror the therapist's own. She addressed the behaviour of the client as being a reflection of personality and behaviour issues for the therapist. She warns that failure to control countertransferential feelings may intensely frustrate and annoy the therapist. She adds that this feeling may need to be shelved away and reflected upon before any action is taken. Only after receiving external validation from a trusted source might the therapist understand that his/her experiences are not only symptomatic of the immediate dyadic relationship, but they are also representative of the patient's interpersonal relations in the larger social realm (Freideberg, 2001).

The benefits of examining one's own countertransference reactions are acknowledged in nearly all psychoanalytic schools (Sotnitz, 1979 in Schultz, Glickauf-Hughes, 1995). Blum and Goodman state that therapists closely scrutinizing feelings that rise out of countertransference are frequently diagnostically accurate when interpreting the significance of client comportment. Also, identifying themes and symbols in one's

own countertransference will likely lead to a speedy grasp of issues nestled in the unconscious of the client (Blum and Goodman, 1995). Garfield echoes this thought:

“Paying close attention to one’s own emotional reactions becomes not only a useful informational tool but an important requirement for treatment stability” (Garfield, 1995, p.11).

Racker writes that therapists need not resist looking at their countertransference reactions for fear of analyzing them too much:

“According to my experience, the danger of exaggerated faith in the messages of one’s own unconscious, even when they refer to very “personal” reactions, is less than the danger of repressing them and denying them any objective value” (Racker, p.171 in Garfield, 1995, p.68).

Howard Searles, a Washington-based psychoanalyst, describes how his exploration of his countertransference helped him to understand his client:

“Another aspect of the countertransference manifested itself in relation to the intense scorn which he so frequently expressed to me...in an effort to become clearer and more comfortable about the countertransference... I tried something new...I let myself free associate...this procedure brought to light much material on the significance of this patient in my feelings...my associations indicated to me that I had hitherto unrecognized intense scorn towards my father during those years and towards this patient currently” (Searles, 1979, p.87).

While a therapist must not be afraid to examine his/her own feelings within the course of a therapy process, it is also important for him/her to take care not to classify *all* feelings as representative of countertransference. Blum and Goodman warn against this.

“It is important to determine whether a behavioral phenomenon in the analytic situation represents a specific countertransference toward the patient or a manifestation of pervasive characterological behavior on the part of the analyst. There are, after all, angry analysts, sad analysts, overly active or overly passive analysts, and so forth...Behaviours from the analytic side may reflect symptoms or characterological traits rather than specific responses to elements in the patient’s presentation or unconscious” (Blum and Goodman, 1995, p.125).

Blum and Goodman also say that the presence of countertransference can be identified through a careful scrutiny of personal behaviours, such as urges to be more

attentive to certain clients or to only explore and interpret selective topics with which the client presents.

Colson describes countertransference in a co-therapy situation. He explains that a co-therapist might convey envy and annoyance at seeing another therapist preferred by the group. The rejected co-therapist might unknowingly interpret that as the client's wish to denigrate him/her. Co-therapists leading a group might both feel a countertransference push to act as parents for group members. If they accept this impulse, they may unwittingly be infantilizing their group (Colson, 1985).

As the preceding discussion has shown, countertransference is a much-discussed topic in the psychoanalytic/psychiatric arena. Sigmund Freud made an extraordinary contribution to the field with his identification of countertransference, though countless others studied and expanded the definition, and some of them developed new terms and perceptions of the phenomenon themselves. Clearly, countertransference can be a useful element within the therapeutic process. It seems to come in many different forms but it always provides the therapist with a key of sorts; an instrument that when used effectively can unlock the vault to the client's unconscious.



## CHAPTER TWO

### **FOUR MODELS OF DRAMA THERAPY**

“Dramatherapy<sup>1</sup> is involvement in drama with a healing intention” (Jones, 1996, p.6). It is a mode of psychotherapy that draws on the powerful medium of the dramatic arts to aid creative expression and exploration of the self, resulting in a greater sense of well-being and health. The following chapter details four theoretical models of drama therapy each developed by a prominent American drama therapist.

#### **DRAMA THERAPY MODEL #1: Psychoanalytic Approach to Drama Therapy**

##### **THEORIST: Dr. Eleanor Irwin**

##### **Background Information about Theorist:**

Dr. Eleanor Irwin is a former clinical professor of Psychiatry at the University of Pittsburgh, a founding member of the National Association for Drama Therapy, a registered drama therapist, a board certified trainer, a licensed clinical psychologist, and a graduate of the Child and Adult Program at the Pittsburgh Psychoanalytic Institute where she is on the faculty. At present she runs her own psychoanalytic private practice in Pittsburgh, Pennsylvania.

Before forging her path as a drama therapist, she discovered she was using drama naturally in her work:

“Although therapy took place in a variety of settings, the inclusion of drama seems natural, given my long-standing interest and training in both drama and psychology” (Irwin, 2000, p.27).

---

<sup>1</sup> The spelling ‘Dramatherapy’ is used in Britain, while the spelling ‘Drama Therapy’ is used in the United States. Since I am writing about four American drama therapists, I will use the latter spelling.

After becoming a clinical psychologist and drama therapist, becoming a psychoanalyst completed Irwin's trinity of professional hats:

“Over time, my therapeutic orientation became a psychoanalytic one, largely because my first supervisor was an analyst and I worked in a clinic that had this orientation...Learning in this way, I felt that I had, indeed, found a congenial theoretical home. Behavior that once seemed strange no longer seemed so foreign. Having an analytic orientation helped me to see reflections and echoes of others in myself, and this understanding eventually led the way to an informed and empathic way of working” (p.28-30).

### **The Impetus for this Model:**

Even before being strongly influenced by her powerful psychoanalytic training, Irwin was interested in literature about creative drama, theatre games, play therapy, psychoanalytic child therapy, gestalt therapy, and psychodrama. However, she didn't find the object of her search in any one of these fields:

“But while these fields have a great deal in common with what I began to call drama therapy, there were enough differences to make them seem more like relatives than siblings” (p. 27).

### **Influences:**

When Irwin chanced upon several drama therapy practitioners in her own place of work, University of Pittsburgh, she became intrigued. She discovered that the director of the Cleft Palate Center at the University of Pittsburgh had supported and funded a study researching the benefits of an intensive creative dramatics program for a group of preschool cleft palate children (Irwin and McWilliams, 1974). Irwin was further inspired by an analyst at the Pittsburgh Child Guidance Center, someone who wanted to implement an outcome study about the responses of emotionally disturbed children to a spontaneous drama program. Those who inspire Irwin are described in articles about her work, and are all professionals who marry the use of drama and child therapy.

### **Brief Summary of the Drama Therapy Model:**

Irwin helps her clients to “gradually confront the self that is, the self that one fears, yet wishes to be” (Irwin, 1985, p.33). She attempts to bring the internal external when she encourages clients to freely express anything on their minds.

She tries to digest the manner a particular individual goes about designing his/her view of the world:

“As the patient’s internalized cast of characters is projected and enacted, scenes depicted and dialogue improvised, the therapist gradually comes to understand the unfolding story and how it came to be” (p. 34).

In her psychoanalytic model, she notes two levels to drama apparent within the passage of time. The immediate drama she notes is that which is enacted though play, yielding both conscious and unconscious concerns. The other kind of drama Irwin attributes to the complex relationships that develop because of countertransference/transference issues.

Object-relations theory, with its concepts of identification and projection, is very important to Irwin:

“Drama therapy offers a rich opportunity to study these processes which reveal an internal world, peopled with the characters of self and object representations. This is particularly true of drama therapy with children who, in the (transitional) play space that is provided, vividly depict their introjections and identifications through a repertoire of roles and enactments” (Ibid, 36).

Irwin describes her approach by stating her definitions of drama therapy along with a very detailed report about the history of psychoanalysis. Accordingly, her approach to drama therapy follows psychoanalytic principles; a natural occurrence given that she also practices traditional psychoanalysis.

**Goals of Therapy:** Irwin states her goals clearly:

“Depending on the age, population, and reasons for coming together, drama therapy goals might include: 1) fostering insight to lessen anxiety and conflict; 2) problem solving to gain control (not just relief) of the symptom; 3) recognizing and handling feelings; 4) improving social skills; 5) reducing social anxiety; 6) increasing self awareness; and 7) forging a stronger sense of self identity. The ultimate goal of drama therapy is to help individuals to develop more positive feelings about the self, bringing about changes in personality” (Irwin, 2000, p.28).

**Basic Concepts: The Unconscious and Resistance, Symbolic Play, Transference-Countertransference**

*The Unconscious and Resistance:* Since the unconscious often consists of forgotten painful memories and associated feelings, Freud felt that the patient could become free of symptoms once these repressed memories were expressed. Irwin emphasizes that therapists must be alert to the fact that unconscious feelings usually lend themselves to conscious behaviour (p.36).

Irwin notes that the activity of the unconscious is apparent in numerous places:

“While this is most apparent in the dream, it can be seen in accidents, slips of the tongue, and, indeed, in all aspects of normal as well as abnormal behavior” (Ibid).

A client is resistant when he thinks, speaks, or behaves in a manner non-conducive to further exploration of himself. By being resistant, a client forms a shield against any potential unpleasant discoveries.

*Symbolic Play:* Irwin encourages her child clients to play in a free-associative manner. She sees many symbols emerge out of this play, those dealing with the unconscious, resistance, and transference-countertransference.

*Transference-Countertransference:* Irwin notes the presence of transference when a client projects/displaces a role onto the therapist. Unconsciously, that serves the client to enact

his/her drama. She observes the occurrence of countertransference when the therapist, in turn, reciprocates with feelings or fantasies about the client.

*Interpretation:* This is the therapist's act of verbalizing her analysis about the state of the other. Irwin notes that often this doesn't happen in favour of creating an empathic, non-judgmental therapy space, however "when an interpretation is accurate, it can be enormously helpful and clarifying" (Ibid).

### **Individual vs. Group:**

#### Group:

*Focus:* The focus is on the free expression of all group members and creativity and spontaneity as it relates to healing for all.

*Role of Therapist:* The leader must be alert to the needs of the group as a whole and the idiosyncratic needs of each group member. The leader should be well-trained in group dynamics. The leader should also note which themes engender incapacitating anxiety, and be able to redirect the course of therapy to the benefit of all.

#### Individual:

*Focus:* All focus necessarily being on one person, the therapist is very implicated and is the only available object that can contain the client's projections. The intimate dyadic relationship means transference/countertransference issues are strong.

*Role of Therapist:* The therapist must delve into the inner fantasy world of the client:

(The therapist must form)... "an alliance which will facilitate the emergence of this fantasy life, and then put this real/not real situation into a therapeutic framework which will lead to understanding and change" (Irwin, 1985, p.33).

**Populations Served:**

Irwin's work focuses on children, though her model is adaptable for use with adults. The type of people who benefit most are those who have a facility for insight, since the therapy is non-directive and clients are encouraged to make their own realizations about their life issues.

**Role of Countertransference:**

As a classically trained psychoanalyst would do, Irwin goes to an analytic supervisor to process her countertransference. While doing therapy, she sometimes responds through her countertransference to let the client know how she feels about the transference. Irwin does this to increase client awareness of the possibility that s/he is transferring an emotion or feeling onto the therapist and there may be someone else who would be more appropriate as a receiver of that feeling:

“For contemporary analysts, countertransference reactions become a crucial way of understanding the other” (Irwin, 2000, p.36).

**EXCERPTS FROM PHONE INTERVIEW WITH ELEANOR IRWIN, 2003/05/23**

**I know you are a practitioner of both drama therapy and psychoanalysis. Can you comment on the difference you feel in countertransference in both modes?**

*The action. Even though the whole of the personality is involved in an analytic situation, still it is somewhat a more removed situation than occurs in drama therapy, which of course by definition is an action-oriented situation. The analytic situation really demands neutrality and distance from what the individual is saying and doing, and there are transient identifications that go on constantly in an oscillating function, whereas in drama therapy one is more likely to be involved in an action-identification ongoing with the individual. The 'internal' works very hard to try to follow the patient's ideas,*

*identifications, associations. We are all much more affectively involved. So I do think there is a big distinction.*

**According to your case studies, the type of countertransference evoked in you usually led you to think about your past experiences - to confront some part of yourself. Can you say more about that?**

*I think that is very often the meaning of all therapy. I think that countertransference does come from the unconscious. I think it depends also on your definition of countertransference. My notion of countertransference, just like my notion of transference, is that it does come from the unconscious. Parts of it might be conscious, as you work with an individual more and more, but it does come from the deep parts of one's being, whether one is a patient or a therapist. The patient, in large part, unconsciously transfers early relationships onto the therapist. The therapist's transferences are unconscious too, but if the therapist knows more about himself/herself than the patient, he/she can lead the process into deeper analysis.*

**Do you also work with the somatic countertransference?**

*Yes, I do. That is a very important part of it. Freud said that the first ego is body-ego so it is very likely that we are aware, for example, of a sinking feeling in the stomach, a headache, irritability, or anger. Those are more feeling states, but somatically one does register states in the body, and they give really important clues that something is going on between the self and the other.*

**What is one instance in which you found that your countertransference helped you understand your client?**

*Today for example, it's not drama therapy, but I did find myself getting sleepy with a man as he went over what was basically old material, a relationship he had had with a woman. When I realized that I was beginning to feel sleepy, I wondered what it was about. I realized that the man's passivity was existing in me. This man didn't want to be angry that the woman had deceived him and rejected him. In accord with him, I did not want to register my anger towards him. I was hiding my own anger just as he was hiding his anger and when I became aware of this, I realized that I was annoyed, and irritated. I wondered through talking about it today - could it be that he would rather focus on this individual woman?; could it be that he would prefer to be angry with her than focus his actions on what had driven her away? What I did not say to him was that the reason I was feeling sleepy was that I was protecting him from my anger just as he was protecting himself from an awareness... (My countertransference)... helped the client understand more about himself, his fear of damaging the woman, his fear of expressing his rage.*

**Do you have advice for beginning therapists?**

*I really do think that it is primary that one can be one's own instrument if one has a thorough as possible understanding of one's own personality, one's past, one's present, one's fears. That might be the best advice I can give: try to find a therapist who is the most skilled individual you can find, but also one whose style might fit your style. In other words, just because somebody has three or four degrees doesn't mean that that person could be a good therapist for you. It has to be a match between therapist and individual.*



*You ask yourself the question – in which session did I feel most understood? In which session did I feel the most potential for deeper analysis? What did I think of each person's technique? Personally, I think that 'warmth' is a crucial factor in being able to help. When one begins to understand the pathological parts of oneself, the problems inherent in each one of us, then the work becomes less difficult. But, if the therapist has the capacity for warmth, for patience, for empathy, then it is easier.*

**Case Vignettes involving Countertransference in Psychodynamic Drama Therapy with Drama Therapist Dr. Eleanor Irwin:**

**Both cases are taken from Irwin, 2000, *Psychoanalytic Approach to Drama Therapy*.**

**Client #1:** Lisa, five-years-old.

**Presenting Issues of Client:** Lisa was severely traumatized after waking up one morning to find her father dead in a pool of blood, and to hear that her mother was tied, gagged, and drowned in a nearby lake. Lisa needed to digest the horror of this experience in small portions, by playing out one scene at a time.

**Drama Therapy Approach:** Psychodynamic Drama Therapy. Lisa was introduced to an array of toys. She used them to play out disturbing scenes surrounding the trauma, so she could further her understanding of the gruesome events. Irwin followed the child in her play, encouraging her to use any material in the room to freely express her feelings and concerns.

**Countertransference Evoked:** Irwin felt deeply sympathetic for this child, and also felt a strong urge to ease her client's suffering immediately. Also, when Lisa kept giving Irwin contradictory orders, Irwin became puzzled.

**Approach to Countertransference:** Irwin used her feelings of deep sympathy and puzzlement and included them in her written process notes and her discussions with her supervisor. Within the therapy, Irwin tolerated her feelings and used them to help understand Lisa's world. In the first instance, when Irwin felt like easing Lisa's suffering immediately, she used Lisa's play to express her feelings in the metaphor, by describing a happy scene free of trouble. In the second instance, Irwin expressed her puzzlement by telling Lisa that she didn't understand what she was supposed to do. This way, she gave Lisa the opportunity to explain and clarify the situation.

**Client #2:** Kathy, six-years-old.

**Presenting Issues of Client:** electively mute, wouldn't sleep alone at night for fear of a wolf coming to eat her, intense separation anxiety with her parents.

**Drama Therapy Approach:** Psychodynamic Drama Therapy. Irwin accommodated Kathy's wish to communicate non-verbally, by introducing her to various toys, art materials, and games with dramatic gestures. Irwin joined Kathy in her dramatic games, including one in which she "stole" markers and other objects from Irwin and took pride in not letting her have them back when Irwin "noticed" them gone. Kathy also drew a series of sketches, identifying Irwin as the evil character who contained all the bad qualities so Kathy could have none. These enactments helped Kathy recognize and fuse the good and bad parts of herself. Long-term therapeutic gains included a reduction in aggression, which led to the client finding herself taking on a helper role for children in her neighbourhood.

**Countertransference Evoked:** Irwin felt incredibly denigrated and worthless in the face of Kathy's attacks. Irwin also felt confused and frustrated since Kathy consistently ignored the words that were said to her.

**Approach to Countertransference:** Irwin used her countertransference to help her better understand Kathy's negative feelings. Irwin's countertransference was a result of Kathy's projection of the bad, unwanted side of herself onto the therapist. Hence, Irwin felt that her countertransference helped her tolerate her frustration from Kathy's hate in light of her understanding that Kathy was simply demonstrating to the therapist that she hates a part of herself. Hence, in this case, Irwin used an internal supervisor to help her sort out her feelings within the therapy.

#### DRAMA THERAPY MODEL #2: Role Model

THEORIST: **Dr. Robert J. Landy**

#### **Background Information about Theorist:**

Dr. Robert J. Landy began his career as a theatre director, actor, and playwright. At the beginning of his career, he spent several years working as an educational drama specialist for special needs children. Always interested in drama of some form, he earned a PhD in 1975 in Dramatic Education. In his mid-thirties, he abandoned his paid work as a creative artist and concentrated on developing the field of drama therapy. At present, he has written seven books and contributed countless essays to journals supporting this field. He founded the first North American drama therapy graduate training program in 1982, an M.A. at New York University, where he continues to serve as Director and Associate Professor. His latest book is about children's perception of God. He is a

registered drama therapist, a board certified trainer, and also the current Editor-in-Chief of the international journal *Arts in Psychotherapy*.

### **The Impetus for this Model:**

It was one of Landy's drama therapy clients, a young actor named Michael, who incited Landy's thought process about creating a role model. Just before Landy went on a sabbatical, he noticed that Michael had focused his drama therapy work into the revealing of various roles and stories. It was only with the aid of these fictional elements that both client and therapist could clarify key issues posing problems for the client. (Landy,1996). For instance, Michael demonstrated to Landy the most desperate, hopeless part of himself when he created the role of Patty, an abused child, blind and deaf.

Landy spent much of his sabbatical reading plays. This inspired him to connect his drama therapy work with Michael to the characters he encountered in the fictional world:

“I began to think of Michael's roles as just that – roles, parts in a play. So many of the roles were repeated – the innocent young boy, the angry young man, the enraged one, the lawyer and judge, and, especially, the victim”(Ibid).

He decided to read more plays to further ground his fledgling theory. His research always yielded the same conclusion: that yes, there were indeed a vast collection of characters who resurfaced in multiple generations and cultures (Ibid). This planted the seed for Landy's eventual creation of a taxonomy of roles. The seed was further embedded in the soil by his reading of Stephen Jay Gould's book, *Wonderful Life* (1989), which rejects Darwin's linear evolution for all animals, and argues that the fossil creatures at the Burgess Shale Quarry in Canada challenge the popular version of evolution, because they do not fit into the linear taxonomy of classifying animal and plant

life. Landy thought it interesting that an existing taxonomy could serve as a base for a plethora of discoveries. He understood that the ground-breaking discovery that the fossil creatures were an exception could not have been made if there was no rule. Hence, Landy set about creating a “rule” for drama therapy, or rather, a taxonomy of roles, which he felt was badly needed for his work:

“I think such a system is desirable for several reasons: for one, it provides a kind of theatrical archetype system that responds to the universal quality of the theatrical experience. At a time when, generally, theatre forms and purposes are being questioned in terms of their relationship to commercial entertainment, education, therapy, spiritual values, and the like, such a system might provide coherence, or, at least, a point of departure. Specifically, a theatrical archetype system might well apply to the relatively new field of drama therapy, providing a tangible framework in which to formulate diagnostic, treatment and valutive strategies, and against which to evaluate new role phenomena” (Ibid).

Landy felt that elaborating a list of possible roles that people take in life could show clients all the possibilities of behaviour that they have. He refers to his taxonomy as ‘a blueprint for the possibilities of being’ (Landy, 1991).

Landy also maintains that he is the first to apply role theory to its dramatic origins within the theatre. His role theory is based on decades of his personal research into hundreds of plays in Western Dramatic Literature. His development of a role theory is fueled by his strong conviction of the importance of a solid backing of theory to firmly support the developing field of drama therapy. In fact, he expresses several times throughout his various writings his wish for more theoreticians to further the field of drama therapy by grounding it in research.

### **Influences:**

Landy gives credit to many people in the field of theatre for his ideas:

“I have certainly been influenced by the critics and philosophers writing about theatre like Aristotle and Cicero, Goethe and Nietzsche, Walter Benjamin and Northrup Frye, Martin Buber and Victor Turner” (Landy, 2000, p.51).

He attributes his deep understanding of the meaning and function of role to various pensive theatre directors and writers. Among many others, he credits those who were pioneers in this field that modeled for Landy the dedication and introspection needed to achieve a high level of excellence in this work (Ibid). Landy admits that he is far from the first to theorize on the idea of various roles making up our personality. He acknowledges great thinkers who came before him; theorists and practitioners who held a strong faith in Shakespeare’s lyrical idea that ‘all the world is a stage and all the men players’ and carried that dramatic metaphor through to a “sweeping analysis of socio-cultural and intrapsychic processes” (Ibid). People in this circle of thought include William James (1890, 1950), Charles Cooley (1922), George Herbert Mead (1934), and Ralph Linton (1936) (Landy, 2000).

Landy also attributes his ideas to the time period when he started developing them.

“The idea of life as performance influenced many social scientists throughout the 1960s and 1970s who analyzed everything from cabdrivers and their fares to gynecological examinations from the perspective of role theory” (Brissett and Edgley, 1975, in Landy, 2000, p.50).

Landy maintains that rather than participating in a social science fad, he was a “1960’s radical suspicious of scientific thought” (Landy, 2000, p.50). He dates his perception of role theory back to ancient performance rituals that detail meaning and purpose as participants enter into a new role.

### **Brief Summary of The Drama Therapy Model:**

Landy's role model is based on his role taxonomy, a detailed elaboration of 84 roles and numerous subtypes found consistently in more than 600 plays in the Western Dramatic tradition. A full explanation of this role taxonomy is found in Landy's book *Persona and Performance* (1993). Landy's rationale for undertaking such a tedious task consists of finding within the theatre that which imitates life; roles which compose the repertoire of humanity. Three key assumptions propel Landy's work. Firstly, he believes that it is a natural instinct for human beings to enter into the guise of the other. Secondly, he stipulates that any thought or action of human beings is complex and contradictory and hence, can be further clarified in reference to its counterpart. This idea will be elaborated in the ensuing discussion of role and counterrole. The notion of the human capacity to live with ambivalence is integral to Landy's work. He states:

“It is not ultimately the need to resolve cognitive dissonance that motivates human behaviour, but the need to live with ambivalence” (Landy, 2000, p.52).

Thirdly, he assumes that the human personality is made up of an interlocking hierarchy of roles.

### **Goals of Therapy:**

The main goal of therapy within the role model is to help the client increase his/her role repertoire, therefore finding within him/herself the role(s) needed for an improved quality of life. Landy adds that “the initial task of therapy, then, is to help the client access that role and identify it” (Landy, 2000, p.53).

### **Basic Concepts: Role, Counterrole, Guide**

*Role:* one name for the “discrete patterns of behavior that suggest a particular way of thinking, feeling or acting” (Landy, 2000, p.52). Roles can change as life circumstances

of the role-players change. Landy acknowledges the theatre as the primary source of role, since it is in the theatre that an actor actively and consciously embodies a role to the purpose of portraying the motivations and traits of a particular character. He theorizes that much of our lives focuses on resolving the struggle between contradictory wishes. Landy relates his play-reading, when he first discovered the repetitious dramatic struggle between the antagonist and protagonist, to be representative of the opposing desires of each individual. Landy implies that in each of us there exists two contradictory voices, but our thought process must bring these opposing characters to resolution so we can be coherent individuals (Landy, 2000).

*Counterrole:* The counterrole does not imply a direct opposite of the protagonist (role), just another side of the role that may be repressed. The counterrole doesn't have to be a feared figure. For instance, a social role of sister might imply counterroles of mother, brother, or father. Landy stresses the dependent nature of the counterrole, only able to appear when role is present. However, role does look for counterrole. As Landy explains:

“To be a truly moral person demands an ability to acknowledge and make peace with the immoral or amoral qualities that lurk on the other side” (Landy, 2000, p.53).

It is normal for role and counterrole to trade places often. For instance, a client might choose to explore a moral dilemma by alternating the embodiment of ‘saint’ and ‘winner’.

*Guide:* Landy describes the guide:

“...a transitional figure that stands between role and counterrole and is used by either one as a bridge to the other. One primary function of the guide is integration. Another is to help clients find their own way. As such, the guide is a helmsman, pilot and pathfinder, a helper who leads individuals along the paths they need to follow. In its most basic form,



the guide is the therapist. One comes to therapy because there is no effective guide figure available in one's social or intrapsychic world" (Ibid).

Any role that the client may take out of the 84-role taxonomy can be linked to a counterrole and a guide.

### **Individual vs. Group:**

#### Group:

*Focus:* Landy refers to the strong interplay between the theatre and his therapy work:

“Much of the focus in a drama therapy group has been upon group dynamics, role, and communication structures. As such, drama therapy has remained true to its natural connection, to the theatre and the theatrical event. Embodied in the theatrical event is the notion of enactment in role, in a particular space, with others who sometimes participate overtly, as fellow actors, or more covertly, as observers” (Landy, 1996, p.84).

*Role of Therapist:* Since group therapy is so closely linked with the theatrical process, the role of the therapist is very similar to a theatrical director. S/he must think about how s/he sees the end product emerging and what method s/he must take to get there. S/he must continuously problem solve to overcome natural blocks in creativity, or difficulties among players to get to his/her beautiful vision of the whole. At the same time, s/he must be flexible enough to alter his/her vision with the changing nature of the group (Landy, 1996, p.84)

Landy compares the role of a drama therapist leading a group to the role of a basketball coach:

“Like the basketball coach, the drama therapist helps the group develop strategies to defeat a common enemy. The locus of that enemy, however, tends to be within the individuals in the group. That internal enemy tends to take on demonic shapes as fears and insecurities are projected and transferred onto individuals in the group. A drama therapy group experience can be quite dizzying as projected roles dart about, bat-like. And like that of the basketball coach, the role of the drama therapist is a strategic one – helping to shape a group strategy that will lead

individuals to a knowing of what their social roles are and what they can become in relation to others in a group” (Landy, 1996, p.86).

### Individual

*Focus:* The focus is similar to group work, as goals are still related with those of the theatre, even though this time it is at most a two-person play. Uncovering roles, bettering communication, and forging strong therapeutic alliances are all focuses of this work.

### *Role of the Therapist:*

The major difference between individual work and group work is the composition of the participants. In individual work the therapist comprises half of the group. In this case, the therapist still acts as theatre director and maintains a vision of the whole, but that vision is likely to change very often because of the strong presence of one client, who has considerable input into the direction of the therapy.

### **Populations Served:**

Landy has applied Role Theory to his work with attention deficit hyperactive disorder (ADHD), alcohol and heroin addiction, eating disorders, post-traumatic stress disorders (PTSD), bipolar disorder, sexual disorders, borderline and schizophrenic disorders, physical and developmental disabilities, and normal neurotics. In addition, Landy’s students have applied this model in their work with conduct-disordered and incarcerated adolescents and adults, war veterans, sexually abused children, homeless mentally ill, and frail elderly. Because the normal neurotic population shows great awareness, and is so verbal and highly responsive, Landy says that they appear best suited for this work. However, Landy also cites a recent study (Sussman, 1998), which offers evidence of the ability of people with schizophrenia to invoke roles and thoughtfully make the life-drama connection (Landy, 2000).

### **Role of Countertransference:**

When faced with countertransferential feelings, Landy evokes within him the guide figure, an internal supervisor that is developed through integrating positive external supervisory experiences. This internal guide keeps his feelings balanced so he is able to provide effective therapy. More on this follows in the interview below.

### **EXCERPTS FROM PHONE INTERVIEW WITH ROBERT LANDY, 2003/03/12**

**According to your article, *Role Model of Dramatherapy Supervision*, countertransference is achieving ambivalence between the three contrasting roles of therapist, client, and supervisor. Can you say more about that?**

*That article is specifically about supervision though it can be tailored to understand the entire process of therapy and the 'internal dialogue'. In other words, if I am a therapist doing therapy and I am not necessarily in therapy myself, I still have this notion of an internal supervisor, what I call a 'guide'. And, when issues come up, what I try and do is check in with this internal supervisor, the part of me that can catch those moments of countertransference. The model works both on an actual level, thinking of myself as therapist and supervisor, and on an internal level. When I'm doing the work, I try to be aware, as best I can, of the issues that are coming up that are mine. Rather than push them away or do nothing with them, I try to bring myself to an awareness that these feelings are going on, and I have this way of thinking of an internal supervisory figure to help me process it as it's going on. And, if it's too intense, of course I bring it to an actual supervisor. The model does hold true for me whether I am in actual supervision or not.*

**So then the role model informs the therapist that countertransference is occurring because you see yourself in a different role. Is that it?**

*No, it's not that I see myself in a different role. I don't think of countertransference any different than anyone else does; it's just that I have a different way of processing it. I'm aware of this guide figure, this internal supervisor that I can turn to, and it gives me a way of thinking about countertransference. The most important part of the whole model to me is the discovery of the guide figure, and that figure is important to me for dealing with countertransference. That becomes the guide and also the supervisor, something super, something above, something that extends above your everyday way of seeing things. Anybody who gets embroiled in a difficult therapeutic situation with a client – the client pushes your buttons in some way – can never be on top of all those feelings inside. You need some help outside of yourself. That's where this notion of supervisor comes in. From a role theory point of view this supervisor is the guide view. That might be the original contribution of role theory – this notion of containing the countertransference and dealing with it.*

**Do you have advice for beginning therapists?**

*Beginning therapists are working with lots of external supervisors. When you are in training you have your internship supervisor, your teachers etc. When you finish your training and are a new therapist, most people will have some kind of supervisory relationship in their job or have a personal therapist/supervisor that they work with, that they consult with. That relationship remains constant. So, over time, you are internalizing these guide figures and they become of course your own internal supervisor...*

*My model is really about looking at not only the dyadic relationship, but the triadic relationship, so there is a third piece someplace. If you just see it as two – as teacher and student, you are missing a part. It is the same as in therapy. When a therapist is doing an individual session with a client and does not have an official supervisor, then that therapist cannot think of his/her supervisor, and there is something missing. My model tries to address the missing piece, what we call the guide...*

*The notion of supervision is that everyone needs supervisors in life. The notion of supervision is constantly about every role you play in life because the theory is that we all need guides every step of the way. We all need a super vision (two words) and when countertransference occurs when you are in the role of a therapist, supervisor, teacher, or whomever in a power role, it is very easy to get lost in one's feeling towards a client/student and at that point you need that super vision, that guidance from a figure beyond that of what you can see. To the extent that your external guide is effective you internalize that external guide figure.*

### **Case Vignettes involving Countertransference and the Role Model with Drama Therapist Dr. Robert Landy**

**The first case is taken from Landy, (2000), *Role Model and Supervision*.**

**Client #1:** Fay, middle aged alcoholic woman

**Presenting Issues of Client:** Fay felt like a victim in every aspect of her adult life, each job, each relationship. She was unable to find the other side of the victim role, the side where she felt able to feel the qualities of love and care. She needed a guide to help her get to them, due to her history of sustained abuse.

**Drama Therapy Approach:** Role Model. Fay was asked to name a role which caused problems for her and work with it until it was clearly defined (identify qualities in Landy's six domains: somatic, cognitive, affective, social, spiritual, aesthetic). She chose the victim role:

(She identified it as)... "physically weak and exhausted, as ignorant and learning impaired, as lifeless and unlovable, as socially isolated, as spiritually separated from God and as uncreative and unplayful" (Landy, 2000, p.117).

Landy then asked her about the function of this role in her life. Fay said that the victim part of herself helped shield her from further trauma and abuse. It was also very unhelpful because it caused her to face the world with the expectation of failure caused by others. Landy then looked at aspects of style and noted that Fay at first played the victim in a very emotional and realistic way that had little style or distance. With distancing techniques, such as putting the role qualities onto a character in a story, drawing, or figure in a sandbox, she was able to externalize the victim role, see it as separate from herself. At this point, she was able to locate her counterrole, the good mother who gives love, care, and affection. She identified Mrs. Smith, a woman who cared for her in her youth, as the guide who would help her rediscover her worthiness for love, care, and affection. This guide would also help her integrate her role and counterrole.

**Type of Countertransference Evoked:** Landy felt a lot of anger working with Fay because she forced him to recognize the wounded and demanding part of himself.

**Approach to Countertransference:** Landy brought his concerns about Fay to supervision. The supervisor, acting as Landy's guide, helped him identify the role he feels while with Fay. This was the victim role, since Landy identified strongly with the

client's dilemma. His counterrole was the 'tormentor' who was represented in Fay when she tormented the therapist into making him believe that he is incapable of helping her. The supervisor asked Landy to identify his guide, which Landy identified as the supervisor. The supervisor then asked Landy about the qualities the guide needs to have. Landy said the guide needs to be wise and caring.

Through talking with his supervisor, Landy realized that he is cast in the counterrole of the 'tormentor' for Fay when he goes on vacation. because he reminds her of everyone who neglected her and didn't deem her worthy of love. He also realized that Fay acts as a mirror for him, reflecting the parts of himself that feel unworthy of being loved. Through the supervisor's questioning, he realized that he cannot help her by acting in the counterrole, and that Fay needs him to be the wise and caring guide. The therapist also realized that Fay acts as a guide for him when she is in the angry role, making the therapist feel like a victim. This guides him back to his own pain.

**The following case is taken from Landy, 1996, *The Double Life: A Case of Bipolar Disorder*.**

**Client #2**– Sam, a man in his late 30s

**Presenting Issues of Client** – bipolar disorder. Sam was caught between many opposite poles, such as the struggle to be moral and religious when he believed himself immoral and faithless. He was also guilty of sometimes bingeing and sometimes depriving himself of food, as well as sometimes getting very high with illegal drugs and sometimes attending cult-like church services in an effort to be born again. The role model assessment identified Sam's inability to integrate his roles and counterroles. He was unable to find a state of balance in his life.

**Drama Therapy Approach:** Role Model. Landy encouraged Sam to freely express his feelings at the beginning of therapy. Once Sam identified depression as a significant feeling, Landy aimed to give this role quality a role, so Sam could better see his misery. For instance, Sam drew his depression in the role of a giant hippo, with a screaming mouth surrounded by razor wire. The hippo had one bloodied eye, and was disembodied and floating in space. This figure gave Sam space to talk about his mother, someone who required so much nurturing herself that she was unable to provide him with motherly care. This made Sam feel like he had no right to focus on his concerns with his mother, hence the imprisoned huge animal who had no right to scream. Also, he felt like his eye was bloodied because he couldn't see himself clearly in the situation. Landy continued encouraging Sam to construct roles. The theme of opposing desire was apparent in every embodiment. Sam worked extensively with projective play so he could more easily see the contents of his mind and invoke roles. Sam drew several sketches, created a box representing his world, cut up a doll representing his ex-wife, and had a mock funeral, all to express his emotions. Near the end of therapy, Sam said for the first time that he believes he is living double lives. As he began to recognize this, he gradually felt enabled to use the therapist as guide to achieve a healthy state of ambivalence between the opposing roles in his life.

**Type of Countertransference Evoked:** Sam's actions, especially that of cutting up a doll representing his ex-wife, often horrified Landy, making him frequently wish for the enactment to end. He feared what Sam might do next.

Also, Landy felt feelings stir inside him when Sam put on a costume to do the execution ritual. Watching this lean and strong man disrobe and dress up in childish



costumes made Landy feel uncomfortable, firstly for watching him disrobe, and secondly, because of his fear that Sam's costume might inspire more grotesque acts.

**Approach to Countertransference:** Landy used his internal guide to help him through his feelings of horror and fear. This internal supervisor told him that even though he might be scared of Sam's process, it was essential to let it continue so that Sam could feel accepted, and the therapeutic alliance could remain strong. This guide told him that Sam had trusted him enough to express these deep feelings, which was a certainly a positive therapeutic occurrence.

In the second instance, Landy's internal supervisor calmed his fears by looking realistically at this grown man in a childish Halloween-like costume and seeing the ridiculous appeal of it.

### DRAMA THERAPY MODEL#3: Developmental Themes Approach to Drama Therapy<sup>2</sup>

THEORIST: Dr. Penny Lewis

#### **Background Information about Theorist:**

Dr. Penny Lewis is a Jungian analyst, a dance movement therapist, and a drama therapist. She has taught for over thirty years at Antioch New England Graduate School. She is the author of numerous books, a former special guest editor of the international journal *Arts in Psychotherapy*, Co-director of the Certificate Program in Transpersonal Drama Therapy, a private practitioner in Amesbury, Massachusetts, and Co-editor of the comprehensive drama therapy textbook *Current Approaches in Drama Therapy*. Dr. Lewis currently serves on the Board of Directors of the National Association for Drama

---

<sup>2</sup> Lewis has also developed 'Recovery and Individuation, a Two Stage Model in Drama Therapy' (Lewis, Johnson, 2000).

Therapy as Education Chair. She is a registered drama therapist and a board certified trainer.

### **The Impetus for This Model:**

Lewis noticed from her work in 1971 that both children and adults reveal clearly identifiable symbolic developmental themes in their improvisational dramas. She found that she could aid her clients in healthy development by intervening in role within the symbolic imaginal realm in question. She was also intrigued by Anna Freud's work with interconnecting developmental lines. From these influences came her first book. Even though this book refers explicitly to dance therapy, Lewis sees it as also valid for the field of drama therapy (Lewis, 2000).

### **Influences:**

Lewis' three biggest influences are J.L. Moreno, Marianne Chace, and Carl Jung. Other influences include object relations theorists such as Melanie Klein, Margaret Mahler, D.W. Winnicott, and Ronald Fairbairn. These are people who closely studied the phenomenon of 'good-enough mothering', and how it gives the child both an idea of who s/he is and an internal support so the child is able to feel the mother's presence within him/her. Lewis was also influenced by Erik Erikson's theme-based stages of child development (Lewis, 2000). Lewis describes the contributions of Jung, Neumann, and Von Franz.

“(They) ...have taken culture's externalizations of universal life themes and characters found in myths, fairy tales, religious rituals, and stories of gods and goddesses, and provided a rich view of the powerful archetypal mythologems in the life quests and cycles of individuals” (Lewis, 2000, p.130).

Other influences for Lewis have included Sheehy, Moore, and Gillette, who studied and wrote detailed accounts of adult life stages.

**Brief Summary of the Drama Therapy Theory:**

The Developmental Themes Approach involves the therapist's core belief that all problems are caused by an inability to successfully master one or more normal human development life stages. Hence, the therapy room becomes a place where a person can regress into a developmental stage in which s/he was unable to achieve satisfaction and which is consequently causing problems in his/her present life. Lewis has identified various art media (1993) and ways of working in drama and dance therapy that correspond to each developmental stage.

**Goal of Therapy:**

The goal of therapy is to heal stages of development through the imaginal realm. These stages of arrested development are identified by the therapist by noting any developmental stage-appropriate movements the client constantly repeats. The themes that cause problems for the client become clear once the therapist leads him/her into exploratory role-play.

**Basic Concepts: Health, Dysfunction***Health:*

Health is defined by the successful mastery and integration of all developmental life stages as well as the ready availability of the themes from each stage for helping a person cope with life in the present.

*Dysfunction:*

Dysfunction happens when a healthy progression of development gets blocked due to inability to master a developmental stage. Hence, the person continues along the

developmental progression carrying with him/her the threads of incompleteness and all the problems attached to the problematic life stage.

### **Individual vs. Group:**

#### Group:

##### *Focus:*

Lewis makes reference to the historical importance of group work in healing.

“The power of groups to evoke the transformative force of the imaginal realm has been well-documented in ethnographic studies. Community rituals utilize the arts through dance, dramatic enactment, singing, and chanting. They can bridge the human world with the sublime. They would enact the metaphoric thus aiding the society and its members through seasonal cycles and developmental rites of passage” (Lewis, 1993, p.22).

For her work, she says that groups can function as a safe and supportive place for vulnerable individuals to slowly express their needs. Groups provide a place for each person to be able to take the role of giver, which is itself therapeutic.

##### *Role of Therapist:*

The role of the therapist is to skillfully manage the group dynamic, making sure that each person is heard and responded to.

#### Individual:

##### *Focus:*

The focus is on exploring the individual's arrested developmental stage through re-dramatization of object relations, use of various art media, unconscious-to-unconscious communication between therapist and client, and dance and drama exercises.

### *Role of Therapist:*

“The role of the therapist is that of genuine care and concern seeking connection (relational model), contact (Gestalt model), and genuine intimacy” (Lewis, 2000, p.132).

### **Populations Served:**

Lewis maintains that the developmental nature of this model allows for all ages of people to be successfully treated. She has used this approach with many diverse populations including those with personality disorders, post-traumatic stress disorder, addictions, eating disorders, dissociative disorders, adjustment disorders, mood and anxiety disorders, some forms of schizophrenia, mental retardation, developmental delay, autism, and learning disabilities (Lewis, 2000). However, she does assert that there is less relevancy for this approach for problems that are not a result of unsuccessful development, such as paranoid schizophrenia, sleep disorders, and some cognitive and medically related disorders.

### **Role of Countertransference:**

Lewis uses somatic countertransference as a technique within both her Developmental Themes Approach and her Two-Stage Recovery Model. In each model, the interplay of both personal and somatic countertransference is very important. While personal countertransference relates to the original Freudian definition of repressed conflicts in the therapist's psyche that are evoked by the client, somatic countertransference is about feelings, sensations, images, and thoughts that enter the therapist from the client and disappear once the client claims them as his/her own. In the ensuing interview, Lewis explains this concept in detail.

## **EXCERPTS FROM PHONE INTERVIEW WITH PENNY LEWIS, 2003/05/21**

**Can you describe one instance of somatic countertransference?**

*You mean the four – feeling, sensing, intuiting and thinking?*

*For example, an individual may be talking to you, involved in a psychodrama, or in an embodied psyche technique, and as they're speaking, you as the director or the drama therapist, start feeling a great deal of sadness which is different from your feelings of empathy or compassion for the individual. It just fills your stomach or your heart. It's an experience of feeling like you could cry at any minute. You the therapist know that you feel for this person, but these feelings are very basic and fundamental and you know that you are not the one feeling this tremendous sadness, since it hasn't evoked anything in your history that would provide a personal countertransference. You have received an unconscious transmission of the individual's split-off sadness, and what you can do of course is double the double or suggest to the double in psychodrama "I am feeling very..." and have the person complete the phrase, or "the most powerful feeling that I am trying to hold back is..." and have the person complete the sentence. What I do when I'm working one-to-one is ask "what are you feeling right now?" It's almost like a time-out from the process to check in. Or, you might generalize it by saying "I'm feeling sadness in the room". If the person continues to deny whatever you are quite certain they are feeling, say "I am willing to hold (your sadness) for you, but it is yours, and it only can be healed by giving it back to you and having you express and experience it".*

**So you contain those feelings for the individual?**

*Exactly. You can hold or contain the feelings, thereby allowing the person to then express...Hold the feelings or help the person claim the feelings.*

*Also, you can feel sensations. Those are different from feelings. Knowing this, you can feel a switch through sensations. The important switch for me is when I'm mirroring, reflecting, or doubling someone. First, I might for example, get the positive mother transference, then I get the negative mother transference. In that negative mother transference, the individual, the protagonist, feels that I'm trying to enmesh with them, merge with them, whereas a moment ago, they felt I was attuning to them in what we were doing. I will start feeling a sense of nausea because the sense of self develops first in the belly, or an 'interoceptive' sense of self. It's almost as if the good milk is soured with the sick mother, the emotionally disturbed mother, the narcissistic mother, the borderline mother, or the abandoning mother. When I start to feel that sensation and I know I don't have the intestinal flu or anything else that would cause that, I know that that's definitely coming from the client. That will result in me immediately holding the negative transference, imagining it in a held position within me. I will imagine boundaries around me to protect the individual from what they have transferred into me.*

*In more psychodramatic work, I'll have several people create a protective wall around the person, or even if a negative transference was made, I'll move out from the giver space. So there are responses I will do so I come to respond more as the rapprochement mother based on the mother that encourages the child to have boundaries and to say no, to disagree and not to mirror or seek attunement with the mother. That's an example of experiencing a sensation.*

*You can also receive images. Often I will ask the person to imagine going inside the body and locating the core of who they are and allowing any feelings, thoughts, or sensations to emerge from that. What I do is I journey with them. I might sense a lot of*

*anger, fear, or mistrust, behind something. What I'm imaging may be a very tiny child hiding behind a rock.... From there, if the person picks up the same images, I might ask if I can role-play. Some people can tolerate the inner child. That's really what I'm talking about. Then I say of course, "if anything doesn't feel right, please let me know". Then I might say something like "I don't trust you", "you are telling me not to feel," or "you know you need rest", or "I need for you to care for me". I'm hoping that at the day's end the client will take on the role of the child. We'll switch roles and begin the choreography of object relations and then re-dramatization of object relations. That is the idea of images.*

*The other form of somatic countertransference is that one can have thoughts. Sometimes the thoughts are really the unconscious thoughts of the individual and sometimes they are the kinds that we are using in doubling: "If there's one thing I want to say to you...(protagonist fills in the rest). If there's one specific thing that's happened that typifies what you have done to me...(protagonist fills in the rest)." I like to do sentence completion as the double so the person can easily express their emotions. I do believe that we are not alone here and there is information that we can receive on behalf of others. So, from a particular message, especially if people are doing individuation work in the two-stage model, I also look at what I call "knowings", that which I couldn't have known that are worded in the suggestion or in some words which will bring forth a person's relationship to the transpersonal...So that's the four, feeling, sensing, imagining, and thoughts.*



### **What is your advice for beginning therapists?**

*Check yourself out first by not making generalized statements. If you're feeling something and you don't think it's yours do a time-out and ask yourself what you're feeling now, what you're feeling in your belly, what's going on. Ask very open-ended questions. The other thing is when the person leaves, all the somatic countertransference leaves with them. You're not held with any of it so you're not still sad or angry or nauseous or imagining holding the person. It is gone with them. If you're holding on to, dwelling, or thinking of a particular client, then that generally suggests that there is a leak in your vessel that is holding countertransference and it moves out and triggers something for you, or that it did in fact come from your personal countertransference. What you do then is have good supervision, somebody who understands. Or peer supervision, or good therapy. Drink a lot of water, take a shower...do what you need to do to clear up that energy because it is energy which comes down into the body.*

### **Case Vignettes involving Countertransference with Drama Therapist Dr. Penny Lewis**

**The first case is taken from Lewis, (2000), *Developmental Themes Approach to Drama Therapy***

**Client #1:** Laura, a woman in her early thirties.

**Presenting Issues:** Through the somatic countertransference, Lewis instantly identified Laura as someone who craved the love of a mother figure. Due to Laura's empty mother and narcissistic father, she felt ignored and uncared for, and had never developed a sense of self. Lewis identified that Laura "needs to have a new sense of self encouraged and supported as she claims more of herself"(Lewis, 2000, p.153). Through Laura's work in

drama therapy, Lewis identified various developmental stages in which Laura needed to work out her blocks: symbiosis, differentiation, practising and rapprochement, self formation, identification and relationship with parents, puberty and adolescence, claiming her sexuality and de-throning the old rule, and young adulthood. These are among the first ten developmental stages, and the only ones which Laura at her age could have experienced. The eleventh developmental stage concerns midlife.

**Drama Therapy Approach:** Developmental Themes Approach. Lewis started work chronologically, with the earliest developmental stage Laura showed problems with, that of symbiosis (attachment to the mother). Lewis role-played Laura's mother, interviewed Laura, and attuned to Laura's breath.

It took five sessions for trust to be established between therapist and client, at which time Lewis began deep work, helping Laura find her lost sense of self. After Laura made the realization that she had traded the development of her soul for the hope of parental love, Lewis, after asking permission, used her own soul to symbolically search for Laura's. This all happened in the transpersonal realm.

In another instance, the technique of 're-dramatization of object relations' was used. Laura dramatized her response to Lewis' role-playing of the supportive object Laura never had. Lewis played this supportive object by mirroring Laura in her dream that brought her into the light (a type of rebirth).

Lewis transmitted to Laura feelings of genuine care, which prompted Laura to ask "will you receive my anger too?" Lewis' response was to imagine Laura whole (integrated with the split-off parts of herself such as anger) and send that image back to her through the somatic countertransference.

Through this work, Laura was able to feel supported and better attached to her inner mother so she could move on to her next troubling developmental stage. In the working out of each subsequent developmental stage, Lewis closely mirrored and reflected the client, often using psychodramatic techniques to let the client speak to split-off parts of herself, so she could work towards integration of the whole.

**Type of Countertransference Evoked:** Lewis often felt projected into the role of good or bad mother depending on which character Laura needed to work with.

**Approach to Countertransference:** Lewis used her understanding of the somatic countertransference to fill herself with the good or bad mother character so she could image whatever split-off self Laura was sending to her. By absorbing the fragments of Laura's self, Lewis was able to imagine them pieced back together and then return that whole and integrated image back to her client. By simply imagining the client's self in this way, and letting her unconscious communicate with the client's unconscious, Lewis was able to help the client achieve integration of the fragmented parts of herself.

Lewis warns that personal countertransference might be a hindrance to this work:

“If the patient isn't progressing, the therapist may need to look at personal countertransferential issues which may deliver the unconscious message to the sensitive patient that the mother-therapist does not have the needed sense of self within to encourage the patient's separation”(Lewis, 1993, p.49).

**This case is taken from Lewis, (1992), *The Creative Arts in Transference/ Counter-transference Relationships***

**Client #2:** man, “who came to my office complaining of a growing passivity in his work and rage toward his wife” (Lewis, 1992, p.321).

**Presenting Issues:** Through exploration into the history of his problem, Lewis and her client together found “the origin of this complex to be an anxious, unfulfilled, smothering mother – now internalized and transferred onto the world” (Lewis, 1992, p.321).

**Drama Therapy Approach:** Developmental Themes Approach. Lewis worked through the developmental theme of ‘differentiation’, which is about separation and individuation. She reasons that the troubles clients face in this stage stem from a lack of proper parenting:

“(Developmental blocks in the differentiation stage stem from a)...smothering or narcissistic mother or primary care giver who has no real inner sense of self and so keeps ‘glued’ onto the emerging toddler in the hopes of siphoning off the child’s developing sense of self” (Lewis, 1993, p.57).

Lewis absorbed the negative transference of the ‘smothering mother’ and spoke through her when she found herself denigrated and attacked. At this time, the client embodied his inner child. As Lewis spoke through the mother, her own ego empathized and gained more of an understanding for his case. In the somatic countertransference, she instructed him:

“Be passive, leave your wife, get fired, come home and live with me, I will take care of you...all you have to do is promise that you have no important relationships with anyone: no friends or lovers, and no enjoyment from anything you do...” (Lewis, 1992, p.321).

After Lewis went on like this, the patient agreed in astonishment that she had captured his feeling precisely. The therapy continued with the client aiming to imaginally expel the smothering creature from within him and slowly let his split-off angry inner child emerge and become expressive. Once his inner child came into view, he worked with it devotedly and had many dialogues with his negative internalized mother complex. The bad mother inside of him became replaced by the good mother image that Lewis

projected, and over time he internalized this image of the supportive parent for his inner child.

**Type of Countertransference Evoked:** Lewis initially felt confused and disoriented by her client's hateful attacks, but once she understood that he was projecting his negative mother image onto her, she absorbed it willingly, knowing that doing so was therapeutically beneficial. At times the client also projected a positive mother image onto the therapist.

**Approach to Countertransference:**

Lewis dealt with the client's projections by allowing herself to completely attune to his rhythms and absorb his transferences. She was then able to speak through the negative mother so that the client could clearly differentiate the therapist from the mother figure and respond differently to the two. This way, Lewis' own ego was not hurt by the client's attacks, since she knew he was responding to her creation of his mother, and her own ego could stay intact to empathize and listen actively to the client.

**DRAMA THERAPY MODEL #4: Developmental Transformations**

**THEORIST: Dr. David R. Johnson**

**Background Information about Theorist:**

David R. Johnson has been pairing his experience in dramatic improvisation with his expertise in therapy since 1974 (Johnson, 1991, p.290). He is one of the founders of the National Association for Drama Therapy, the director of the Institute for the Arts in Psychotherapy, New York, New York, the director of the Institute for Developmental Transformations and the co-director of Post Traumatic Stress Center, in New Haven, Connecticut. He is also an Associate Clinical Professor at the Department of Psychiatry,

Yale University School of Medicine. He is a past Editor-in-Chief of the international publication *Arts in Psychotherapy*, a past Chairperson of the National Coalition of Arts Therapy Associations and a past president of the National Association of Drama Therapy. He is a registered drama therapist and a board certified trainer.

### **The Impetus for this Model:**

Johnson found the need to create a “drama psychotherapy” (Johnson, 2000, p.87) model, which addressed all levels of human expression. He discovered many methods which use the idea of free and spontaneous expression. However, he also found that none of these methods helped the clients play with their associations and encounter someone else who would help them define their rising images.

Johnson states that the goal of Developmental Transformations is the uncovering of useless layers of protection surrounding our essential beings:

“(The goal is...) to be able to play with the unplayable, for it is the unplayable that blocks our way to the Source. This process is essentially what Grotowski referred to as the *via negativa*, the negative way, being a process of removal of blocks” (Johnson, 2000, p.91).

### **Influences:**

Johnson relates his use of a developmental paradigm to many theorists who ascribe to similar ideas:

“Freud (1905), Werner (1948), Piaget (1954), Levinson (1978), and many others have sought to explore this journey which each person takes through life” (Johnson, 1982, p.183).

Johnson also credits many psychological and philosophical theories, such as Jacobson and Mahler’s psychoanalytic object relations theories (1964-1975), Piaget’s developmental theories (1951), Sartre’s existential philosophy (1943), and Derrida’s philosophy of deconstruction (1978), as being influential in the development of his ideas.

Johnson also maintains that his work has strong theatrical foundations, because of its strong adherence to the ideas of Jerzy Grotowski:

“Jerzy Grotowski’s proposal for a ‘Poor Theatre’ (Grotowski, 1968, Richards, 1995) serves as an apt metaphor for a model of drama therapy that relies on the unobstructed encounter between therapist and client in the therapeutic playspace” (Read Johnson, Forrester, Dintino, James, Schnee, 1996).

Johnson mentions the Freudian psychoanalytic concept of free association as a major forerunner for his work:

“Transformations is essentially free association extended beyond words into movement, sound, gesture, and dramatic character” (Johnson, 1990, p.287).

Johnson also relates his work to Mary Whitehouse’s (1979) elaboration of Jung’s active imagination technique, authentic movement:

“Transformations attempts to elicit in drama what authentic movement does in dance” (Johnson, 1990, p.287).

Johnson also refers to Carl Rogers’ client-centered approach:

“Transformations follows Rogers in this level of active, empathic involvement by the therapist in the client’s world” (p.287-288).

Johnson consequently acknowledges the contribution of Eugene Gendlin, a student of Rogers:

(He)... “developed a technique called *focusing*, in which clients are trained to pay attention to their inner states, specifically called the *bodily felt sense*” (Ibid).

Johnson describes this felt sense as integral to the Transformations process, since it allows the client to explore him/herself at a deeper level than verbalization permits. Along with free association methods through the body and voice, Johnson’s Developmental Transformations Method utilizes a stream-of-consciousness writing technique.

### **Brief Summary of the Drama Therapy Model:**

Developmental Transformations encourages clients to feel in tune with their bodily impulses so they can use the evoked images and roles to freely express various sides of the self (Johnson et al. 1996). Hence, Johnson's method aims to increase client awareness of him/herself. Developmental progression is important to Johnson, whose sessions unfold through a series of stages, commencing with group movements and sounds, and then moving on to the definition of images, elaboration of potential roles, structured role-playing and unstructured role-playing (Johnson, 1991). In Developmental Transformations, it is extremely important that the therapist foster utmost freedom of expression for the client. This free expression then allows personal embodied images to appear so they can be played with. The continuous transformative process implies that created images are not held onto; rather they fade away to make room for emerging associations.

Developmental Transformations does not force the client to define or understand his/her problem; it instead lets the client play with his/her problems to achieve a greater tolerance of one's self, and a lowering of interpersonal anxiety (Johnson, 1991). Johnson praises the value of shedding anxieties through this method:

“It is a method that helps to free up the internal world and, practiced regularly, can be considered good mental hygiene. The benefits it provides include a sense of inner calm, acceptance of oneself and one's painful history, a sense of fullness and increased range of experiencing, deepened by the stirrings of an inner life, moving upward from below” (Johnson, 1991, p.299).

**Goals of Therapy:** Developmental Transformations aims to reconnect the client with his/her Source. The major goal of any one session is to achieve “a seamless flowing quality in which images are in constant transition” (Johnson, 1991, p.290). The aim is to



discover the client's inner world as well as provide him/her with a feeling of inner tranquility, including acceptance of him/herself complete with any disturbing past experiences. Another goal is to better the quality of life for the client (Johnson, 2000).

**Basic Concepts: Developmental Process, Flow, Impasse**

*Developmental Process:* Johnson explains that his method addresses various human developmental processes, of which five are the most important. For instance, people develop in the degree of structure they can tolerate and create. They also pass developmental stages in the type of expression they create (they develop from simple sounds and movements to complex sentences and varied kinesthetic styles). People develop in the complexity they achieve in their articulation in daily activities. They develop in the amount of emotional affect they can withstand from various stimuli, and they also develop to the degree that they can see other people as completely separate from themselves. It is within the playspace that the drama therapy session unfolds, so the therapist is responsible for maintaining this boundary for his/her clients (Johnson, 1991).

*Flow:* Flow is the continuous and consistently linked experience between a player's internal world and the characters and dramatic creations that appear within the libidinal space. The necessary presence of flow means that images and forms within the drama must be constantly rising and falling, a key occurrence in transformations.

*Impasse:* When the smooth nature of the above-described flow is threatened, an impasse is said to occur. Impasses take place because of disharmony between the internal feelings and wishes of the participants and the external demands of the scene. Johnson notes that "the energy in the scene dies, a sense of awkwardness or confusion arises, and the actors

appear to be ‘stuck’”(Johnson, p.289). Impasses can be very helpful and instructive for information about clients’ core conflicts.

### **Individual vs. Group:**

#### Group:

*Focus:* A prime focus of group work is the discovery of the inner emotional state of each group member by means of the embodied free association work.

*Role of Therapist:* The therapist’s role is to respond to and reflect all clients empathically. S/he must be sure that every group structure she introduces has as a goal the spontaneous expression of the unconscious of each client. S/he must move the group through the developmental stages as well, but s/he must leave the session unplanned, because the nature of this method is improvisatory. The therapist is a guide for the group as s/he leads the clients through the magical land of dramatic media.

#### Individual:

*Focus:* As in the group method, the individual method also strives to uncover and reflect the client’s inner world though improvisatory means.

*Role of Therapist:* The therapist is more involved with the client because no other people are present. Because of this, the therapist becomes the only receptacle for any projections the client may have:

“As the client’s playobject, the therapist becomes an animated presence that the client must contain; the roles of container/contained are therefore partly reversed in this method of therapy” (Johnson, 2000, p.95).

The therapist also explores meanings of expressed images with clients by transforming a given scene into one the client has already played out and which bears

some semblance to the present action. This is to present possible links and enhance client awareness.

**Populations Served:**

Johnson indicates his method for all populations, though he cautions that it is not for people who have an aversion to the idea of play or who are violently psychotic and are incapable of engaging in the play process.

**Role of Countertransference:**

The therapist is used as a transference object quite explicitly so there is room for a lot of countertransference. This method deals with countertransference by keeping the focus on the client at all times, and giving the option to the therapist to leave the play and enter the Witnessing Circle to simply observe the client on his/her own.

Johnson instructs that:

“...the therapist must practice with a great deal of discipline so that the drama is not permeated with his or her own issues or imagery...The therapist follows the client’s lead and never purposefully introduces personal material” (Johnson, 1991, p.298).

Johnson has identified two kinds of countertransference: ‘evoked counter-transference’ and ‘real countertransference’. The former is composed of those personal issues that are pressing to the therapist regardless of which client s/he works with, and the latter kind indicates the feelings and thoughts that therapists find evoked in themselves by the client (Ibid). Johnson describes four unhelpful countertransference responses in detail. The first implies that the therapist identifies strongly with the clients’ conflicts, and hence cannot fathom any possibilities for change in the situation. Here the therapist doesn’t transform the scene because s/he is unsure how s/he could help. This apparent therapeutic

block could possibly advance the progress of therapy, because the impasse is quickly brought to light, underlining the core conflicts.

The second unhelpful response occurs when the therapist feels bored with the direction the client is taking in the session, and accordingly decides to introduce his/her own unique responses, including unrelated material. This may be dangerous because the client may feel misunderstood by the therapist. However, this may also be helpful because the client may see novel ways to break hopeless patterns of behaviour.

The third response occurs when the therapist feels annoyed or frustrated because the client stops inventing fictional dramatizations and starts talking about the therapist or process of therapy. In this case, the therapist discourages any such talk, and consequently does not transform to the present time and situation enough. Conveying little or no interest in the client's concerns may make the client feel unsafe, unacknowledged, and unwilling to explore his/her issues with the particular therapist.

The fourth unhelpful countertransference response occurs when the therapist feels so overwhelmed and transfixed by certain issues in the client's play that s/he fails to respond to other very important and pivotal issues. Johnson warns that this is "very common, and can lead to significant delays in therapeutic progress" (Johnson, 1991, p.298). However, Johnson also acknowledges that a client's issues tend to re-emerge so if the therapist doesn't catch them the first time, s/he usually has a second chance.

**EXCERPTS FROM INTERVIEW WITH GRETA SCHNEE, RDT/BCT,  
CLINICAL DIRECTOR FOR THE INSTITUTE FOR THE ARTS IN  
PSYCHOTHERAPY, 2003/03/30**

**How do you approach countertransference in respect to your theoretical model  
(developmental transformations)?**

*Our approach is close to Penny Lewis' approach involving somatic countertransference. We also see it as being a somatic experience. The therapist gets filled up with the client, and has an energetic and bodily reaction to the client. The therapist thinks about what that reaction is and how it feels. We see countertransference in two parts. There is the part that's you because it's coming to you from the client and there is the part that's you because you're you. When I'm experiencing countertransference, I look at what is being communicated to me subconsciously via my experience with this person, and I look at my own personal response. The body is the source of our thinking and feeling. The body operates on a non-verbal level. We communicate to each other not only through words but bodies. My body is a receptacle for the client's feelings. When someone is communicating to me, I receive it with my whole body. We listen to what our brains and bodies are telling us and we reflect that back, so we don't really separate thinking from body functions. It is both a cognitive and somatic experience.*

**Describe a drama therapy experience which involved countertransference.**

*The experience of love. I feel a great love for a particular client – I remember I would ask myself if it's even mine – Yes, there was something about her, but I also asked*

*if she needs me to love her, and I'd reflect that back to her – I started to share with her how much we loved each other because she had never really been loved properly before.*

**Do you have any advice for beginning therapists?**

*Yes. Be honest with yourself and have humility towards yourself, be able to accept uncomfortable as well as comfortable feelings. Ask yourself if this is coming from me or my client or both. I also think it's important to seek out professional help, including supervision in order to become more comfortable in your own inner world. That will make you more available to help other people.*

**Case Vignettes involving Countertransference in Developmental Transformations with Drama Therapist Dr. David Johnson.**

**The following case is taken from Johnson, (1991), *The Theory and Technique of Transformations in Drama Therapy***

**Client #1:** Henry, 24-year-old man, junior management consultant.

**Presenting Issues:** Henry feels depressed, overly ineffective and passive at work, a failure at meeting women. He also had a difficult upbringing, since his parents divorced when he was 13, and neither parent was emotionally present for him. He subsequently did poorly at school, though continued on to college. He then had a fear of being homosexual, which he didn't know how to handle. He harboured excessive anger and shame toward his father, and had difficulty facing his own competitiveness and fear of weakness. The therapy helped him play with his issues, achieve acceptance of them, and learn to be flexible in dealing with new situations and feelings.

**Therapy Administered:** Developmental Transformations. Henry was led through a series of sessions where his inner world was explored by the therapist. During the first

few sessions, Henry described his problems verbally and only after many verbal sessions did transformations begin. At first, he was hesitant and unwilling to explore images that might cause distress for him. Over time, his inhibition was loosened and he was able to play more freely. The therapist used such Developmental Transformations techniques as faithful rendering, act completion, defining, repetition, intensification, joining, pre-empting, action interpretation, bracketing, transformation in the here and now, witnessing, and specialized spaces. These are all techniques to aid the client in immersion in his fantasy world, so he can understand the issues he presents and feel comfortable to continue playing with them with the therapist.

**Type of Countertransference Evoked:** Shame, Guilt, Frustration, Helplessness

**Approach to Countertransference:** Johnson used the above-mentioned Developmental Transformations techniques to play with his feelings. For instance, he used his feeling of being impressed that the client made reference to the therapist-client relationship by responding in the therapy: “You’re right! This is supposed to be a long term psychotherapy!” (Johnson, 1991, p.294). In another instance, when Henry introduced phallic imagery, Johnson delved into his feeling of shame about these matters by playfully presenting a meeting on ‘Penis Anonymous’ and calling himself ‘teenie’. This prompted Henry to call himself ‘weenie’ and do a dance with the therapist before transforming the relationship into an embarrassed father and his son. Another time, Johnson felt like he had missed the point in responding to Henry so feeling useless and frustrated he left for the witnessing circle to let Henry continue the role-play on his own. This prompted Henry to do a meaningful monologue full of emotion.

After the session, Johnson wrote detailed process notes so he could analyze the rich information that he gleaned from the work.

**The following case is taken from Johnson, (2000), *Developmental Transformations: Toward the Body as Presence***

**Client #2:** C, a 36-year-old woman, elementary school teacher.

**Presenting Issues:** C had difficulties with intimate relationships with men, though strongly desired to find a man to marry and have a child. She thought that her difficulties might stem from some abuse she might have suffered by her father when she was three or four years old, though she wasn't sure – her father died when she was seven years old.

**Drama Therapy Approach:** Developmental Transformations. This is a long-term psychotherapy and the session described is the 107<sup>th</sup> session. They are in 'deep play', the session is very embodied, and associations are very personal. The client demonstrates transference fantasies of the therapist being her lover, her baby, or her father.

**Countertransference Evoked:** The close physical contact caused the therapist to feel some romantic countertransference. Also, he felt like he wanted to be the baby she wanted to take care of.

**Approach to Countertransference:** He desired her and he dealt with this by mentioning his feeling within the play, but only when he deemed it therapeutically appropriate for the client. For instance, he did not tell the client he desired her physically, since he was unsure if she was casting him in the role of father, and he didn't want to play the image of the abusing father. However, he did share his feeling that he was her baby, so she could take care of a baby instead of "killing" them as she had in previous dramatic improvisations. Sometimes the therapist illustrated his feeling by expressing a reaction



with his body. For instance, when C came over and put her arms around the therapist, he turned and laid on her lap. In this way, he communicated to her that he wanted to be held, feeling she was like a mother.

**CHAPTER THREE**

**COMPARISON & CROSS-REFERENCING OF THE FOUR DRAMA**

**THERAPY THEORIES AND THEIR APPROACHES TO**

**COUNTERTRANSFERENCE**

In the last section, four theories of drama therapy were discussed in several respects. This section aims to give the reader an overall view of the models and how they compare to each other. Similarities will be noted in the ‘Influences’ lists, as three out of four drama therapists primarily base their influences around psychological theorists. Landy is the only theorist who bases his influences in the theatrical realm.

Therapeutic goals yield almost exact likenesses in both Johnson’s and Irwin’s models, while Landy and Lewis state more idiosyncratic specific goals related to the theories they created.

All theorists work with most populations, though they all imply that those who are violently psychotic are perhaps not best suited for their method. Each method has target populations. For instance, Lewis’ Developmental Themes approach focuses on clients whose problems stem from a block in development. Johnson’s Developmental Transformations model aims to treat clients who are open to the idea of playing. Irwin’s Psychoanalytic Drama Therapy is best suited for clients who have a facility for verbal insight, and Landy’s Role Method is most applicable for clients who have the ability to invoke roles.

Each model differs in its basic concepts, which points to the uniqueness of each.

The group focus is very similar in all four models, as group dynamics represent a large rationale for this kind of work. The role of therapist in group work is also very

similar in all models, though Landy makes sure to use a metaphor from the theatre to emphasize the grounding of his work in this realm. He is the only one who refers to the therapist in group drama therapy as a “theatre director”.

In individual work, the focus is consistently similar to the theorist’s idea of the focus in group work. The only difference is that the aspect of interpersonal relations shifts from group dynamics to intimate therapeutic alliance. As per the role of therapist in individual work, all models state quite different ideas, as Landy’s therapist directs role enactments, Lewis’ therapist adheres to the relational and Gestalt models, Johnson’s therapist surrenders himself as a ‘play object’ for the client, and Irwin’s therapist closely follows the client’s lead in a verbal manner, so the client feels free to reveal his/her fantasy world.

Finally, each theorist adheres to the same definition of countertransference.

### Summary Chart of Drama Therapy Models

<b>Question to Compare</b>	<b>Robert Landy's Role Model</b>	<b>Penny Lewis' Developmental Themes Approach</b>	<b>David Johnson's Developmental Transformations Model</b>	<b>Eleanor Irwin's Psychodynamic Drama Therapy</b>
<b>Influences</b> – this is not intended to be a comprehensive list, simply some of the names that the authors have mentioned in their writings	Aristotle, Shakespeare, Cicero, Goethe, Nietzsche, Benjamin, Turner, Stanislavsky, Brecht, Craig, , Linton, S.J. Gould	Jung, Chace, Moreno, Mahler, A.Freud, Fairbairn, Klein, Whitehouse, Erikson, Winnicott, Von Franz, Perls	Jacobson, Mahler, Piaget, Sartre, Derrida, S. Freud, Rogers, Werner, Levinson, Grotowski, Whitehouse, Gendlin, Spolin	S. Freud, A. Freud, Klein, Mahler, Sandler, Jacobson, Winnicott, Loewald, Kernberg, Kohut, Bornstein
<b>Goals of Therapy</b>	<ul style="list-style-type: none"> <li>➤ Increase client's role repertoire</li> <li>➤ Help clients achieve balance between role and counterrole</li> <li>➤ Help clients internalize guide figure</li> </ul>	<ul style="list-style-type: none"> <li>➤ Identify problematic developmental stage</li> <li>➤ Help clients work through developmental block(s)</li> <li>➤ Help clients integrate successful developmental stage into present life</li> </ul>	<ul style="list-style-type: none"> <li>➤ Guide client to discovery of his/her inner world</li> <li>➤ Provide clients with a feeling of inner tranquility</li> <li>➤ Encourage self-acceptance including any disturbing past experiences</li> </ul>	<ul style="list-style-type: none"> <li>➤ Help individuals develop more positive feelings about themselves</li> <li>➤ Bring about awareness of self</li> <li>➤ Change problem-causing behaviours</li> </ul>
<b>Populations Served</b>	All	All whose problems stem from a block in development	All, except those who are floridly psychotic	Those who demonstrate a capacity for verbal insight

<b>Basic Concepts</b>	<ul style="list-style-type: none"> <li>➤ Role</li> <li>➤ Counterrole</li> <li>➤ Guide</li> </ul>	<ul style="list-style-type: none"> <li>➤ Health</li> <li>➤ Dysfunction</li> </ul>	<ul style="list-style-type: none"> <li>➤ Impasse</li> <li>➤ Flow</li> <li>➤ Developmental Process</li> </ul>	<ul style="list-style-type: none"> <li>➤ Unconscious</li> <li>➤ Resistance</li> <li>➤ Transference/CT</li> </ul>
<b>Group DT focus</b>	<ul style="list-style-type: none"> <li>➤ Group Dynamics</li> <li>➤ Enactment in Role</li> <li>➤ Communication structures</li> <li>➤ Interaction with fellow actors</li> <li>➤ Being witnessed by observers</li> </ul>	<ul style="list-style-type: none"> <li>➤ Group Dynamics</li> <li>➤ Being held and contained by others</li> <li>➤ Experiencing the time-honoured ritualistic tradition of group process</li> </ul>	<ul style="list-style-type: none"> <li>➤ Group Dynamics</li> <li>➤ Discovery of inner states of each individual</li> <li>➤ Developmental Process</li> </ul>	<ul style="list-style-type: none"> <li>➤ Group Dynamics</li> <li>➤ Free expression of all group members</li> <li>➤ Having many people to empathize with client</li> </ul>
<b>Role of Therapist in Group DT</b>	<ul style="list-style-type: none"> <li>➤ Theatre Director/ Guide</li> <li>➤ Strategic thinker</li> <li>➤ Role trainer of social roles and possibilities of roles clients might have in the group</li> </ul>	<ul style="list-style-type: none"> <li>➤ Skillful manager of group dynamic</li> <li>➤ Leader of group process</li> </ul>	<ul style="list-style-type: none"> <li>➤ Leader of group structures, which delve into the spontaneous expression of the unconscious of each client</li> <li>➤ Manager of linear process of developmental stages.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Facilitator for group free expression</li> <li>➤ Skillful manager of group dynamic</li> </ul>
<b>Individual DT focus</b>	<ul style="list-style-type: none"> <li>➤ Similar to group therapy</li> <li>➤ In individual work the therapeutic alliance is more essential</li> </ul>	<ul style="list-style-type: none"> <li>➤ Exploring the individual's arrested developmental stage</li> <li>➤ Redramatization of object relations, bidirectional unconscious communication</li> </ul>	<ul style="list-style-type: none"> <li>➤ Similar to group therapy</li> <li>➤ In individual work, the focus is on the fantasy world of one particular client</li> </ul>	<ul style="list-style-type: none"> <li>➤ Similar to group therapy</li> <li>➤ More importance is given to issues of resistance, transference and counter-transference</li> </ul>

<b>Role of Therapist in Individual DT</b>	➤ Theatre director, directing role enactments of client	➤ Seeker of relational connections, contact (Gestalt model), and genuine intimacy	➤ Play object for the client, so client can use the therapist to help him/her play with issues in his/her life	➤ Follower of the client's projections and enactments, so clients feel free to reveal their fantasy world to the therapist
<b>Definition of Countertransference</b>	➤ CT involves what is evoked by the client and what is from the therapist's past	➤ CT involves what is evoked by the client and what is from the therapist's past	➤ CT involves what is evoked by the client and what is from the therapist's past	➤ CT involves what is evoked by the client and what is from the therapist's past

## **Conclusion**

In this research paper, I have described from a theoretical point of view four methods of approaching countertransference in the field of drama therapy. Data has been retrieved from journals, books, electronic media, and telephone interview sessions with the theorists themselves.

Findings from this study indicate that approaches to dealing with countertransference show clear similarities among Landy's, Lewis', Johnson's and Irwin's drama therapy models. All four insist on the importance of supervision, of knowing oneself and one's eccentricities. All four agree with the classical psychoanalytic definition of countertransference. Penny Lewis is careful to call that definition 'personal' countertransference, which contrasts against the tool she finds more useful in therapy, 'somatic' countertransference. Each theorist agrees on the existence of this type of countertransference, and it is given primary importance in literature about Lewis' and Johnson's method. However, when asked the question, Irwin mentioned that she too had felt striking instances of somatic as well as personal countertransference. The ways each theorist deals with countertransference are idiosyncratic. Lewis uses the imaginal realm to receive negative transference somatically and send back messages to the client unconsciously. Johnson uses his feelings of personal and somatic countertransference as fuel for the direction of the therapy, because they help him develop an impulse to progress with one of his Developmental Transformations techniques. Landy uses his feelings of both kinds of countertransference to sort out his oscillating position within the role triad of role, counterrole, and guide, and Irwin uses both kinds of countertransference

to help achieve understanding of the client's predicament, so she can offer valuable insight.

Results of this exploratory investigation show that these four influential drama therapists manifest many similarities and some uniquenesses in their approaches to countertransference. Much of my research into their work has yielded ideologies about countertransference comparable to countless psychiatrists and psychologists who have written and published on this topic. This finding illustrates the powerful influence that Sigmund Freud had when he developed the term more than a century ago. His basic idea that countertransference is a reaction to the patient's transference, is upheld even today.

Of course drama therapy is quite different than psychoanalysis and accordingly it frequently involves a more intense kind of countertransference. As Eleanor Irwin indicated, drama therapy is a much more action-oriented therapy than psychoanalysis, which is by nature a more removed situation. Hence, the countertransference experienced usually carries more affect and is likely to produce more emotional reactions within the therapist. I believe it is of utmost importance that all drama therapists seriously regard the topic of countertransference. I hope this paper will help drama therapists understand and appreciate this very important and inevitable phenomenon.



## References

- Alexander, I. (1982). The Freud-Jung relationship – the other side of Oedipus and countertransference. *American Psychologist*, 37(9), 1009-1018.
- Bean, M. (1992). The poetry of countertransference. *The Arts in Psychotherapy*, (19), 347-358.
- Bergman, M., Hartman, F. (1976). *The evolution of psychoanalytic technique*. New York: Basic Books, Inc., Publishers.
- Bernstein Lewis P. (1985). Embodied transformational images in dance-movement therapy. *Journal of Mental Imagery*, 9(4), 1-8.
- Bohart, A. (1991). The missing 249 words: in search of objectivity. *Psychotherapy*, 28(3), 497-502.
- Brody, E. & Farber, B. (1996). The effects of therapist experience and patient diagnosis on countertransference. *Psychotherapy*, 33(3), 272-279.
- Callaghan, G, Naugle, A. & Follette W. (1996). Useful constructions of the client-therapist relationship. *Psychotherapy*, 33(3), 381-389.
- Celenza, A. (1995). Love and hate in the countertransference, supervisory concerns. *Psychotherapy*, 32(2), 301-307.
- Climo, L. (1983). Helping some state hospital mental patients make small but necessary changes: Transference openings from countertransference traps. *Community Mental Health Journal*, 19(2), 129-136.
- Colson, D. (1985). Transference-countertransference patterns in psychoanalytic group therapy: a family systems view. *Group Psychotherapy*, 35(4), 503-517.

- Dehing, J (1992). The therapist's interventions in Jungian analysis. *Journal of Analytical Psychology*, 37, 29-47.
- Dosamantes, I. (1992). The intersubjective relationship between therapist and patient:  
A key to understanding denied and denigrated aspects of the patient's self.  
*The Arts in Psychotherapy*, 19, 359-365.
- Eliaz, E, (1994). Road signs – elements of transference in drama therapy: case study.  
*Arts in Psychotherapy*, 21(1), 59-73.
- Garfield, D. (1995). *Unbearable affect*. John Wiley and Sons: New York.
- Grainger, R. (1990) *Drama and healing: the roots of dramatherapy*. London: Jessica Kingsley.
- Horovitz-Darby. (1992). Countertransference: implications in treatment and post treatment. *Arts in Psychotherapy*, 19, 379-389.
- Hultberg, P. (1985). Success, retreat, panic: overstimulation and depressive defense.  
*Journal of Analytic Psychology*, 30, 73-93.
- Irwin, E. (2000). Psychoanalytic approach to drama therapy: defining and finding a therapeutic framework. In Lewis & Johnson (Eds.) *Current Approaches to Drama Therapy*. Springfield: Charles C. Thomas.
- Irwin, E. (1988). Arts therapy and healing. *Arts in Psychotherapy*, 15, 293-2296.
- Irwin, E. (1986). Drama therapy in diagnosis and treatment. *Child Welfare*, 115(4), 347-356.
- Irwin, E. (1986). On being and becoming a therapist. *Arts in Psychotherapy*, 13, 191-195.

- Irwin, E. (1985). Externalizing and improvising imagery through drama therapy: A psychoanalytic view. *Journal of Mental Imagery*, 9(4), 33-42.
- James, Miller, Johnson D. (1997). Drama therapy in the treatment of combat-related post-traumatic stress disorder. *Arts in Psychotherapy*, 23(5), 383-385.
- Jacoby, M. (1990). *Individuation and narcissism*. Routledge: London and New York.
- Jennings, S. (Ed) (1990). *Dramatherapy with families, groups and individuals. Waiting in the wings*. London: Jessica Kingsley.
- Johnson, D. (2000). Developmental transformations: toward the body as presence. In Lewis & Johnson (Eds.) *Current Approaches to Drama Therapy*. Springfield: Charles C. Thomas.
- Johnson, D, Forrester A, Dintino, C, James, B, Schnee, G. (1996). Towards a poor drama therapy. *Arts in Psychotherapy*, 23(4), 293-306.
- Johnson, D. (1994). Shame dynamics among creative arts therapists. *Arts in Psychotherapy*, 21(3), 173-178.
- Johnson, D. (1991). The theory and technique of transformations in drama therapy. *Arts in Psychotherapy*, 15, 23-26.
- Johnson, D. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *Arts in Psychotherapy*, 14, 7-13.
- Johnson, D. (1986). The developmental method in drama therapy: group treatment with the elderly. *Arts in Psychotherapy*, 15, 17-33.
- Johnson, D. (1982). Developmental approaches in drama therapy. *Arts in Psychotherapy*, 9, 183-189.
- Jones, P. (1996). *Drama as therapy: theatre as living*. London: Routledge.

- Klein, R. and Doane, B. (1994). *Psychological concepts and dissociative disorders*.  
Hove and Hillsdale: Lawrence Erlbaum Associates, Publishers.
- Landy, R. (2000). Role theory and the role method of drama therapy. In Lewis & Johnson  
(Eds.) *Current Approaches to Drama Therapy*. Springfield: Charles C. Thomas.
- Landy, R. (2000). Role model of dramatherapy supervision. In Elektra  
Tselikas-Portmann. *Supervision and Dramatherapy*. London. Jessica Kingsley.
- Landy, R. (1997). Drama therapy in Taiwan. *The Arts in Psychotherapy*, 24(2), 159-172.
- Landy, R. (1996). *Essays in drama therapy: the double life*. London: Jessica Kingsley.
- Landy, R. (1995). Isolation and collaboration in the creative arts therapies-the  
implications of crossing borders. *The Arts in Psychotherapy*, 22(2), 83-36.
- Landy, R. (1994). *Drama therapy: Concepts, theories and practices*, 2<sup>nd</sup> ed. Springfield:  
Thomas Books.
- Landy, R. (1994). *Persona and performance*. London: Jessica Kingsley.
- Landy, R. (1992). The case of Hansel and Gretel. *The Arts in Psychotherapy*, 19,  
231-241.
- Landy, R. (1992). A taxonomy of roles: a blueprint for the possibilities of being. *The Arts  
In Psychotherapy*, 18, 419-431.
- Landy, R. (1990). The concept of role in drama therapy. *The Arts in Psychotherapy*, 17,  
223-230.
- Landy, R. (1991). The dramatic basis of role theory. *The Arts in Psychotherapy*, 18, 29-41.
- Landy, R. (1985). The image of the mask: implications for theatre and therapy, *Journal  
of Mental Imagery*, 9(4), 43-56.

- Lewis, P. (2000). The developmental themes approach to drama therapy. In Lewis & Johnson (Eds.) *Current Approaches to Drama Therapy*. Springfield: Charles C. Thomas.
- Lewis, P. (1993). *Creative transformation: The healing power of the arts*. Wilmette: Chiron Publications.
- Lewis, P. (1992). The creative arts in transference/countertransference relationships. *The Arts in Psychotherapy, 19*, 317-323.
- Lewis, P. (1988). The transformative process within the imaginal realm. *The Arts in Psychotherapy, 15*, 309-316.
- Masterson, J. (1983). *Countertransference and psychotherapeutic technique*. New York: Bruner/Mazel.
- Mudd, P. (1990). The dark self: death as a transference factor. *Journal of Analytical Psychology, 35*, 125-141.
- Robbins, A. (1988). *Between therapists: the processing of transference/countertransference*. New York: Human Sciences Press.
- Rutan, J.S, Alonso, A. (1982). Group therapy, individual therapy, or both? *International Journal of Group Psychotherapy, 32(3)*, 267-281.
- Sarles, R. (1994). Transference-countertransference issues with adolescents: Personal Reflections. *American Journal of Psychotherapy, 48 (1)*, 64-74.
- Samuels, A. (1983). The emergence of schools of post-Jungian analytical psychology. *Journal of Analytical Psychology, 28*, 345-362.

- Searles, H. (1979). *Countertransference and related subjects*. New York: International Universities Press.
- Schnee, G. (1993). Drama therapy in the treatment of the homeless mentally ill: treating interpersonal disengagement. *The Arts in Psychotherapy*, 23(1), 53-60.
- Taylor, G. (1984). Psychotherapy with the boring patient. *Psychiatry*, 29, 217-221.
- Yalom, I. (1985). *The theory and practice of group psychotherapy*. New York: Basic Books.