PHYSICAL TOUCH IN DRAMA THERAPY TO INCREASE INTIMACY FOR OLDER

ADULTS IN ASSISTED LIVING

SUSANNAH ELIZABETH SCOVIL SHOWERS

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By: Susannah Elizabeth Scovil Showers

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Research Advisor:

Bonnie Harnden, MA, RDT

Department Chair:

Guylaine Vaillancourt, PhD

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ABSTRACT

PHYSICAL TOUCH IN DRAMA THERAPY TO INCREASE INTIMACY FOR OLDER

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The aim of this paper is to propose an intervention design to facilitate intimacy and physical

contact in a trauma-informed drama therapy group with older adults in assisted living. This study

is an abridged intervention research that includes a literature review and a proposal for an

intervention program structure, but does not include an assessment of the proposed intervention.

The literature review spans findings on the importance of touch, impacts of abuse and neglect on

the nervous system, development and sexuality of older adults, ageism, policy of sexual

expression in assisted living, and group drama therapy. Survival responses from complex trauma,

changes in health and physical ability, and systemic and internalized ageism can lead to isolation,

a loss of bodily agency, and low social engagement. These factors can impede an individual's

ability to find intimacy and opportunity for sexual expression. In this intervention, group therapy

for this population could help restore intimacy when it involves play, body movement, and

metaphor. The proposed intervention outlines a model based on polyvagal theory and drama

therapy for reducing isolation, increasing bodily autonomy, and increasing socialization.

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Chapter 1. Introduction

Physical touch is a basic need at all stages of human development. It signals to the body that it is safe in relationship, making it possible to be calm and present with another person (Porter, 2014). Intentional touch has been shown to decrease pain in inflammatory conditions like fibromyalgia and migraines (Field, 2010). Intimacy can be found when a sense of personal safety is available, making connection to the self and to other people possible through shared knowledge, emotional understanding, or physical closeness (Levine, 2014). Experiencing affectionate contact in early development increases an individual's capacity for nurturing interpersonal communication throughout the lifespan (Van der Kolk, 2014). However, trauma can happen when there is an absence of touch, or presence of negative touch at any developmental stage. Consequently, emotional resilience can decrease while physical tension and pain conditions increase (Jesse & Farabaugh, 2018). Importantly, this decreased resilience can show up as avoidance of meaningful interpersonal connection (Bleuer & Harnden, 2018). Without that intimacy experienced with others, the awareness of one's own bodily presence is diminished, and can show up as isolation, a low sense of autonomy, as well as a limited ability to perceive the self as part of a community (Kain & Terrell, 2018).

Older adults are a group at high risk of isolation, low body autonomy, and low socialization, which contribute to a lack of physical touch and increased potential for harmful touch. Several factors contribute to this, including changes in the body due to illness or surgery (O'Conner & Kelson, 2018), relocation away from familiar social supports and into assisted living facilities (Reinstein, 2002), and ageism within the structure of these organizations as well as internalized negative cultural messages about ageing (O'Conner & Kelson, 2018). These challenges can have a profound impact on sexual expression for older adults within the institution of assisted living.

Group counselling for this population could be beneficial for restoring intimacy and sexuality when it involves play, body movement, and metaphor. The intent behind these tools is to cultivate curiosity of participants' inner experience to then meaningfully connect to other people. By playing in a group, isolation may be reduced as participants try on new roles and

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discover flexibility in relating to others (Jennings, 2013). Bodily autonomy can be increased through investigating inner sensations with curiosity with agreed upon boundaries of exploration (Gendlin 1996). Social connection can be enhanced with playful mirroring in group therapy, and this sense of community can enhance wellbeing in intimacy (Kleinplatz, 2012).

Interventions outlined in this project follow the first two steps of the 5-Step Intervention Methodology as described by Fraser and Galinsky (2010). The activities suggested within the session series will be flexible enough to contain challenging feelings or survival responses from trauma, though the lived experience of trauma will not be directly explored in the therapy group. There is little written about intentionally fostering intimacy between older adults in assisted living. No studies have been done that look at sexuality, drama therapy, and somatic experiencing in combination. Furthermore, literature on drama therapy and the nervous system is minimal overall. The intended study broadens the conversation between drama therapy techniques and polyvagal theory to add creative non-verbal expression to therapeutic interventions for older adults in assisted living, with the goal of making the body a safe-enough site to be curious in meaningful connection to the self and to others.

This work is important because when basic safety and social needs are met in an individual, they are empowered to flourish into optimal development (Hoare, 2002). When a population is hypersexualised or desexualized, they are invisibilized and become more vulnerable to sexual assault (Butt & Nguyen, 2018). They are also less likely to receive adequate post-trauma support and care from medical institutions and social spaces (Conroy & Cotter, 2017). Once individuals navigating these structural rifts in society are armed with a language to express their needs, they are less likely to be targeted with violence, as they are less isolated, more aware of and able to articulate their personal boundaries, and more likely to create strong social bonds.

This research is intended to guide the inquiry: how can physical touch be integrated into drama therapy to enhance intimacy and sexual expression to combat isolation and loss of autonomy?

Chapter 2. Definitions

The following terms: *trauma, skin hunger, resilience, aesthetic distance, felt sense, embodiment, intimacy* and *sex* are defined to help ensure comprehension between the researcher and the reader.

T*rauma* is defined as thoughts, feelings and sensations held in the body that are left over from psychological or physical wounding in adverse developmental experiences (Van der Kolk, 2014).

Skin hunger is defined by Floyd (2013) as feelings of loneliness and craving for affection that may come from a lack of physical contact.

R*esilience* is the speed of recuperation to adapt to feelings experienced in overwhelming adversity (Buckley, Punkenen, & Ogden, 2018).

Aesthetic distance is a therapeutic externalizing technique used often in drama therapy of creating an imaginary space where a challenging issue can be playfully explored from different perspectives, while the body remains in the safer place of the present (Frewen & Lanius, 2015).

The *felt sense* is an awareness of subtle internal sensations of breath, heartbeat, muscular tensions and shifts in weight with the intent of understanding emotions and sources of resilience within the body (Gendlin, 1996).

Embodiment is the awareness and imaginative use of the body's movement, rhythm, and sensory experience (Weisberg & Wilder, 1986). It is the capacity to move guided by instinct, with self-awareness of that guidance, which draws attention to ambivalent sensations of the whole body (Levine, 2010).

Intimacy can encompass the emotional or physical closeness with the self or another person, experienced in a relaxed mental and physical state with a sense of personal safety (Levine, 2014). The World Health Organization (2006) defines it as close association and shared personal knowledge between people.

Sex is all consensual activities that ignite pleasure. Optimal sexuality is a therapeutic stance that shifts away from the medical model and treatment of symptoms in sexual issues and

towards a strengths-based stance emphasizing mental health and discovering means for an inclusive range of intimate connection (Kleinplatz, 2012).

Chapter 3. Methodology

5-step Intervention Research

Five-Step Intervention Research is a methodology used to design and develop programs for clinical and social services, which can be implemented for individuals, families, groups, organizations, communities, and wider social purposes. The interventions can be single techniques to multi-element programs, and are defined as any intentional process that is likely to change a condition or situation (Soydan, 2010). The methodology ensures that claims of effectiveness are backed with directly impactful strategies for changing clearly identified risk factors for a specific population (Fraser & Galinsky, 2010). The goal is to decrease or erase risk factors, to activate and enhance protective factors, and to reduce harm in a specific environment (Soydan, 2010). It is an appropriate frame to guide this inquiry as it provides a reliable structure based in social work theory to develop a multi-element program that adheres to a specific setting and population (Fraser & Galinsky, 2010). Specific health and social problems are addressed and these inform practice activities (Fraser & Galinsky, 2010). The framework ties therapy goals and activities to overarching practice principles that combine theories of care and knowledge of the population's needs, in order to suit the particular model of the agency implementing the activities in the proposed sessions.

Fraser et al. (2009) remark that intervention research often begins with a clinician trying out and recording a new strategy. I was first drawn to this area of investigation in the first term of my Creative Arts Therapy program when working with older adults in a long-term care facility. It seemed that a lack of touch may be contributing to feelings of isolation for residents, and interventions involving physical contact appeared to increase interpersonal connection and wellbeing. My Master's training in The Creative Arts Therapies, specializing in Drama Therapy, has involved readings in group therapy, drama therapy, nervous system regulation, attachment theory, creative embodiment processes, and trauma-informed frameworks. Pertinent theorists in the field of drama therapy, embodied approaches to nervous system regulation, and a consent-

based holistic model of sexuality have been suggested by academic and clinical supervisors throughout my training. This training and my observations in practicum, along with readings on the older adult population, has led to a recognition that older adults' sexuality in structured residential settings is often actively discouraged, leading to isolating behaviour and a low sense of agency. Through consulting relevant literature, this research grounds decisions during clinical work with this population.

The scope of this paper will be a partial completion of the first two steps of the five-step intervention research method, going as far as (1) determining risk and protective factors for the population of older adults in assisted living, and (2) developing a detailed description of a new program.

Ethical Considerations

It is essential to build a strong program framework. This helps to minimize study flaws so that future participants are not put at risk by poor design, while ensuring that there is significant potential to benefit society (McBride, 2016). This study will not involve participants but will be set up to ensure the respect for persons, justice, and welfare that is outlined in the Tri-Council Policy for Research (2018) guidelines for research with human participants. Ethics regarding touch will be followed in proposed activities according to the North American Drama Therapy Association (NADTA, 2019, Code 7).

Data source triangulation will strengthen the reliability of the project as it encourages convergence of data from different standpoints and ensures consistency of findings under various circumstances (Kapitan, 2017). Whitehead (2008) postulates an example of using the perspective of a teacher in a school as a key informant, and comparing their ideas with informants in different roles and with different experiences within that system, such as other teachers, administrators, and students, in order to strengthen the accuracy and authenticity of the key perspective.

When designing the activities, sufficient explanation of intent will be considered through procedural ethics, which Chiumento et al. (2020) define as a common morality to cover shared and serviceable norms to consider a range of social and cultural issues. This involves following

protocol documents and templates for interaction to ensure that the study design avoids deception, involves no harm to theoretical or in-practice participants, negotiates informed and ongoing consent, and ensures confidentiality (Chiumento et al., 2020; Tracy, 2010). The proposed interventions will comply with ethics codes from the NADTA (2019) and the Tri-Council Policy for Research (2018).

Situational ethics, which considers the unique components of a singular environment rather than generalized moral frameworks, requires the clinician to be sensitive to the needs of each specific group (Tracy, 2010). Therefore, proposed therapy activities will include a range of in-practice participation options while maintaining the integrity of data collection that can determine the efficacy of the intervention. Finally, in the review of risk and protective factors for the older adult population in assisted living, data will be collected from sources that do not contain language victimizing or sensationalizing the researched population, as Tracy (2010) notes that stories of individual hardship can further portray marginalized groups as separate from the rest of society.

Methodology Steps

This research includes the first two steps in the five steps of intervention methodology outlined by Fraser and Galinsky (2010). In these steps, a framework manual is proposed to guide principles of clinical practice, and include overall objectives, goals for each session, essential content, and specific activities (Fraser & Galinsky 2010). The first step involves developing problem and program theories through analysis of current available literature on a population to build a picture of factors that perpetuate and potentially attenuate risk factors in a specific environment. This then funnels into focused change strategies formed in a program theory that supports decreasing the risk factors. The second step is the development of specific program structures and processes, from overall objectives of the manual to the goals of a single session (Fraser & Galinsky, 2010). Since the final part of step two and remaining steps three to five all involve pilot testing with participants, they will not be covered as they go beyond the time limit and resources of this project.

Step 1: Develop Problem and Program Theories

Development of a problem theory involves portraying core individual and environmental factors that contribute to a problem (Fraser & Galinsky, 2010). The program theory then outlines malleable mediators, which are practical, specific ways that interventions can decrease the risk factors that sustain the problem. At this stage, the key features of the intervention are defined including the level, whether it is intended for an individual, group, community, or a combination, as well as specifying the agent and setting (Fraser & Galinsky, 2010). A theory of change comes from these categorized promotive and protective factors of risk. In this research, a twofold theory will be developed through a literature review that focuses on risk factors in assisted living (including relocation, ageism, complex trauma, and their effects on isolation, reduced physical contact, and decreased socialization) and then protective factors from current theories of group therapy with older adults with high cognitive functioning in assisted living.

Data Collection. Theoretical data has been collected through PsychINFO, Google Scholar, and CLUES databases. Key search terms included different combinations of the following terms: "older adults OR seniors OR geriatrics OR baby boomers," "drama therapy OR group drama therapy OR creative therapy OR creativity OR creative arts therapies," "embodiment OR somatic OR dance OR movement," "sex OR sexuality OR optimal sexuality," "sexual trauma OR sexual abuse OR sexual assault OR trauma-informed," "long-term care OR assisted living."

Inclusion criteria for the current study are peer-reviewed online and print sources from Concordia University's library, published in English between 1986 and 2020. Once the database has returned results, literature is selected based on relevance of title and abstract under several themes. The main themes used to determine relevance of literature are (1) sexuality in assisted living; (2) impacts of isolation on expression of intimacy; (3) group drama therapy with older adults; (4) trauma-informed embodied therapy techniques; and (5) physical touch in drama therapy.

Data Analysis. After reading an article or chapter, the source is indexed with similar topics, and key words and concepts are logged with page numbers in a reference document. Information is then organized, synthesized, and analyzed after a thorough reading (Abbott,

2016). The problem/program theory framework of analysis builds meaningful connections across theory to build the intervention. The internal logic of an intervention can be assessed as the extent to which malleable risk factors are paired with change strategies of sufficient strength to produce core activities with positive outcomes (Fraser & Galinsky, 2010). This means that data is analyzed categorically to develop an interconnected overview of risks, promotive factors, and protective factors for this population—in other words, how the problem is perpetuated in the environment and what can counteract it (Fraser & Galinsky, 2010). From here, malleable mediators are proposed based on the collected sources that build an argument for components of interventions that can attenuate the risk factors.

Step 2: Specify Program Structures and Processes

The second component of the method involves the creation of structures and frameworks of the program by developing principles of practice. This is the basis of the manual that comprises session-by-session goals, essential content, and specific activities (Fraser & Galinsky, 2010). In considering the effects of lack of touch and identifying body-based experiences that offer the possibility of reducing these effects, a group drama therapy process is developed that draws from theories of nervous system regulation (Levine, 2010), adult developmental stages (Hoare, 2001), and optimal sexuality (Kleinplatz, 2012). A drama therapy approach to group work, and somatic experiencing polyvagal theory is applied as the key change strategy shaping the interventions. The manual's three main goals are to (1) decrease isolation, (2) increase bodily autonomy, and (3) increase social connection and intimacy.

The next steps, beyond the scope of this project, would involve testing and publishing. The final half of the second step involves training staff at agencies, with an in-service presentation for example. Step three involves refining the program through pilot testing with participants in a controlled environment. Step four then takes the program to several uncontrolled settings—in this case, various assisted living centres—and measuring the treatment effects. Step five, the final step, is dissemination of the program findings and materials through journals and developing training materials and certification (Fraser & Galinsky, 2010). This project will

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provide a foundation for further data collection and analysis from agents and clinical participants through pilot testing and public dissemination.

Position of the Researcher

Over the past few months, the impact of touch deprivation is at the forefront of collective discourse on mental health. The world has shared a common challenge of enforced isolation due to societal measures put in place to flatten the curve of spreading the novel coronavirus COVID-19. As people find creative ways to connect to each other through video calls and socially distanced in-person gatherings, the basic need for physical contact is profoundly felt.

I am a mental health practitioner working from a sex-positive, harm-reduction stance. I am an advocate for sexual representation of people with physical disabilities, intellectual delays, and people with unstable housing. Through my work with these invisibilized populations, I have seen that increasing expression of intimacy and sexuality increases well-being and reduces vulnerability to assault. As an intern in a long-term geriatric care centre, I gained unique insight into the challenges faced by residents, such as isolation and few opportunities for self-expression. It was here that I witnessed the social and emotional benefits of warm physical contact in a co-created, non-judgmental space. What calls to me is to facilitate the act of fully receiving and accepting oneself with all of one's own desires and boundaries, and using that compassionate openness to drive a playful curiosity in relationship with other people.

Chapter 4. Literature Review

Benefits of Touch

Touch is defined in Merriam-Webster (2016) as bringing a body part into contact to perceive it through the tactile sense; to handle with the intent to understand or appreciate. It can also mean to be in relation or influence. This review considers the term as meaningful contact with one's own or another's body, ranging from eye contact to tactile connection. Touch is vital for human wellbeing and can be used to calm, reassure, hold, contain, and make contact with another person (Porter, 2014). Physical touch has been shown to contribute to optimal human development (Nelson et al., 2011, as cited in Kain & Terrell, 2018), to nurture secure relational

attachment (Field, 2010), to contribute to high physiological and emotional quality of life throughout the lifespan (Eaton et al., 1989, as cited in Field, 2010; Hillman, 2012), and to promote resilience (Perry, 1995, as cited in Van der Kolk, 2014).

The neurotransmitter response from physical contact causes an increase in oxytocin and production of endorphins and corticosteroids, the endogenous pain relievers that have calming effects (Hillman, 2012). Receiving affectionate, fairly firm touch on bare skin from a trusted person stimulates the vagus nerve to decrease cortisol, which can then promote socialization and reduce risks of isolation (Field, 2010). Massage has been found to contribute to quality of life by lowering feelings of pain and decreasing depressed mood for patients in cancer treatment, and to lower pain in chronic conditions such as migraines, fibromyalgia, and rheumatoid arthritis (Kutner et al., 2008, as cited in Field, 2010). Field (2010) goes on to say that touch of a moderate pressure can enhance cognitive attentiveness and positive psychological responses, as it has been shown that people are more likely to respond affirmatively to requests from another person if they are touched at the same time. For example, Eaton et al. (1989, as cited in Field, 2010) ran a study with older adults that showed that more nourishing food, including more protein, was eaten following verbal encouragement to eat along with intentional touch such as contact with the hand or massage.

Most literature on interpersonal touch and relationship attachment behaviour is focused on optimal development of infants and the influence of their primary caregivers (Fisher, 2004). As ambulatory skills increase in infancy, physical nurturing from the caregiver decreases. However, nurturing relational communication will increase between infant and caregiver if there has been high frequency of affectionate touch in the first six months of life (Field, 2010). As Perry (1995, as cited in Van der Kolk, 2014) explains, the brain is formed by "use-dependent matter" which means that whatever behaviours are repeated form stronger connections in the brain. Hebb's Rule states "cells that fire together, wire together," meaning that when neural pathways are frequently activated, they thicken and form habits of behaviour and thought (Hebb, 2005). In early development, when the individual feels nurtured and has a secure attachment to their caregiver, the neurons fire that promote behaviours of exploration of the environment, play,

and interpersonal connection. However, if the individual has felt repeatedly afraid or neglected, the brain forms to manage those challenging feelings (Van der Kolk, 2014).

Neglect, Abuse, and Trauma

Optimal human development is compromised by a lack of physical touch, or of negative physical touch (van der Kolk, 2014). It increases risk of insecure or disorganized attachment (Kain & Terrell, 2018) and decreases physiological and psychological resilience (Buckley et al., 2018). This manifests in the body as symptoms including physical tension and pain conditions **(**Jesse & Farabaugh, 2018**)**, and numbness to the external and the internal sensory experience (David, 2005, as cited in Frewen & Lewis, 2015). Decreased resilience can also result in avoidance of interpersonal connection and intimacy (Bleuer & Harnden, 2018).

Psychological wounding in the early developmental stages is not uncommon, and the response to such wounding can be mild distress to severe disorder (Loutsis, 2017). Adverse developmental experiences are held in the body and can greatly affect emotional and cognitive processes (van der Kolk, 2014). Again, much of the research for this issue is focused on infants and children. The consequences of the lack of skin-to-skin contact is shown in early research in orphanages where infant mortality rates were at 30-40% despite basic survival needs were met, and it was found that insufficient physical nurturing as well as insufficient relational nurturing was the likely cause (Kain & Terrell, 2018). Nelson et al. (2011, as cited in Kain & Terrell, 2018) found that children up to 12 years old who had lived in orphanages in Romania as infants for over eight months had higher cortisol and lower oxytocin levels than those who had lived in orphanages for less than four months. Thus, it appears that a lack of touch may have harmful long-term effects on optimal human development and rate of survival. Similar possibility exists for those who have lived through or currently live with risk of physical, emotional, or sexual harm from another person. For a person living with overwhelming feelings of trauma, there is a constant anticipation of distress which decreases accuracy of prediction in their environment. This can show up as fight/flight/freeze survival responses to external stress triggers that are markedly less threatening than the traumatic event (Buckley et al., 2018). Buckley et al. (2018) state that anticipatory changes in physiology from survival responses in early life to reduce the

risk of abuse from a parent is a resilient behaviour. The term resiliency is defined by the authors as the capacity to adapt to adversity, rather than the level of immunity from distress. It speaks to the speed of recuperation from overwhelming experience. However, this pattern of behaviour can decrease resiliency in later development, since the constant anticipation of distress decreases accuracy of prediction of the environment, and of the body's internal sensations.

In optimal development, people learn to identify and tolerate various levels of threat. This is a physiological state is often referred to as the individual's *window of tolerance*, and it supports connection and learning (Kain & Terrell, 2018). The window of tolerance is the optimal range of response to a stimulus without becoming overly aroused, and the ability to regulate by naturally settling back into stasis within a short time span. Provocation outside the window of tolerance triggers the survival response and inhibits access to logical thought and awareness of relational safety. Experience of trauma disrupts the ability to self-regulate or co-regulate with another person within the window of tolerance (Kain & Terrell, 2018).

Pain and tension in the body have many causes including childbirth, menopause, medications, medical conditions and the social and emotional impacts that result, and trauma from physical, sexual, and systemic violence (Jesse & Farabaugh, 2018). The authors (2018) state that the impacts of pain on relationships with the self and others causes emotional stress, which can increase the physical pain. Levine (2010) explains the awareness of internal tension patterns empowers the body to complete explosive survival actions that the body is unable to perform in the moment of being immobilized. However, when these defensive movements are not attended to and processed, it can perpetuate a pattern of physical tension resulting in generalized fight or non-directed flight behaviour. This state of hyperarousal diminishes capacity to trust others and experience safety in relationships (Levine, 2010).

Lack of relational feedback from caregivers in early development causes the felt sense— the internal sensing of one's own breath, heartbeat, and muscle tone—to be diminished (Kain & Terrell, 2018). Van der Kolk (2014) says that people who report feeling numb tend to experience a narrow range of physical sensation. The separation of experience and feeling means that expressions can lack nuance, and folks may often experience rage or dissociation with little in

between and have an unclear awareness of the cause. It is therefore hard to feel pleasure, sensuality, and a deep sense of meaning. David (2005, as cited in Frewen and Lewis, 2015) says that people with unresolved trauma and numbness may recall incidents with no sense of personal involvement, blunted emotions, and feeling unanchored to surroundings. There may be a sense of derealization, that the environment is not real and the body exists outside it, or experience parts of their body as numb. They believe that they are fundamentally different from others, that their mind body is unlike anyone else, or may even feel nonhuman (David, 2005, as cited in Frewen & Lewis, 2015).

Adults with a history of complex trauma can have challenges maintaining satisfying and healthy relationships (Bleuer & Harnden, 2018). When feelings of trust begin to form towards friends and intimate partners, individuals who have experienced trauma or do not have a secure base of trust from infancy and childhood may quickly close themselves off to protect themselves from potential harm or disappointment (Bleuer & Harnden, 2018). The rupturing incident blocks the ability to see the self as interconnected to others, and to feel the benefits of interpersonal connection (Kain & Terrell, 2018). This leads to low self-esteem, isolation, and rigidity to change (Stolinsky, 2002). Isolation is a defence against attack from people who lack empathy, and so it spares the individual from being judged, but also from becoming authentically intimate with others (Stolinsky, 2002). This disrupts ability to experience physical or emotional pleasure from intimate and sexual contact or touch (Jesse & Farabaugh, 2018).

Sexuality and Older Adult Development

The World Health Organization (2006) defines sexuality as the integration of somatic, emotional, intellectual and aspects of sexual experience in ways that enhance the individual, the community, and feelings of love. Such expression is inclusive of notions of intimacy such as close association and shared personal knowledge between people. Porter (2014) explains that intimate pre-touch contact with another person can be made through the gaze, facial expression, and psychological presence. Metz (2007) created the Good Enough Sex model, which primarily upholds inner and interpersonal satisfaction. He says there are five basic purposes of sex: (1) to feel enjoyment; (2) to reduce physical tension; (3) to increase self-esteem; (4) to encourage

relationship cohesion; (5) and, for some heterosexual partners, reproduction. Intimate activities that focus on relaxation align with this model, as does an exploration of a range of connection and touch techniques (Metz, 2007). Kleinplatz (2012) defines sex as all consensual activities that ignite pleasure. In describing her model of Optimal Sexuality for couples navigating changes in their physical condition and experience of desire, Kleinplatz (2012) outlines components including: communication and empathy; interpersonal risk as adventurous exploration; emotional authenticity and transparency; and the security to be vulnerable and surrender to sensation. These frameworks of sexuality highlight that sexual expression is not only tactile-focused and encompasses a range of communication.

Within sexual interaction, mindful focus on pleasure and away from pain—with emphasis on relaxation and curiosity—can start to rewire and strengthen neural pathways for relational connection (Jesse & Farabaugh, 2018). O'Connor and Kelson (2018) remark that challenging physical issues change an individual's perspective of their body image and their experience of sexual ability, which bring up feelings of emotional and physical vulnerability, as well as adjustment stress to the new illness and pain. Furthermore, the realities of mobility limitations mean that reliance on other people can increase a sense of powerlessness (O'Connor & Kelson, 2018). This challenge is an opportunity to negotiate an arrangement in intimate relationships where both individuals feel good about shared sexual activity and the relationship as a whole (Markovic, 2005, as cited in Watter, 2012). When pain or numbness is present in the body, the issue is not whether to have less or more sex, but to enter into a state of curiosity of the self and the other in an ongoing negotiation where all involved can experience the pleasures of intimacy (Markovic, as cited in Watter, 2012).

In later stages of older adult development, individuals commonly reflect on resilience and vulnerabilities throughout their life, and this significantly informs the ability to continue adapting to change and experience secure attachment (Reinstein, 2002). The experience of a secure attachment from physical contact can be interrupted by triggers from complex developmental trauma, or by bodily change such as illness or surgery (O'Connor & Kelson, 2018). Obstacles to optimal development include challenges with physical limitations, often compounded by ageism

(O'Connor & Kelson, 2018). Bowlby's (1980) view of optimal development through the lifespan involves an increasing awareness of life goals and refining the means of achieving them, and a higher ability to relate these plans to other people. In Erikson's final developmental stage of integrity vs. despair, the individual has the opportunity to find the core of their pain and joy, and the sources of hope and despair (Erikson, 1989). This final stage integrates all other stages of life development, where the individual reviews and acknowledges the triumphs and disappointments from their life (Reinstein, 2002). In this stage, connections to family and social networks shift with retirement, death or divorce from a partner, or relocation (Erikson, 1995, as cited in Reinstein, 2002). Many experience changes in health and physical functioning (O'Connor & Kelson, 2018). Optimal development can result in increased resilience, high quality of life, and secure attachment to other people, and development interrupted by trauma can be experienced as avoidance of interpersonal connection and feelings of regret, shame and numbness (Reinstein, 2002). Erikson (1989) emphasized the role of society and culture contributing to conflicts within the self. Loneliness and isolation are commonly expected to be experienced by older adults, yet this is not in accordance with optimal development, and therefore environmental and cultural factors must be scrutinized (Cookman, 2004).

A third of the population in Canada was born between 1945 and 1965 and are increasing their use of health services, so it is important for these systems to expand to accommodate the unique needs of this cohort (O'Connor & Kelson, 2018). The average resident in assisted living is an ambulatory, widowed, or single 85-year-old woman who needs assistance with at least two activities of daily living, most often bathing and dressing (National Center for Assisted Living, as cited in Hillman, 2012). O'Connor and Kelson (2018) report that this group is generally different to preceding generations of older adults as they place higher value on autonomy and independence, they spend more time on physical and social activity, and tend to have greater awareness and advocacy of their rights. Hillman (2012) notes that for older adults who lose a spouse after age 65, a third are dating within 18 months, and most date for companionship and up to 90% seek sexual satisfaction. Comparatively, the previous generation born before 1945 is less likely to divorce, less reliant on technology, and somewhat less sociable, and these

differences call for a shift in institutional models of medical and social care (O'Connor & Kelson, 2018).

Gerwitz-Meydan et al. (2018) state that much of the research available on sexuality neglects the voices of older people, and therefore fall short of encompassing the diverse experience of sexual expression. They go on to say that since sexuality is a fundamental social and somatic source of resilience, it must be placed in the centre of discussion on ageing through all adult development. According to a survey from the Older People And Sexuality (OPAL) Institute (2016), older adults are seeking access to more information regarding skin hunger, desire, pleasure, age-related decline in sexual performance, and disability and disease as it impacts intimate relationships.

Environmental Obstacles to Sexual Expression

Ageism is an obstacle to optimal development and fulfilling sexual expression. When oppressed populations are given cultural messages that their bodies are deviant or damaged, this is then internalized by the oppressed group and can manifest as avoidance of meaningful relationships (Valadas, 2018). It is a negative systemic impact across the lifespan that is compounded in this stage, and can result in low motivation to seek intimate contact (Valadas, 2018). Disability and illness do not inherently prevent the ability to be sexual or to experience pleasure, but ageism does play a significant part (Everett, 2007). Internalized ageism taken from cultural messages of "successful aging" feeds a story of shame about changes in one's health or mobility (O'Connor & Kelson, 2018). Thus, shifts in physical mobility and consequent relocation to assisted living can negatively affect quality of life when there is not an established inner sense of security (Fisher, 1993).

Metz (2007) remarks that Western culture promotes a sexuality which undermines the vast range of possible healthy and satisfying sexual activities because it is overly focused on performance and perfection. He goes on to say that while sex is inherently good, shame and low self-esteem negate this experience. Kleinplatz (2012) says "when we quit exploring the person within, forgoing passion and focusing instead on the more expedient goal or orgasm...sexual problems begin," (p. 102). Here she demonstrates that sexual success should not be determined

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by performance and achievement, yet obstacles to satisfying sexual expression are often linked more clearly to physical issues, so mental health and systemic oppression are diminished as contributors to feelings of tension, pain, and numbness.

Another risk factor for suboptimal development and re-traumatization is relocation from independent living to an assisted living facility. Relocation to a medical environment is often necessary for older adults due to loss of health, mobility, and social support; it is in this transition that loss of autonomy is often increased (Fisher, 1993). During relocation adjustment, the individual must adapt to the new environment and establish new goals and activities that match their changing needs and abilities (Fisher, 1993). Fight/flight survival responses to these changes can show up as feelings of depression, preoccupation with bodily functions, self-reproach, and poor mental concentration (Reinstein, 2002). Furthermore, reliance on other people for activities of daily living can increase a sense of powerlessness (O'Connor & Kelson, 2018). Hillman (2012) remarks that for people with complex trauma, increased reliance on others due to loss of mobility and independence can take the nervous system out of the window of tolerance, triggering flashbacks of times in the past when they were vulnerable and were not safe, which can lead to maladaptive survival responses.

Policy for Sexual Expression in Assisted Living

Assisted living is a long-term alternative to medical residence that provides services and assistance with activities of daily living, with levels of care ranging from verbal prompts to hands-on assistance with medication, bathing and dressing, as well as escorting individuals to meals and scheduled activities (Beuscher & Dietrich, 2016). Social services such as dances in assisted living aim to increase quality of life and the autonomy to meet other residents (O'Connor & Kelson, 2018). Institutions generally run on a social model of care rather than the medical model found in long-term care, and therefore aim to prioritize privacy, autonomy, and quality of life. These values aim to generate holistic support, but often fall short of being inclusive of sexual expression (Frankowski & Clark, 2009).

Frankowski and Clark (2009) argue that a care facility which empowers its residents to express themselves is the first step to rediscovering secure and satisfying intimacy, and this can

increase overall quality of life. This is crucial for incoming cohorts in long-term care, since this generation has higher frequency, acceptance, and normalized perception of sexuality than previous groups, whose sexual expression is often extremely private (Frankowski & Clark, 2009). Everett (2007) addresses the discrimination of older adults in policy making for assisted living facilities, imploring staff to reduce unsafe sexual activity by providing safer sex supplies, as well as provision of ongoing education for staff and residents in the institution. Steps to harm reduction in sexual expression are often not identified in policy or training, though this age group has one of the fastest growing rates of sexually transmitted infections (O'Connor & Kelson, 2018).

The overemphasis on safety in the majority of existing policy on sexuality and lack of focus on informed choice negates the autonomy of residents' ability to consent in intimate relationships, as they are rarely consulted about the nature of their care (Frankowski, 2015). Everett (2007) argues that it is discriminatory to prohibit residents from using private areas of their homes for sexual activity, for example, and that creating any ethical or legal policy to manage this behaviour is stigmatizing. Importantly, staff's attitudes that reflect society's disregard of sexuality of older adults are a risk factor that can result in complaints of abuse from residents not being taken seriously (Frankowski & Clark, 2009). Everett (2007) calls for a clear definition of "offensive" sexual behaviour in long-term care. This is so that safety interventions are only used when risk is objectively deemed unreasonable and the individual is incapable of consent, This helps determine that these interventions do not generate greater harm to the individual than they aim to prevent (Everett, 2007). Future policy must distinguish between intimacy and sexually inappropriate relations, and outline common indications of verbal and nonverbal consent (Hillman, 2012).

One example of an assisted living facility that does have a clearly stated and enforced policy is the Hebrew Home in Riverdale, New York. It upholds the decision-making capabilities of its residents and is a leading model in provision of person-centred, holistic care. The *Sexual Expression Policy* (RiverSpring Health Care Solutions, 2017) defines sexual expression as "words, gestures, movements, and activities that appear motivated by the desire for affection,

relationship, intimacy, and/or sexual gratification," (p. 1). The policy emphasizes the importance of comprehensive, culturally competent staff training to ensure safe and healthy sexual expression, and to protect residents from sexual harassment or assault (RiverSpring Health Care Solutions, 2017). The policy is grounded in the understanding that touch and intimacy are basic human needs and recognizes that this is not often discussed in assisted living facilities (M. Rutigliano, personal communication, March 9 2020). Ongoing staff training reinforces the policy and invites staff to examine their biases and discomfort with sexuality, helping ensure that care remains person-centred and focused on quality of life for residents. As part of providing holistic care, "G-Date" is a social service available for residents actively expressing interest in another person living at the facility. Assistance with bathing and dressing is given to prepare for the date, as it is for any occasion, and a semi-private room is offered for a period of time, if requested. Family members are informed and educated on the resident's capability to make decisions if this is a concern. The facility's programming includes "meet n' greets" to encourage residents to make use of the service; clinical teams remain present, noting hints and non-verbal cues of interest between residents and later offer to set up a date (Rutigliano, 2020). Support with sexual expression for residents experiencing isolation or physical challenges was not outlined, nor was there an indication of support for those who may not be comfortable to voice their desires. Despite these unaddressed issues, the Hebrew Home at Riverdale compares as a progressive outlier that puts the holistic needs of their residents at the forefront of policy, in stark contrast to the majority of practices outlined in the literature and organizational policies.

Everett (2007) remarks on the general inadequate policy made for supporting residents' sexual lives and emphasizes that awareness of disability and sexuality appears to be largely absent from nurse training overall. D'Avello (2015) similarly argues that there is a need across the field for clearer policies in assisted living that encompass behaviours of consent, bodily autonomy, and privacy around sexual behaviour. Hillman (2012) lists suggestions to foster sexual expression which include providing privacy rooms, offering erotic literature, minimizing nighttime bed checks, or supplying wider beds. When surveyed, frontline staff remarked that this could post practical challenges as it encourages behaviour that would need to be managed on an already overloaded schedule (Hillman, 2012). A shift in practice requires frontline staff to

identify and question their personal values and biases around ageing and sexuality in order to put any stated policies into effect, yet there is often a lack of practical support from those higher up in the organizational system to ensure that this self-examination is sustainable (D'Avello, 2015).

Risks Related to Absence or Negative Physical Touch

Residents in assisted living facilities receive care that is not inclusive of sexuality, which can contribute to depression, specifically low self-esteem, loss of bodily autonomy, and isolation (Hooper et al., 2016; Reinstein, 2015). Increase in mobility challenges and physical illness further result in a loss of body integrity (Hillman, 2012) and reduced opportunity for interpersonal connection (Stolinsky, 2002). Staff moral or cultural bias, as well as lack of understanding, training, or institutional policy, promotes a culture of ageism which prevents residents from expressing sexuality (Everett, 2007). Staff may encourage residents to abstain from sexual activity by making jokes or threatening to tell their children, who are often discouraging of this behaviour (Frankoswki & Clark, 2009). This restriction promotes poor quality of life. Next, residents often only receive physical touch from staff as part of a duty of care for basic functioning in daily routines such as dressing and bathing, and often report feeling infantilized (Levete, 1982). Isolation is a possible result of this, as the contact does not provide love, social recognition, or esteem (Reinstein, 2015). Additionally, as the individual's role seems to be reduced to that of 'patient,' trauma may resurface as increased reliance on others mirrors past relationships where they were overpowered (Hillman, 2012).

According to the World Health Organization (2006), depression is a primary cause of low sexual expression. Hillman (2012) says that 85% of older adults have at least one chronic illness, and the emotional and physical impact of this on sexuality is generally not discussed with clients. O'Conner and Kelson (2018) explored the counselling needs of the incoming cohort entering the long-term care system, which include the loss of a partner from death or divorce, stress of relocation, and adjustment to chronic pain or illness. Changes in health and ability that require dependency on others for care can result in a loss of developmental integrity, which can deteriorate resilience (Weisberg & Wilder, 1986). Hillman (2012) notes that amputation can bring up internalized ageism that causes feelings of being abnormal or not whole, and this can

result in a loss of body integrity. Chronic medical illnesses such as cancer, Parkinson's, arthritis, and heart disease are often comorbid with depression (Beuscher & Dietrich, 2016). Hillman (2012) reports that clinical depression in nursing homes affects about 30% of residents. Residents may not be comfortable to share their mental health challenges with staff because they do not want to overburden them, or they internalize the stigma of depression (Beuscher & Dietrich, 2016). Beuscher and Dietrich (2016) found that failure of staff in assisted living to recognize and treat depression in their clients increases risk of suicide. Hillman (2012) remarks that loss of mobility and independence for people with complex trauma can trigger memories of being overpowered and result in survival responses that spike outside the window of tolerance when receiving assistance with activities of daily living. Reinstein (2015) notes that isolation is inherent to an institution, as duty of care fulfills basic needs but does not provide love, social recognition, or esteem. Isolating behaviour is a defensive response to the environment to protect the individual against attack from people who do not demonstrate empathy (Stolinsky, 2002). This spares the individual from being judged, but also from becoming authentically intimate with others (Stolinsky, 2002). Risk factors that contribute to low sexual expression in assisted living include lack of privacy, reduction of bodily autonomy, change in social role and self-identity to "patient", and inability to openly discuss sexuality (Hooper, De Boos, Nair & Moghaddam, 2016).

Protective Factors of Physical Touch

Fraser et al. (2009) define protective factors as areas of strength that protect against vulnerability from risk. Reduced body autonomy, decreased socialization, and increased isolation can be counteracted through several factors. Contact or touch with intent to increase intimacy is shown to reduce physical tension and pain (Jesse & Farabaugh, 2018), to increase quality of life (Grewen & Light, 2003), to enhance resilience (Gerwitz-Meydan et al., 2018), to encourage secure relational attachment (Metz, 2007), and can ease emotional stress caused by physical mobility limitations, illness, and developmental changes (Kleinplatz, 2017; Markovic, 2005, as cited in Watter, 2012). Grewen and Light (2003) saw that touch in secure relationships positively influences physical health and ran a study with heterosexual older adult couples in romantic

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relationships who were asked to hug for 20 seconds. They found that affectionate physical contact from people who are significant to the individual attenuates heart rate and blood pressure, which can reduce the intensity of fight/flight survival responses to daily stressors (Grewen & Light, 2003).

Drama Therapy

The contribution of drama therapy as a modality lies in its opportunity for non-verbal expression through creative means. In drama therapy, the use of metaphor and aesthetic distance through role play, use of props, or storytelling allow a softening of intense feelings and indirect expression of emotional experience (Jones, 1996). Drama therapists work with the body and the imagination in relationship to the self and other people (Loutsis et al., 2017). Embodied drama therapy is effective for people with communication difficulties, those who use non-conventional communication methods or devices, or who have physically limiting patterns of movement (Porter, 2014). The use of ritual can support safety in the group as a repeated collective action to open and close the group can contain and structure the emotional experience when there is a sense of uncertainty.

In a group, Reinstein (2002) supports the therapeutic frame of safety as the first step, saying that trust is first built through games aimed to encourage laughter and relaxation. Renee Emunah's (1995) Five-Phase Model outlines a structure of practice that begins with highly structured, fun dramatic groundwork and builds trust through developing self-expression in scenes and roles, through to final celebration and containment. Depending on the population, not all five phases will be explored. Phase One, Phase Two, and Phase Five are most pertinent to reducing isolation, increasing bodily autonomy, and increasing socialization with intimate connection. Phase One emphasizes dramatic play, with fail-proof physical and social activity developing group skills and trust. This can increase self-esteem, confidence, and awareness of other people in the group. Phase Two moves into scene work, wherein participants can take on roles that do not reflect their own lives and therefore do not require self-disclosure, and still express parts of the self that were hidden, or wished-for qualities of the self are embodied. In the final Phase Five, dramatic ritual, individual healing and community growth is possible through

participation in the process, as sessions are reviewed, achievements are celebrated and marked as a life event. In a collectively developed ritual, there is opportunity to non-verbally express the intimacy gained through the work (Emunah, 1995).

Drama Therapy and Physical Touch

Valadas (2018) posits that the elements of drama therapy that promote intimacy are eye contact and physical touch, as well as clear and open communication, mirroring movement, and active witnessing. Establishing safety at the beginning stages involves a gentle delicate touch as trust is still forming (Portokaloglou, 2018). Any body-based or non-verbal therapy must include support for potential triggering of traumatic memories stored in the body that may not have even surfaced into consciousness (Levine, 2010). Guidelines around touch in drama therapy are included in the NADTA's (2017) code of ethical principles, which states that physical contact can be used when consistent with therapeutic goals, when given informed consent, and when applied in a culturally humble manner. Furthermore, touch is never imposed or required, and the therapist makes ongoing assessment of the usefulness of touch with each individual, while carefully documenting the therapeutic effects. Finally, touch is used in interventions with an awareness that it can evoke strong emotional response from a client.

In Developmental Transformations (DvT), a type of play-based drama therapy, physical touch is a non-prescribed element of embodiment where the client can locate the self within the other. The ethics of DvT for physical touch state that it is a natural act which is contextual, to be used as needed in the scene or role (Johnson, 2009). This therapy challenges the client's fears of proximity to others, and of their own bodily presence, after initial discussion of boundaries of touch. Godsal (2017) argues that despite knowing the effects of touch on helping regulation and encouraging development of parts of the brain, a few sessions of touch-based intervention do not guarantee a rewired, healed system. They go on to say that it is within the relationship, guided by the client, that growth takes place (Godsal, 2017).

Drama Therapy to Reduce Isolation

Mirroring. Van der Kolk (2015) says trauma creates feelings of isolation, and fear of conflict. Since trauma happens in relation, so can repair (Levine, 2010). Other bodies resonate

with each other's feelings, emotions and thoughts (Van der Kolk, 2014). Allegranti (2013) remarks that we do not inhabit our bodies alone, as we learn behaviour by imitation and can feel connected by physically mirroring another person. If movement in the body is a space for meaning-making, using mirroring techniques in therapy with intentional attunement create relationship from their nervous systems and the social patterns that inhabit one another (Allegranti, 2013).

Play. Jennings (2005) describes play as "a developmental activity through which human beings explore and discover their identity in relation through others through... their own bodies, projective media and a variety of role-play" (p. 15). Play with adults can help participants feel listened to, affirmed in their experiences, and find adaptive ways to tell their life stories through the body, with props, and in role play (Jennings, 2005). Play allows older adults to express the resilient parts of self that are hidden behind an isolating role of ageing (Lev-Aladgem, 2000, as cited in Reinstein, 2002). Stolinsky (2002) states that imaginative play builds spontaneity, and this increases trust in one's creative process and overall self-esteem, which may then help reduce isolation. Play creates a safe container for exploring the experience of isolation, by adding levity to confront and transform fears (Smith, 2000). In their clinical experience using play in drama therapy with a group of older adults in a nursing home, Smith (2000) observed that relieving the angst formed from isolation could have contributed to increased intimacy with the therapist and with each other.

Drama Therapy to Promote Bodily Autonomy

Levine (2010) posits that to be embodied is to be guided by one's instinct while remaining self-aware, so that sensations can be felt without attaching them to story, thereby harnessing the qualities of the here-and-now experience. In other words, using the body to communicate can help to increase awareness of the present moment (Valadas, 2018). Drama therapy uses the body's position in space to play with the range of posture, gesture, shape, pace, and dimension, and finds metaphors within the body to personify roles with the whole self (Milloni, 2007). Milloni (2007) observes that when the body is helping describe a memory in drama therapy, there is more playfulness, use of metaphor and acknowledgement of other people.

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Metaphor. This tool is a bridge between the body's expression and conscious awareness, and using the imagination with movement-based therapy offers tools to support increase of body autonomy and physical boundaries (Milloni, 2007). Frewen and Lanius (2015) state that the silence and numbness from traumatic incidents can be alleviated by placing a narrative framework around it that denotes a temporal context. Drama therapy uniquely creates a contained reality where the imaginary is made tangible, which builds a more flexible and tolerable place to speak the unspeakable, where the event can be playfully explored from different narrative perspectives, while the body remains in the safer place of the present (Pendzik, 2008). Bleuer and Harnden (2018) state it is possible to regulate overwhelming emotions and sensations by working indirectly with the trauma story, using distancing techniques of metaphor, symbols, and storytelling. These containers create meaning out of confusing memories and feelings, and make it possible to explore difficulties in the early stages of working alongside trauma (Bleuer & Harnden, 2018).

Play. This offers a space separate from daily life that allows the freedom to be creative and a chance to set boundaries, through symbolic action and metaphoric expression (Jennings, 2005). Identifying desires and stating boundaries in therapy can then come from a space of confidence in personal relationships (Stolinsky, 2002). Dieterich-Hartwell (2017) says that it is the client who controls the pacing of the process of positive attachment. In this trusting relationship, exploration of the body's material boundaries and of the internal sensations can begin. Bannerman (2017) states that by gradually building trust in the therapy space and simultaneously building resources of strength within the client's body, they can begin to relax the physical sensations that accompany oppressive memories, thus decreasing somatic vigilance and dissociation. Using dramatic play and imagination is a chance to try exploring the internal and external world with pleasure (Portokaloglou, 2018). Levine (2010) suggests that enduring sensations of wellbeing are cultivated by releasing powerful emotion caused by trauma to create an inviting space for deeply pleasurable feelings. Drama therapy helps to manage the intensity of emotions and intrusive thoughts and sensations by playfully transforming the present embodied state to explores alternatives, thus transforming "what is" to "what could be" (Bleuer & Harnden, 2018, p. 178).

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Felt Sense. This is a term coined by Eugene Gendlin (1996) that refers to the "experiencing body," as what is most essential in relating to an external situation is that which is sensed from the inside. It prioritizes the emotional experience over cognitive activity and builds practice of increasing awareness of meaningful body sensations. This practice increases bodily autonomy by locating and fostering embodied intuition, as well as feelings of focus, valuable purpose, and resilience (Bannerman, 2017). In drama therapy, building the felt sense lends itself to creativity, spontaneity, and flexibility to allow change (Loutsis, 2017). Levine (2010) states that to prevent and reverse trauma, one can make the body a safer place by slowly becoming aware of inner sensations. This involves acknowledging awareness of heart rate, breath, tensions, temperature, shifts in weight, and gut sensations, in order to identify emotions (Bannerman, 2017). This builds a skill of perceiving internal change before and after interventions to be able to observe or "sit next to," rather than feel overwhelmed "inside" the feelings. For example, after saying "I am sad," the participant or client is asked to focus inwardly to check on internal sensations and then try saying "something in me feels sad," then focus in again to feel for new interoceptive or felt sensations or emotions (Leijssen, 1998). This acknowledges discomfort and makes space for self-compassion and intimacy with oneself (Leijssen, 1998). To further support the integration of the felt sense into drama therapy interventions, Gendlin (2000) says that verbal reflection after spontaneous movement that arises from the felt sense is its own creative process to put words to non-verbal expression, and often resembles poetry.

As a caution, Bannerman (2017) says that intentionally connecting to the felt sense for the first time with clients who have complex trauma might deregulate the nervous system and so must be explored gently to avoid re-traumatization. Maintaining awareness of arousal level is crucial for the client as well as the therapist, who can model awareness of their own felt sense to help identify the emotion in the moment (Bannerman, 2017). Leijssen (1998) notes that when there is hesitation, music can be an aid to invite movement, and further suggests focusing on a single area of the body to move. Conversely, when a client is overwhelmed by emotions – a possible jump from being too far removed – guide them to find the parts of self that can be controlled, using metaphor to grow that space and recognize resilience.

Drama Therapy for Increasing Social Connection and Intimacy

A sense of community generally enhances the dimension of wellbeing in intimacy and sexuality to find optimal expression (Kleinplatz. 2012). As people age, more stimulation is needed for interpersonal interactions, and the brain thrives on artistic expression (Jennings, 2005). Grainger (1990, as cited in Reinstein, 2002) comments that drama therapy gives older adults:

> freedom to experiment with their own image of themselves especially with regard to the crucial boundary between self and other....for the ability to give and receive more effectively is what they secretly crave. Above all, they need to find a way of sharing. (p. 49)

In Reinstein's (2002) own therapy work with older adults, they noted that distancing tools of metaphor, objects, and role play offered participants opportunity to share their inner thoughts. This was found to increase respect for themselves and others, a personal sense of meaning, and fun beyond the therapy session (Reinstein, 2002). Van der Kolk (2014) says that to build resilience, participating in activities like dance and theatre that promote agency and community give a sense of reward when the individual can feel they are making a difference to others. Collective ceremonies alleviate trauma by confronting pain and transforming it through communal action using play, pretend, puppetry, and props. In theatre, actors find and play with internal experience so it can emerge in the voice and body on a stage performed to witnesses (Van der Kolk, 2014). This gives voice to emotions, and the opportunity to find rhythm in new roles (Butler, 2018).

Play. Coded language and metaphor are often used to discuss sex amongst the present cohort who are beginning to relocate to assisted living, and this can be used as a starting point in group therapy in order to find shared meaning and understanding. (Frankowski & Clark, 2009). Sue Jennings (2005) used humour and novelty as grounding values for her therapeutic theatre work with older adults. Following the theatre performance, there was a report of increased relaxation and discussion of sex around the residence overall (Jennings, 2005). An increase in social relationships between residents was also noted (Jennings, 2005).

Mirroring. Mirroring exercises get people into a shared rhythm, and this offers a chance to feel out how they differ naturally from others, and explore how new movements make them feel (Butler, 2008). It can attune the awareness to the visceral, and quieten the cognitive (Van der Kolk, 2015). Butler (2018) describes a case working with a non-verbal client and using rhythm through percussion instruments and the body. The client tapped a rhythm on the therapist's hand and she responded with the same, which made him smile. Then he tapped out a different one which she followed, then varied, and they continued this embodied conversation of leading and following. For those clients with whom touching is not yet possible, a therapist or other group members could subtly mirror them to increase feelings of belonging in the space (Russo, 2018). Eye contact is connection to another person through the gaze (Loutsis et al., 2017). Levine (2010) emphasizes that the use of heartfelt human expression in face to face engagement is therapeutic, as it often brings up primary emotions that manifest as nonverbal expressions such as tears or laughter. From here, communication is more honest and less inhibited by shame or self-consciousness (Stolinsky, 2002).

Chapter 5. Intervention

Step 1: Developing Problem and Program Theories

Problem Theory

Fraser et al. (2009) outline problem theory as a consideration of individual and environmental factors to understand biopsychosocial processes that result in social and health challenges. Older adults coming into assisted living have relocated due to loss of mobility, deterioration from chronic illness, or death of a spouse, and are consequently unable to carry out at least two activities of daily living (Beuscher & Dietrich, 2016; Hillman, 2012). Without meaningful, intimate relationships, many residents in assisted living are unable to express themselves fully and can experience depression that manifests as low self-esteem, loss of bodily autonomy, and isolation (Hooper et al., 2016). Therefore, older adults need a comprehensive model of care that includes consideration of intimate and sexual expression, which is often not recognized or available (Everett, 2007; Frankowski and Clark, 2009).

Risks, Promotive Factors, and Protective Factors. Potentially malleable risks contributing to lack of touch for older adults in assisted living include complex trauma in early development, challenging shifts in health and physical condition, and poor communication between residents and care staff. Promotive factors are contributors to the issue being addressed (Fraser & Galinsky, 2010)**.**

Complex Trauma. Firstly, complex trauma interrupts early development and often prevents individuals from trusting other people (Bleuer & Harnden, 2018). Armouring against interpersonal connection can promote isolating behaviours (Beuscher & Dietrich, 2016). Fight/ flight/freeze survival behaviours and feelings resulting from trauma received in early development can be triggered when receiving non-nurturing contact as well as prolonged absence of touch (Kain & Terrell, 2018). Residents may only receive physical touch from staff as part of a duty of care for basic functioning in daily routines, such as dressing and bathing, and report often feeling infantilized (Levete, 1982). Isolation can be the result of this, as the contact does not provide love, social recognition, or esteem (Reinstein, 2015).

Changes in Health and Physical Ability. Next, changes in health and physical ability can impact self-esteem, and hinder an individual's motivation to socialize with other people. Increase in mobility challenges and physical illness further result in a loss of body integrity (Hillman, 2012). Relocation away from familiar social support can negatively affect quality of life (Fisher, 1993). Being faced with a dramatic change of role to "patient" could cause trauma to resurface as increased reliance on others mirrors past relationships where they were overpowered (Hillman, 2012).

Ageism. Finally, systemic and internalized ageism is a block to self-advocacy for older adults. For example, residents report low communication with staff about mental health issues for fear of being a burden (Beuscher & Dietrich, 2016). Without communication of needs and boundaries, bodily autonomy for older adults in assisted living is put at risk. Staff moral or cultural bias around sexuality, as well as lack of organizational training or stated institutional policy, all promote a culture of ageism which in turn prevents residents from expressing sexuality (Everett, 2007). Staff may encourage residents to abstain from sexual activity by

making demeaning jokes or threatening to tell their children, who are often discouraging of this behaviour (Frankoswki & Clark, 2009). Anticipation of distress from being stigmatized can diminish trust and decreases willingness to receive assistance involving physical contact (Levine, 2010; Jesse & Farabaugh, 2018).

Fraser et al. (2009) define protective factors as areas of strength that protect a population against vulnerability from risk. The literature shows that a loss of intimacy relating to reduced body autonomy, decreased socialization, and increased isolation can be counteracted through several factors: (i) emotionally connective physical touch ; (ii) socialization ; (iii) fun, humour and playfulness ; (iv) sense of agency ; (v) self-expression ; and (vi) co-creation of positive, meaningful activity.

Program Theory

A problem theory alone is insufficient to develop a manual, since steps must be outlined to show how the risk factors will be changed by the interventions (Fraser et al., 2009). The overall idea is that drama therapy and embodied therapy methods are an effective way to address social, emotional, and physical obstacles to intimacy within assisted living (Jesse & Farabaugh, 2018; Kleinplatz, 2017; Grewen & Light, 2003, Stolinsky, 2002; Levine, 2010).

Malleable mediator is term is used by Fraser et al. (2009) to encompass protective factors that can be influenced by the proposed drama therapy program, which, if influenced positively, will decrease feelings of isolation, strengthen bodily autonomy, and promote socialization. On the other hand, a drama therapy group with older adults would have little direct influence on the promotive factors of cultural ageism, touch received through duty of care, and hierarchy of roles within the institution. The methods to influence malleable mediators listed below are determined from the data.

- Container: Therapy framework, ongoing consent, opening and closing ritual
- Creativity: Play and metaphor
- Co-regulation: Felt sense, mirroring, physical touch

The program objectives are:

- To provide embodied group drama therapy to residents in assisted living

- To increase intimacy with the self and with others through embodied contact and physical touch

- To fully integrate drama therapy within comprehensive social model of residents' care

- To educate staff regarding goals, interventions, and outcomes of embodied group drama therapy in assisted living

Immediate outcomes are positive changes that support the malleable mediators identified from the literature review and comprise drama therapy treatment goals, scaled depending on the group's level of stress or trauma, and level of physical ability.

i) increased self-esteem

ii) increased sense of bodily autonomy

iii) reduced isolation

Step 2: Program Structures and Processes

In this component, a framework manual is proposed to guide principles of clinical practice, and include overall objectives, goals for each session, essential content, and specific activities (Fraser & Galinsky 2010).

Goals and Objectives

Goal 1. To reduce isolation.

Objective 1.1: create a safe-enough group structure

Objective 1.2: increase contact and physical touch

Goal 2. To increase sense of bodily autonomy

Objective 2.1: play to engage the imagination

Objective 2.2: play to try a new life role

Objective 2.3: increase bodily autonomy

Goal 3. To increase socialization

> *Objective 3.1:* mirroring to increase belonging

> *Objective 3.2:* rhythm to attune group members

Program Intake Process and Restrictions

- The group is open to residents of all genders, in couples and singles who have a history of sexual trauma, who have had challenges expressing their sexuality, who have recently relocated to assisted living or experienced other losses such as a spouse or dramatic bodily change.

- The group will be no larger than eight people, and an even number of participants is crucial. The drama therapist will create alliance with front-line and therapeutic staff who will refer people to the group.

- The setting for sessions should be in a closed space away from other activities, with a sign outside the door reading "*Poetry in Motion Group in progress: Please do not disturb.*" The room should have enough space for chairs and mobility devices to move in a large circle.

Session Format and Phase Structure

- Each session will follow the same format, addressing the same goals with emphasis depending on the progress of the group.

- Each session is 45 minutes in length, with time on either end for residents to arrive and leave with or without assistance.

  Format

    1. Opening ritual

    2. Warmup exercise

    3. Relaxation and connection to the breath and felt sense

    4. Movement activities involving contact

5. Reflection

6. Closing ritual

Beginning Sessions (Phase One: Dramatic Play)

Goals.

- Decrease isolation: establish safety with a clear therapeutic framework

- Increase autonomy: establish boundaries with ritual

- Increase socialization: co-create positive, meaningful experience through play

Warmup.

54321 Sensing. This is a fairly quick grounding technique for transitioning into the therapy space. It uses the senses to become aware of the environment and help participants notice that they are safe in the room, and it can help lower stress. Focussing on the external is a good place to start when establishing safety in a clear therapeutic framework, and sets up for internal sensing later.

To accommodate participants with sensory limitations, normalize potential challenges and encourage use of the imagination in each sense. Individuals with diminished auditory capacity can be invited to move closer to the facilitator to hear more clearly.

Facilitator script:

Start by scanning the room with the eyes, slowly moving the head from the left to the right, passively taking in your surroundings, allowing the scene to paint itself on your eyes. Out loud or in your mind, name five things you can see.

Next, close the eyes, or keep the eyes open with a soft focus. What are four things you can hear? They might be far away or close by, inside or outside the room. Let the sound travel to you, rather than straining to hear anything.

Keeping the eyes closed or gently lowered, name three things you can feel right now.

What are two things you can smell, or imagine smelling?

Finally, what is one thing you can taste, or imagine the taste of?

Open or raise your eyes.

Reflection questions:

Do you notice any differences from when you arrived in the space to now?

When could this grounding be useful outside therapy?

Framework Setting.

Spectrogram. A spectrogram uses the concept of making group decisions based on data collection and non-verbal consensus through embodied expression. The room itself can be used as a data plot for people to place their position. Establish which end of the room represents yes/ no, or most/least, and so on depending on the question, so people can move themselves according to their needs in the therapy group.

Adapt the range of physical movement to the needs of the group, so if moving the body through the space is too challenging due to physical limitations or to restrictions in the room, participants can move a clearly marked small object on a page that has a line drawn through the middle of it, or direct the facilitator to move it on their behalf.

Create a list of questions ahead of time that prompt the formation of a framework tenants agreed upon by the participants in the space for people to feel safe and welcome enough to express themselves. They will also help the group get to know each other. These could include:

Who has been living here the longest?

Who would call themselves creative?

Who feels good when they are speaking?

Is body movement a part of your daily routine?

Is it easier to express yourself when you know what happens here will stay here?

Who needs a lot of space around their body to feel comfortable?

Who feels comfortable talking about sexuality in a group?

Do you agree that physical touch is important?

Do you need to give permission before you are touched?

What other questions can we ask to feel welcome here?

From this embodied data collection, speak and write down all responses from the group to form the therapeutic frame and group norms on a large page, to bring to each subsequent session.

Main Activity*.*

Simple Movement. This routine assesses what parts of the body participants are feeling more or less aware of. Through repetition of these movements there is opportunity to increase comfort with using the body to locate and express feeling. Try these movements by yourself before bringing them to the group to get a sense of what is activated in your body. Find music with a gentle rhythm for participants to move to.

Facilitator script*:*

Find a seated position, with both feet resting on the floor or a flat surface if possible. We are going to move each part of the body one by one, with help of the breath. If a limb is less mobile, use it like a pencil, for example push it with your arm, or improvise and move a different part of your body.

Head: As you inhale, raise the head and chin to the ceiling, then exhale as you lower the head and chin to the chest. Repeat this cycle three times.

Shoulders: Inhale and raise the shoulders towards the ears then with a big exhale, drop them downwards. Repeat three times.

Arms: Place your hands on your shoulders and draw small circles forwards with your left elbow, like tracing a tea saucer, then a salad plate, then a dinner plate, then a platter, and reverse the circle, getting smaller. Do the same sequence with the right elbow. Then draw circles with both elbows, both forwards and reversed.

Hands: Inhale as you draw your arm up and squeeze the left hand and fingers into a fist, and then sigh a big exhale to completely release and let the arm drop into the lap. Repeat this three times and again with the right hand three times.

Torso: Inhale and stretch both arms straight out forward, staying upright. Squeeze the muscles you use to pee until you feel them lifting, then contract your abdomen and belly. Keep squeezing and then exhale as you imagine you are pulling something heavy slowly towards your stomach.

Legs: Inhale as you keep your core engaged to lift your left foot off the floor with your knee bent, and slowly release it down again as you exhale. Repeat three times and then again with the right leg.

Feet and ankles: Place both heels on the floor, then inhale to raise the heels, keeping the balls of feet on the floor, and exhale to drop them down on the floor again. Repeat this cycle three times.

Full body: Following the rhythm of the music, loosely shake parts of your body however feels good, paying attention to breath and letting a sound come out if there is one, starting with the head, then your shoulders, down to the arms, then hands, wriggle your torso, your ankles, your legs.

Reflection questions:

What did you notice as you went through this?

What parts felt open?

Where was there tension?

Was there a part that felt particularly nice?

How was it to do this in a group?

Main Activity.

Who Started the Motion? This mirroring exercise is a playful way for participants to connect to each other through eye contact and movement. Explain the rules before choosing roles.

Facilitator script:

In this game, one person is chosen to be the guesser and leaves the room. While they are gone the group chooses one person to be the leader, so everyone follows their improvised rhythmic movement that they can choose to change after a few beats. Eye contact is key here, so watch each other equally so the guesser can't easily tell who's leading the motion. When the guesser comes back into the middle of the room, we are already in motion.

Closing Ritual.

Self Hug. These final moments of wrapping up the work and transitioning to the rest of the day can change appearance as the group progresses.

Facilitator script:

This next movement is a self hug, and it can help you come into the present moment and maybe feel some calm, and it's something you can take out of the therapy space with you into your day. First take your left hand and place it under your right shoulder, and then put your right hand over your left arm. Now squeeze with a medium firmness, so it feels secure. Doing this for 20 seconds can help your brain to release the same chemicals into your body that are activated when another person is hugging you.

To finish, stay in this self hug position and make eye contact with every member of the group, as a way of honouring the work we've started doing together. Then release the hug.

Middle Sessions (Phase Two: Scene Work)

Goals.

- Isolation: increase sense of attunement through mirroring

- Bodily Autonomy: increase awareness of the felt sense

- Socialization: co-create positive, meaningful experience through play

Warmup.

Body Scan with Sunshine. At this point in sessions, participants will be ready to focus on their inner sensations. This body scan uses visualization as a container to maintain aesthetic distance from experiencing the body as a site of danger, which is a risk for those with complex trauma. Start the session with a grounding exercise like the one described in the beginning session, one that brings the group into the here-and-now, to offer a sense of safety in the therapy space. This slow exercise sets up for the next activity of body mapping.

Facilitator script:

Close or lower your eyes. Let gravity hold you. I'm going to guide you through a meditation focusing on the body. You can open your eyes for a moment if you feel any stress arise throughout this, and then close or lower them again to relax, and this can help you feel safe in your body and your surroundings.

Imagine you're in a beautiful place outdoors, somewhere you've been before or somewhere you make up, and the sun is warming you. Feel it on your entire body, and find where the warmth is highest. Is it your stomach? Your thighs? Or maybe your arms?

Now focus on your toes and imagine how it feels right now, bathed in the sun. Even just your big toe.

Move the sunshine up to the muscles of the feet. Keep going up the calves. The sun is warm on your knees now.

Move up the thigh muscles to your hips. Remember you can open your eyes to come back into the room at any time if you need to.

Let the sunshine warm your hips and pelvis.

Imagine feeling the warmth of the sun across your belly.

Let it warm your chest, moving up to your shoulders.

Feel the warmth spreading down the muscles of your upper arm, then pooling in the elbows and down into the long muscles of the forearms.

Feel the sun warming the palms of your hands and into the fingers.

Let the warmth spread over your neck and jaw.

The sunlight is resting over your whole body, and now let the sun warm your face and notice how the muscles relax there. Bask in the sun and keep testing each part of you to check how relaxed or tight it is.

Reflection questions:

Could this be done while you're in the shower?

Where else could this exercise be useful?

What pleasant substance would you imagine instead of sunshine?

Main Activity.

Body Mapping. This is a body scan that hones the felt sense, with findings recorded for later reflection. It can be done over a few sessions to identify any changes in awareness and sensation. Participants can share their drawings with optional verbal reflection to the group or in pairs.

If drawing is not accessible, scarves or pieces of paper of different colours can be draped over a pre-drawn outline. Investigating sensations inside the body can present risks for people with unresolved trauma, so be observant of signs of dissociations like fast breathing or fidgeting, bringing the group back into the here-and-now if needed, and return to the exercise with more layers of guided imagery for aesthetic distance, such as imagining the self as a character.

Facilitator script:

You're going to draw a map of sensations and feelings going on in your body. Take a paper and two or three coloured pens, and draw an outline of your body in a neutral stance. Don't fill it in, just the simple outline.

Settle into a resting position with the paper and pens close to you.

Close or lower your eyes and take three steady, deep breaths, filling your belly and then your lungs up to the top of your chest, and out again.

Now, imagine you can move your awareness like a magnifying glass to check around your body to look for and discover the different feelings and sensations I am going to suggest. You might find it in one part of your body, or several places.

Focus on finding a sensation of coolness.

If you find this sensation, move your body's position enough so you can comfortably draw it on the page of your body outline, in scribbles, lines, dots, symbols; any way that best describes what you find. You can label it with the word if it helps you. If you didn't find the feeling, just rest and wait for the next suggestion.

Go back to your resting position when you're done and settle in with a full, steady breath.

Where can you find relaxed, free, soft areas?

Breathe in and out fully.

Is there a place in your body that holds tension?

Settle back with a full breath.

Is there a place that feels like an animal, a bird, or a fish, hiding or moving about?

Breathe in and out again.

Is there anything you have found inside that has not been mentioned? Take a bit of time to draw in any new discoveries on your map.

Main Activity.

Partner Mirror. This exercise attunes participants' nervous systems playfully, offering opportunities for contact without touch. Use this especially when it is still challenging for group members to meaningfully connect after beginning sessions. After a few minutes softly prompt pairs to switch roles, and then to play with no clear leader.

It can be adapted to just moving the face or finger, or making sound as well as movement to accommodate differing abilities. If improvising abstract movement is a challenge, the exercise can be contained by slowly miming an activity such as eating or picking up the phone. If eye contact is not possible for any participants, the pair can mirror side by side.

Facilitator script:

Two people face each other, and imagine the other person is your reflection in the mirror. Choose who will lead first. Start by slowly moving one hand. Follow your reflection's movements as precisely as possible. Once you feel ready, move the other hand too. Go slow and steady, with intent to synchronize. Keep direct eye contact rather than looking at the other's body.

Reflection questions:

What was it like to focus so much on another's movement?

What was it like to be looked at closely?

How was it to lead/follow?

Did you feel that you were leading or following more?

Main Activity.

Stick Game. A spontaneous dance is created with another. This exercise encourages movement and play with a partner, and participants can experience how their body influences another's, giving a sense of attunement. Play for a while together in pairs and then take turns witnessing each pair. It can be a warmup for, or used in conjunction with Line Repetition.

Bring enough sticks for all members of the group to use in pairs. The stick can be replaced with a large ball or another object with more surface area for ease of movement.

Facilitator script:

move through the space or in your spot with a stick balanced between your hand and your partner's. Play with tension as you push toward and away without letting it drop.

Main Activity.

Line Repetition. This scene work is for partners, but can begin with the group repeating a line together as a warmup. Rehearsal can happen for all partners simultaneously before giving each pair a chance to be witnessed by the rest of the group. Take time to reflect on this verbally, or through non-verbal improvised movement responses. The group should be fairly used to playing together and have an established sense of trust in the room, as these lines may bring up memories of challenging relationships. This can be tempered with giving playful direction, encouraging different emphasis, emotional tone, pace, and volume. Begin with repeating the same line before moving to call and response, to get participants used to the rhythm.

> Suggestions for a single line repeated by both:
>
> *I'm not ready! (eventually turning into) I'm ready!*
>
> *I'm here!*
>
> *Yes!*
>
> Call and response: each can also be used as a single repeated line as above. Try swapping me/you pronouns too.
>
> *1. Person A Do it!*
>
> *Person B I won't do it!*
>
> *2. Person A I can do this!*
>
> *Person B No you can't!*

Closing Ritual.

Hand Squeeze. Come closer in the circle, with assistance from the group leader and peers. With permission, take hands of people next to you and close or lower your eyes. When you feel a squeeze, squeeze the next person's hand. Challenge the group to pass as quickly as possible, like an electrical current or a heartbeat. A variation of this is to add a single-word verbal expression of present feeling or image, or something they want to take with them from the session as they squeeze the next person's hand.

If joining hands is not possible or comfortable for individuals, accommodate with a hand on the shoulder or arm, or simply stand near.

Ending Sessions (Phase Five: Ritual)

Goals.

- Isolation: nervous system regulation with physical contact

- Autonomy: express feelings through metaphor and movement

- Socialization: increase group connection through mirroring

Warm up.

Emotion Mime. This group mirroring game offers opportunity participants to play with different expressions of emotion that they might be feeling but not expressing, or have not felt but now have the chance to try it out.

First, arrange the seating into a U-shape to make room for easily visible performance space. Next, warm up the group by giving an emotion for everyone to take a turn to mime one at a time, until people are comfortable with the format. Then one person goes to the front of the group where all can see. and is given or chooses an emotion to portray, through a facial expression, sound, and body movement. The rest of the group mirrors their mime.

Reflection questions:

What emotions felt new?

What were you more comfortable expressing?

Main Activity.

Game of No. This exercise allows participants to nonverbally express boundaries by playing with giving and receiving embodied consent. Movements can be slow and gentle, and proximity can be negotiated between partners. Normalize the possible challenge of sensing or expressing "no," especially when those with trauma react with "freeze" and override their own personal boundaries. This may show up as stilted or infrequent movement, laughter with no perceptible

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cause, refusal of eye contact, or expressing "yes" very quickly. If "freeze" actions are noted, pause to gently remind the group to continue paying attention to their felt sense, possibly leading a quick body scan.

As always, the area of movement can be adapted to the hand, arm, or other single part of the body to be accessible to all physical abilities and to honour ongoing consent. The game can be put to music to encourage attuned, flowing movement.

> Facilitator script:
>
> *Find one spot on your body that is ok to be touched, but don't tell your partner. That's your "yes part." All other places on the body are a "no part." Your partner will slowly move their hand around your body without touching, and you show them no by gently moving your body away from their hand. When your partner is close to the yes part, show them yes by moving that part to their hand to make physical contact.*
>
> Reflection questions:
>
> *What was it like to see and feel your boundaries being respected?*
>
> *Did anything change when your partner found your yes part?*
>
> *How did it feel to be searching for your partner's yes part?*

Main Activity.

First Contact. The emphasis on curiosity in this main activity is a distinction from habitual movement and contact. It is common to slip into a routine of care-taking when touching another person, and this aims to bring focus back to the sensations in the here-and-now, rather than the hoped-for outcome. This allows the receiver of touch to simply receive, without pressure to show the other person their enjoyment of the touch. Imagining the play as an alien meeting a human brings levity to temper a potentially intense interaction.

If individuals are not comfortable with touch with another person, they can adapt by using self-touch.

> Facilitator script:

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Imagine you are an alien who's come to Earth to document the lifeforms on the planet. Now you are meeting a human for the first time. Once you have consent, take your partner's hand in yours and explore it, as if you are taking detailed documentation of the species. Notice what it looks like, what the different parts of the hand feel like. Observe the way it moves, how the skin dances over the muscle and bone. Be aware of slipping into giving touch for the other, such as massage or stroking with the intent to provide care. This is for your curiosity.

After a few minutes, switch roles.

After participants have each touched the other's hand with curiosity, reflect together about what it was like to be in each role. Then share the experience with the group, with the option to express through movement, sound, or words.

Main Activity.

The Human Spa. Create groups of three, in which one person is receiving touch and the other two give touch, following the facilitator's guided instruction. The theme of the instruction can be adapted to reflect the interests of the group, and the levity will provide aesthetic distance from possible intensity of being touched.

Touch can be adapted to focus on hands and arms only. If touch is not comfortable for a member of the trio, sound that matches the tone of the instruction can be used for that group instead.

Facilitator script:

Imagine the ultimate spa day, as if it were one of the newest bespoke services at the assisted living space. Choose one person to receive this luxury care first, and the other two provide. Ask the receiver if there are any areas they want to avoid being touched. The face is a no-zone for everyone.

Begin with a rinse. This is a pitter patter finger movement from the head down to the toes, like a gentle shower.

Next is a nourishing shampoo. This is a medium-firm circular rubbing motion with the flat of the hand from the neck down to the feet.

Then a deep conditioner, applied with a firm squeeze using the whole hand with the intent to really hold each part.

The squeegee is a pulling-down and flicking-off motion with the edge of the hand like you're getting water off a fine suit, from the head to the toes.

Finally, a Boutique Brightening, using quick light, small circular motion with the finger tips from the top of the head down to the toes.

Then switch roles till everyone has had a turn to receive.

Closing Ritual.

Cheers! This important closing ritual is a celebration of achievements of the group and of individuals. Be sure that every member is recognized for their strengths, and their contributions to the group. For example, Judy showed up for every session. Frank kept us on track with time. Eva shared her musical expertise. We got through a fire alarm. It's a chance to reflect on memories of play and connection, as well as rupture and repair. Have actual drinks to toast with, even if it's a cup of tea made the way each person likes it. After each statement, the group all says "cheers!" and raise their cups to touch or come close in the middle.

Chapter 6. Discussion

The goal of these interventions was to create a space that is safe, consistent and contained enough to feel intimacy in group therapy with participants who are easily brought out of the window of tolerance. It aims to offer moments of social success, positive attunement with other participants, and feelings of empowerment to increase quality of life.

Implications

It is hoped that these playful embodied therapy interventions can offer autonomy and meaningful connection for older adults navigating challenges in assisted living, particularly those suffering with isolation and complex trauma. The sessions outlined here build on experiencing safety in order to move towards intimacy, first in the environment, then in exploration of the self and the inner landscape, and finally in other people.

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It is important to retain confidentiality of participation in the therapy group, as the space used for therapy is likely to be within the grounds of the participants' communal living space. Consideration must be taken for the recruitment process and for obtaining informed consent, as challenges may arise if non-participating residents or staff are made aware of an individual's participation and show unsupportive behaviour. An ideal room has doors that close, has a large open space for movement, and is set away from excessive foot traffic. Facilitators for this drama therapy group should have training in Creative Arts Therapies or other embodied therapy, and experience in theatre or improvisation so that they can model comfort with the imagination, the body, and play. They should be familiar with their own (a)sexuality and demonstrate awareness of their intersecting identities that place them in their social location of power and oppression, and understand how that affects their own sexual expression. This will help them facilitate open discussion of intimacy and sexuality for the group.

Future directions for this research can highlight internalized ageism and its impact on the daily functioning of an individual, including physical, social, and mental health. A systemic understanding of care staff's contribution to a culture of ageism would incorporate the stresses placed on front line workers by a hierarchical structure that does not afford them time and cultural humility to meaningfully connect with residents, nor to provide practical support for sexual expression. Critical work that underpins these two possible directions is to integrate a consent framework into assisted living policies regarding sexual expression and physical touch, with a range of tools to support residents with diverse physical and cognitive functioning.

Program Restrictions and Limitations

Limitations of the research can be drawn from a critical analysis of the cited literature, which often polarizes residents and staff in assisted living and long term care as oppositional, with little acknowledgement of the structural forces influencing power disparities (Frankowski & Clark, 2009). Furthermore, in the search for specific policies of physical touch and sexuality on websites for assisted living organizations, very little was available. Thus, conclusions were drawn from literature that generalized policies as inadequate in this area (Everett, 2007). This calls into question the validity and reliability of published literature on sexual expression in

assisted living, suggesting that further research be conducted with frontline care staff and their supervisors, as well as policy makers, to supplement these gaps. Finally, there is minimal literature available that emphasizes the voices of older adults, and the selected research used small sample sizes, making it difficult to generalize the results of the experience of this population (Jennings, 2013). Literature on the experiences of LGBTQ+ seniors was not sought, and research collected on sexuality often did not mention the unique strengths and challenges faced by this population. Changes in sexual desire and expression connected to hormonal shifts were not explored. The activities within the intervention were created for older adults in assisted living with physical limitations and high cognitive functioning, thus excluding residents with decreased cognitive functioning. This study focused on ways to increase intimacy using a trauma-informed approach, and was limited to adequately address critical safety issues around sexual assault prevention and direct post-trauma support for this population.

Chapter 7. Conclusion

This research paper outlines an abridged version of an intervention research paper with a literature review on touch, trauma, sexuality and older adults, policy on sexual expression in assisted living, and group drama therapy processes. This study has guided the inquiry of using contact and physical touch in group drama therapy to increase opportunities to reduce isolation, increase bodily autonomy, and provide space for meaningful, positive social connection in order to experience intimacy and sexual expression. Touch is a basic human need, and when it is absent or negative, it has long term impacts on developmental health, often showing up as fight/ flight/freeze survival responses (Van der Kolk, 2014). These behaviours can put individuals at further risk of isolation and depression, particularly when moving into residential settings away from familiar social support, due to changes in ability to perform activities of daily living (Reinstein, 2002).

Older adults entering into assisted living now are often more aware and expressive of their rights, and policy for assisted living and long-term care must adapt to a person-centred holistic care model (Frankowski & Clark, 2009). Sexuality is often missing as a stated tenant of institutional policy, and this contributes to a climate that shames older adults for having sexual

desire, which could lead to withdrawal and a loss of agency (O'Connor & Kelson, 2018). Playing in a group with a clear therapeutic framework can help participants build an empowered self-image by playing with new roles, decreasing rigidity in the body and emotions, and offering meaningful connection between peers (Jennings, 2013). In this study, using theories of nervous system regulation, a trauma-informed approach underlines embodied activities within a drama therapy frame. Techniques from drama therapy that can help foster intimacy between participants include play, metaphor, felt sense, mirroring, and movement (Bleuer & Harnden, 2018; Stolinsky, 2002; Valadas, 2005; Van der Kolk, 2014). When engaging in play for therapy with older adults, the facilitator walks a thin line of empowering and infantilizing, meaning that care must be taken in tone, language, and any objects or materials used. This requires an openness to listen to participants' verbal and embodied feedback. By fostering a structured safe-enough environment of levity and communication with consent, participants will have space to grow as individuals and as a community.

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