Drama Therapy and Psychodrama: An Integrated Model

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ABSTRACT. This article contains a model that integrates—purposefully and systematically—core concepts, processes, and purposes of drama therapy and psychodrama. The model involves a gradual, paced progression from playful dramatic work that facilitates interaction and a sense of liberation from real-life constraints to psychodramatic work that deepens one's examination and transformation of personal, emotional life issues. Eight therapeutic issues are examined from the perspective of the integrative model: group cohesion, group versus the individual, resistance, transference and the client-therapist relationship, the use of metaphor and the role of interpretation, levels of intervention, conflict and difficulty among group members, and spirituality. Case examples and vignettes are interwoven throughout, offering the reader a vivid picture of the work in a variety of contexts, including both group therapy and individual therapy settings.

JACOB MORENO'S BRILLIANT AND VISIONARY WORK has been a cornerstone of all curative uses of drama in the 20th century. But psychodrama, which Moreno invented, and drama therapy, which has no single founder, have a common source dating back at least 20,000 years in human history (Achterberg, 1985, quoted in Snow, 1996): the dramatic healing rituals of shamanistic cultures. In recent years, there have been a number of publications contrasting psychodrama and drama therapy (Kedem-Tahar & Kellermann, 1996; Johnson, 1991a; Blatner & Blatner, 1988; Chesner, 1994), but few about their complementary interface or about models that integrate the two disciplines.

I begin here with a brief historical background on drama therapy and follow with a review of the similarities and differences between psychodrama and drama therapy. I then present a model of drama therapy that purposeful-

ly and systematically integrates the core concepts, techniques, and processes of psychodrama. In the article, I examine eight therapeutic issues from the perspective of the integrative model. Case examples and vignettes are interwoven throughout to illustrate the work in a concrete and vivid manner and give a sense of the wide range of applications. The 8 selected areas are (1) group cohesion, (2) group versus the individual, (3) resistance, (4) transference and the client-therapist relationship, (5) the use of metaphor and the role of interpretation, (6) levels of intervention, (7) conflict and difficulty among group members, and (8) spirituality. The first, second, and seventh areas are specific to group therapy, whereas the others are applicable to both group and individual therapy contexts.

The development of drama therapy as a distinct field progressed over a period of time in primarily two countries—the United States and the United Kingdom—through the efforts of individual practitioners and as a result of varied influences. The larger umbrella for the new field was creative arts therapies that include art, music, dance/movement, and later poetry therapies. Each of the creative art therapy modalities sprouted from its particular art form, extending the art form from a purely aesthetic domain to the exploration of its potential for healing. The majority of creative arts therapists began as artists in their respective art modalities and were intrigued by the personal transformation, clarification, enrichment, or soothing that they experienced while engaged in their art or that they noted in students or clients with whom they were working.

The experimental theater in the 1960s and 1970s, which explored the psychological, spiritual, and consciousness-raising aspects to theater and challenged the traditional boundaries between actor and audience, was a central influence on the development of drama therapy. Another important influence was improvisational theater, pioneered by Viola Spolin (1963), which emphasized spontaneity, immediacy, and collaborative interaction. In the United Kingdom, which has always been a hub of theater, child dramatists articulated the significance of drama in child development, learning, and healing. The most notable child dramatist, Peter Slade (1954), coined the term *dramatherapy*. In 1973, Sue Jennings, British pioneer in drama therapy, published a ground-breaking book, *Remedial Drama*, in which she described therapeutic uses of drama with children who have special needs. Jennings and Marian Lindkvist, whose work also focused on children with special needs, particularly autistic children, founded the first two training programs in England.

In the United States, a number of people in the 1970s were separately developing drama/drama therapy programs in institutional settings. Gertrud Schattner worked at New York's Bellevue Psychiatric Hospital and, along with drama specialist Richard Courtney, coedited the first major U.S. publication on drama therapy, *Drama in Therapy* (1981). David Johnson worked

with schizophrenic patients and later with veterans; Eleanor Irwin worked with disturbed children in a psychoanalytically oriented children's clinic, and I worked with adults and adolescents in psychiatric day treatment and halfway houses. Early articles by Johnson (1982a, 1982b) focused on improvisation, spontaneity, and styles of role playing; those by Irwin (1981, 1983) on psychoanalytic issues in play and drama therapies; and those by Robert Landy (1983) on projective techniques and notions of distancing. My writings (Emunah, 1983, 1985; Emunah & Johnson, 1983) and documentary videotapes illustrated the progression from playful improvisational drama to emotional psychodramatic work and the use of performance in drama therapy.

The work of these and other individual practitioners/researchers converged with the founding of the National Association for Drama Therapy in 1979. In the early 1980s, the first graduate training programs were founded in New York (directed by Landy) and in San Francisco (directed by Emunah). It was not until 1994 that an international think-tank of drama therapy trainers and educators occurred—an event spearheaded by Alida Gersie, director of one of the British drama therapy programs. Leading U.S. and U.K. drama therapists, along with counterparts from several other countries, began to discuss their common interests as well as their differences in theory and practice.

The central debates and questions within the field of drama therapy are interrelated. First, is it important to connect what emerges in the realm of play and pretend to real life? Some believe that the healing takes place within the realm of metaphor and fiction and that interpretation is unnecessary and indeed can be contraindicated; others believe that it is in understanding the connection between one's acting and one's life that much of the therapy occurs. Second, does healing come through a gradual discarding of roles, akin to the notions of acting of Polish theater director Jerzy Grotowski, or by working through the embodiment of roles (Landy, 1993, 1997)? Third, should the fictional dramatic work lead to psychodramatic work, or is it best to sustain the client's engagement in imaginative, symbolic play and let psychodrama remain a separate modality?

The last question leads to the differences between psychodrama and drama therapy. The two fields, in my view, are far more similar and overlapping than different and separate. The foundation of Moreno's philosophy is his theory of creativity, spontaneity, role, and interaction (Yablonsky & Enneis, 1956). Those elements also form the basis of drama therapy, and in that sense, the link between drama therapy and psychodrama is profound and essential. However, there are also clear distinctions in both concept and clinical practice.

In group work, typical of both psychodrama and drama therapy, psychodrama focuses on one person in the group at a time, who reenacts scenes that are clearly connected to his or her life dilemmas and unresolved conflicts. Although the group is involved as audience or as actors in the protagonist's

drama, the therapy is nonetheless individually oriented. In a sense, this individual orientation is surprising, given that Moreno pioneered group therapy and even coined the term *group psychotherapy* (Blatner, 1997). Yet Moreno himself acknowledged the individual focus in psychodrama: "Even the so-called group approach in psychodrama is in the deeper sense individual-centered . . . and the aim of the director is to reach every individual in his own sphere, separated from the others" (Moreno, 1946, in Fox, 1987, p. 18). Drama therapy, on the other hand, is more group oriented; the focus tends to be on the group process and interaction, rather than on a single person. It would be untrue, however, to say that drama therapy never focuses on a single individual. The examples in this article illustrate the way the group process, at the heart of drama therapy practice, also supports intensive work on an individual level.

One of the central distinctions between drama therapy and psychodrama is that the scenes in drama therapy are not necessarily directly related to the person's real-life experience. Drama therapy uses far more improvisation of fictional scenes, with the belief that engaging in the world of make-believe offers not only a healthy sense of freedom but also the disguise that enables self-revelation. "Man is least himself when he talks in his own person," stated Oscar Wilde. "Give him a mask, and he will tell you the truth" (Ellmann, 1969, p. 389). Contemporary psychodrama, on the other hand, is more therapeutically direct, involving enactments that are "tenaciously faithful to the living experience of the protagonist" (Hug, 1997, p. 31).

The distinction between drama therapy and psychodrama is key because, as a result, drama therapy tends to be more playful and psychodrama more intensely self-disclosing. Yet making the distinction involves the risk of simplification and even distortion. Drama therapist Stephen Snow (1996) and psychodramatist/drama therapist John Casson (1996) both appropriately offered a critique of Kedem-Tahar and Kellermann's (1996) claim that drama therapy remains only within the metaphoric realm and does not involve self-disclosure. "It would be a caricature to say that drama therapists always work through emotional distance and never address anything directly," Casson wrote. "A caricature of psychodrama as underdistanced and drama therapy as overdistanced would result in both missing the mark of the necessary, aesthetic, therapeutic proximity" (p. 308). Snow asserted: "I assure the authors that the drama therapist is fully equipped to catalyze and encounter the baring of the soul in therapeutic practice. I refer them to the section on autobiographical performance pieces in Landy (1993) and especially to the case studies and the chapter on Self-Revelatory Performance in Emunah (1994)" (p. 204).

It is important to note that Kedem-Tahar and Kellerman (1996) cited Jennings (1990) when stating that drama therapists discourage personal identifi-

cation with a metaphor and that drama therapy remains in the universal, archetypal realm for the entire session, with no movement toward personal, individual connection to the material. Indeed, Jennings did write that "the metaphor is the treatment itself" (1990, p. 20), and in recent years, she has returned yet more fully to the theatrical source, in which she often uses text as a basis for drama therapy. Johnson, although working very differently from Jennings, also foregoes self-analysis or interpretation, believing that the healing lies within the improvisational "playspace" and the active encounter between therapist and client (Johnson et al., 1996). However, it is important to recall that there are a number of different approaches and methods within the field of drama therapy, including Landy's Role Method (1993), Johnson's Developmental Transformations (1991b; Johnson et al., 1996), Emunah's Integrative Five-Phase Model (1994, 1996), Gersie's storytelling/narrative approach (1991, 1992), and Jennings's (1987, 1995) anthropological/ritual focus. Statements about the field as a whole, based on one or two practitioners, will likely be inaccurate generalizations.

Despite the variety of approaches within the field, all drama therapists have as their inspirational source the art form of drama/theater. Unlike psychodramatists, drama therapists are *required* to have a theater background in order to become registered. They use a wide array of theatrical processes—not only psychodramatic role play, role reversal, and reenactment but also adapted versions of improvisation, creative drama, theater games, storytelling, puppetry, masks, mime, movement, scripted scenes, and performance. Obviously, the decision about which of these processes to incorporate depends on the population, age group, and particular therapeutic needs of the individual client, his or her stage within the treatment, and the theoretical approach and affinities of the drama therapist.

The ironic aspect to the distinctions between drama therapy and psychodrama is that Moreno himself—with his background in using improvisational theater, his theatricality (in staging, stage lighting, etc.), and his fascination with group dynamics—would appear to be more of a drama therapist (Emunah, 1994). The number of psychodramatists today whose work embodies Moreno's original theatrical/interactive emphases is growing; two such examples are Fox (1987, 1994), who created the improvisational, theatrical, aesthetic form of Playback Theatre, and Blatner (1991, 1997), who has emphasized the significance of creative play and role dynamics. Perhaps in the future, the two fields will more fully embrace one another, which may be the same as stepping back to the encompassing, expansive arms of Moreno. In the model presented in the following section, the line between drama therapy and psychodrama is noticeably thin. It is a line that is not only thin, but interconnecting, creating a delicate and deliberate passage from drama to psychodrama.

An Integrative Framework and Model of Practice

The following integrative framework and model of practice involves a gradual progression over the course of treatment from playful, creative, dramatic work to in-depth, emotional psychodramatic work. The model is based on a number of premises:

1. The therapeutic journey is eased and strengthened by a sense of gradual unfolding, in which the work is paced and progressive, creating in the clients a sense of readiness at all times for the next step or level.

2. Beginning the therapeutic process within the creative drama mode is liberating, enabling clients to experience a sense of freedom from the constraints of everyday life and from engrained patterns. The engagement in the fictional realm also circumvents the tendency to rehash predictable, familiar life issues immediately. Over time, the associations one has between the fictional scenes and one's real life lead to a more direct working through of real-life issues, but from a fresh, often unexpected, perspective.

3. The fictional realm is protective, at the same time that it enables self-revelation in a safe and distanced manner. Over time, the need for a safeguard diminishes. But just as theater director Chaiken (1984) poetically described the way the wearing of a mask changes the actor's face, so too the process of taking on roles affects the client's self-image/perception/awareness. When the time comes to discard roles and unravel layers of masks, the person is not the same as she or he was before the acting processes.

4. The building of trust and interrelationships within the group provides a critical foundation for the later psychodramatic work. The therapeutic value of an individual's psychodramatic scene work is integrally linked to the depth with which other group members witness, support, empathize with, and thereby help contain that person's work (Emunah, 1994). In addition, clients will play auxiliary roles in a fellow member's psychodramatic scene with greater commitment once they have established a caring relationship to that person.

5. The development of an ease with and skills in acting leads to greater authenticity in the eventual performance of psychodramatic scenes. The more authentic the en/acting, the more deeply the client/actor is affected. A familiarity with dramatic processes also reduces self-consciousness and the cognitive distance/disruption that can occur when one is adjusting to various directions at the same time that one is dealing with emotional scene work.

6. Intense and varied emotions can be safely expressed in the context of fictional roles, scenarios, and acting processes. Through the drama therapeutic processes, the therapist comes to know the client's capacity and tolerance for emotional expression, and the degree of containment she or he needs—information that is very useful for guiding the client and making interventions when the client later engages in psychodramatic scenes.

7. In drama therapy, the client's creativity, expressiveness, spontaneity, playfulness, and imagination are accessed—qualities that enhance self-esteem and self-image. Experiencing, and having others witness, one's strengths enables a person to feel freer later to disclose and grapple with parts of the self that are frightening, shameful, or painful. The increased access to one's creativity also becomes an asset in the latter stages, in terms of being able to master intensely emotional content. One of my clients, who described our process as "turning pain into art," added, "This is what gives me hope and gives my life meaning."

The goals in the integrative framework of drama therapy include facilitating emotional expression and containment, developing the observing self, expanding role repertoire and self-image, and enhancing interpersonal relationship skills. This dynamic, creative approach to psychotherapy "engages the person's strengths and potentialities, accesses and embraces the person's buried woundedness, and enables the practice and rehearsal of new life stances" (Emunah, 1994, p. 31). The model is guided by central concepts of humanistic, existential, psychodynamic, and cognitive-behavioral approaches to psychotherapy. "Emotional catharsis and mastery, cognitive insight and behavioral change are all essential and intertwining parts of the therapeutic process" (Emunah, 1994, p. 31).

In the following section, I describe the therapeutic process that is based on the premises cited above. The process progresses through five distinct phases that gradually and intentionally shift from what is more traditionally viewed as drama therapy to what is typically associated with psychodrama. Nonetheless, the process is not strictly linear: there are overlapping aspects throughout; each stage encompasses and builds on elements of the prior stages; and the final phase is reminiscent of the first phase, bringing the process full circle. The initial playful stages form a backbone for the later intensely personal and often painful stages of work. At the return to the playful, one discovers an even greater capacity for joy and spirit. Maslow has said that in "protecting ourselves against the hell within, we also cut ourselves off from the heaven within" (1968, p. 142).

The Therapeutic Process

In classical psychodrama, the warm-up—generally a brief stage early in the session—tends to be more interactive and playful than the ensuing scene work, but it is goal driven, serving the purpose of selecting a protagonist and preparing the group for the psychodramatic enactment. The warm-up in psychodrama is akin to foreplay, aimed at opening up participants to what is considered the main activity or "meat" of the session. In drama therapy, foreplay

may be the "meal" itself; indeed the entire process may be *for play* in and of itself.

In the Integrative Five-Phase Model of drama therapy, there is a movement—not necessarily within a given session, but over the course of treatment series—toward increasingly personal, psychodramatic work. Each stage paves the way for the next, diminishing self-consciousness and creating anticipation for what is to follow. The following is a brief synopsis of the Integrative Five-Phase Model (Emunah, 1994, 1996).

The focus in the early stages is on fostering interrelationship and trust among participants, or in individual therapy, toward the therapist. The first phase uses dramatic play as a means of facilitating interaction and generating spontaneity. The improvised play and structured dramatic processes in the first phase gradually progress to sustained dramatic scenes, composed of developed roles and characters. Those scenes, typical of the second phase, are fictional, but through acting, clients express strong and varied emotions and exhibit both familiar and unfamiliar aspects of themselves. Throughout the first and second phases, clients experience a sense of freedom and permission to be and act in new ways. Until the group or individual client naturally connects the fictional material to real-life roles or issues, the therapist does not make interpretations or push the participants to reflect on or "own" the roles they play. Instead, the therapist tries to safeguard the freedom and permission inherent in the theatrical arena and avoid cognitive processes that might inhibit the sense of liberation that acting offers.

By the end of the second phase, clients spontaneously make personal connections to the enactments. The verbal processing of scenes steers the ensuing work in a more personal direction. In the third and fourth phases, drama is used to explore real life more directly. It is in these stages that psychodrama is an essential part of the treatment process.

The third phase involves role play and enactments dealing with current issues, dilemmas, relationships, dynamics. In the fourth phase, clients explore more core issues and long-term themes; these psychodramatic "culminating enactments" are at a deeper level, accessing more intense and sometimes primal emotions. By the time the client has reached this stage of self-disclosure and self-examination, there is a high level of cohesion, trust, and intimacy within the group. Many of the scenes are not only powerful therapeutically but also compelling on a theatrical, aesthetic level. The performance of self-revelatory theater (Emunah, 1994; Emunah & Johnson, 1983) is often composed of phase-four scenes.

The third and fourth phases are psychodramatic in nature, but the context differs from classical psychodrama in that the client in drama therapy has begun by acting, rather than re-enacting. The issues that emerge in these stages are often outgrowths of discoveries that occurred in the earlier phases.

Also, by this point, the clients have developed skills at, and ease with, drama/acting, which result in scenes performed with a great deal of complexity and authenticity.

The fifth phase revolves around closure, review, and integration of the entire journey. A central process is dramatic ritual, which serves to reunite the group and provide an outlet for the expression of the multifarious and often intense feelings evoked by the treatment series and the fact that it is coming to an end. Elements of the fifth phase are also present at the close of every session (see Figure 1).

Essentially, the therapist is carefully observing and supporting the natural progression of the group and tailoring processes and interventions accordingly. Naturally, some groups will gravitate toward, or seem most in need of, work in a particular phase, rather than traveling at an equal pace through all five phases. The bulk of their work will remain in a single phase. Children and developmentally disabled adults tend to find the playful, metaphoric work of the first and second phases most comfortable and beneficial. Eventually, those clients generally progress to the third phase and, if in individual therapy, also to the fourth phase. Adolescents thrive in the second and third phases; the first phase can seem too childish, and the fourth phase too personally exposing. Highly functioning, motivated adults are often eager to enter the more psychodramatic phases (the third and fourth). Emotionally disturbed adults generally derive significant benefit from the work of each of the phases, although groups will travel through the phases at varying paces.

Different drama therapists may also have a particular affinity with one of the phases, and their practice may incorporate little of the other phases. Many drama therapists, for example, will steer away from the psychodramatic work of the third and fourth phases. Personally, I believe that the incorporation of

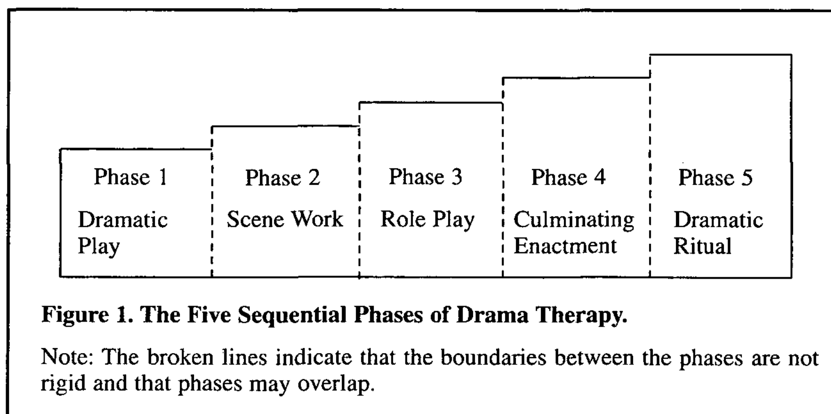

Figure 1. The Five Sequential Phases of Drama Therapy.

Note: The broken lines indicate that the boundaries between the phases are not rigid and that phases may overlap.

psychodrama within the context of the progressive and unfolding stages is a natural evolution and that it vastly increases the depth and intensity of the healing that is possible within the dramatic modality.

Therapeutic Issues

Group Cohesion

Group cohesion is of central importance in drama therapy. The degree of cohesiveness of the group has a direct relationship to the depth of individual work that takes place. The more emotional, psychodramatic work does not occur until there is a strong sense of trust and support within the group. This trust and support enable more authentic, intense levels of expression and self-revelation. More important, they provide the containment that is needed following deeper therapeutic work. Without this containment, clients often experience a kind of post-enactment alienation (Emunah, 1994) following intensely emotional and exposing psychodramatic work. The sense of being truly witnessed, empathized with, and cared for by a group of people one has come to know and respect is as significant a therapeutic factor as the "working through" of individual issues.

Given the focus in drama therapy on group cohesion, closed groups are generally recommended, along with an emphasis on firm commitment and regular attendance. The cohesion that develops within the group helps sustain members' commitment to the treatment process. Each person becomes an integral part of the group and the process and experiences a strong attachment to the group. Naturally, the experience also evokes fears of loss and betrayal and concerns about other's leaving or about one's own ambivalence or fears of betraying others. These issues are made conscious through playful drama therapy processes, discussion, and dramatic enactment.

The interactive nature of dramatic activity helps to promote interrelationships within the group. Drama is a collective art form; the use of dramatic processes in therapy is a natural means of facilitating interaction and collaboration. In this sense, drama therapy is an ideal modality for work with people who are socially withdrawn or isolated or with those whose central issues revolve around relationships. The work in the first phase focuses on facilitating group interaction, developing trust, and establishing a sense of group identity. Throughout the treatment series, sessions typically begin and end in a circle, bringing the whole group together.

As in all group-therapy processes, attention is given to the roles people play in the group. Given that role play is a central process in drama therapy, as in psychodrama, the examination of roles within the group occurs actively and creatively. For example, at times I have asked members to role play one anoth-

er or to take on qualities of others in the group whom they admire. Group members may be asked to create sculptures (by placing and molding fellow group members) to depict the group dynamics from their individual perspectives. In general, there is more fluidity in drama therapy than in verbal groups about the roles people play and the ways in which they are perceived by others. That is largely because the participants are constantly seeing one another playing a multitude of roles, such as imaginary roles, real-life roles in a variety of contexts, and auxiliary roles in other people's psychodramatic scenes. More aspects of the person are witnessed live than typically occurs in stationary, verbal encounters.

At the same time that drama therapy groups aim to create a sense of group identity and unity, there is an equal and ultimately complimentary focus on understanding and respecting individual differences. Through dramatic enactments, as well as psychodramatic interventions such as role reversal and doubling, group members begin to share and comprehend their differing life experiences and perspectives. Drama therapy, like psychodrama, can be used to bring together groups from different factions, such as Arab and Israeli youth, or to facilitate multiracial diversity training. The combination of heightening an understanding and respect for differences and of achieving a sense of commonalty and universality is a very powerful, if not sacred, aspect to group drama therapy.

The Group Versus the Individual in Group Drama Therapy

Given the emphasis in drama therapy on group cohesion, choice points often arise regarding group versus individual needs. The drama therapist is constantly paying close attention to the struggles, challenges, dynamics, and levels of readiness of both the group and the individual. At times, an individual in a group may be ready to tackle an emotional issue dramatically, but the group as a whole is not at that stage of readiness. Naturally, an individual's readiness influences the group as a whole and the pacing with which the group progresses through the five phases. As Yalom (1985) pointed out, there is often an "emotional leader." Nevertheless, the dynamics of the group as a whole affects the pacing of the work for individuals, which is one way in which drama therapy differs from classical psychodrama. The protagonist is always at the center of the psychodramatic stage. A psychodramatist will likely take his cues from an individual/protagonist, trusting that the group/audience will follow along. In the Integrative Five-Phase Model of drama therapy, assessing the phase of the group's therapeutic process helps the drama therapist determine the best way of proceeding.

> Deborah, a 25-year-old woman in a psychiatric day treatment center, approached me before a group session asking if she could enact a scene in which she prac-

> tices confronting her father on the childhood sexual abuse she recently recalled. The group was in the early stages of Phase Two, and I felt that most group members would be frightened by such a scene at this time, especially as its content would evoke memories and emotions many were not yet able to contain. Moreover, because the scenes we had until now been enacting were fictional, and clients had not yet related these scenes to their own lives, the shift would be too abrupt, and would break a trust and comfort in the process that were just being established. Despite Deborah's readiness, I had to forego exploring her scene at this particular point, knowing that for her too the work would be far more healing at a later stage, when the group would be fully available to offer her the emotional support she would need.
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> However, I devised a compromise that would permit Deborah to express some of her feelings, but at a greater distance. I directed her in an enactment in which she confronts a friend who has betrayed her. Deborah imbued this simple scene with passion. The enactment gave her some of what she needed, and equally important, it developed the group's toleration of emotionality and courage to approach emotional terrain. Deborah and other group members shared emotional responses and associations to the scene, moving the group to the end of Phase Two. (Emunah, 1994, p. 90)

Following dramatic work that focuses on one individual, the drama therapist will involve the rest of the group in related work. For example, after one man's scene about his isolation and loneliness, the other group members were invited to discuss and enact scenes pertaining to the ways in which loneliness manifested itself in each of their lives and their ways of responding to that state. At other times, the group's responses will be elicited within the course of a protagonist's scene. For example, one may invite multiple doubles for the protagonist or have the group become a chorus within a scene. Such interventions enable group members to be active participants rather than passive spectators and also help sustain the engagement of people with brief attention spans for the work of others. Sessions may also culminate with an emotional orchestra in which each person expresses in sound or word feelings that have been evoked within the session.

Resistance

Resistance is minimized when the work is paced, with each step leading organically to the next. Drama therapy is not composed of isolated techniques but rather involves a developmental process involving smooth transitions and interconnected methods. The therapist carefully chooses methods that will ease clients' entrances into both the dramatic language and self-revelatory experience. The therapist is keenly aware of clients' fears and anxieties about the process and helps to ensure the safety of the journey. At the same time, the therapist challenges clients in accordance with their capacities.

The playfulness inherent in drama therapy, along with the option of distance from tackling real-life issues directly, tends to reduce resistance. On the

other hand, clients in drama therapy may be wary of play that seems childish or of being asked to act other than how they feel or who they are. It is important that the therapist immediately dispel those fears by choosing age-appropriate methods, which make use of clients' actual state of being rather than asking them to play characters. According to Kipper's analysis of clinical role playing and identification of types of simulation conditions, the drama therapist would choose spontaneous conditions, in which the person plays herself or himself (Kipper, 1986, 1992).

Adolescents are particularly wary of any activity that may appear childish, and they prefer enacting realistic scenarios, based on relevant themes. They often gravitate toward sociodramatic scenes they can all identify with, rather than those that focus on individual concerns. Props can be used to increase a scene's realism or to create necessary distance. For example, a telephone is a prop I frequently use with adolescents. Because the phone is such a familiar and cherished object to teenagers, it tends to invite participation and reduce inhibitions and resistances. A telephone also signifies communication, at a distance, making it an appropriate tool in therapeutic work. The attentiveness to choice of method reduces resistance.

Clients are first invited to enact actual feelings and emotional states rather than those that are foreign. For example, acting-out clients may enact—in the context of a dramatic game—rebelliousness or hostility, and thereby immediately experience an acknowledgment of who they are and how they feel, at the same time that they experience success at the activity. The exaggeration of one's actual behavior promotes humor and perspective on that behavior (Emunah, 1983) and gradually enables clients to experiment with alternate behaviors. The activation, as opposed to the suppression, of the resistance releases energy that can be channeled constructively and creatively—for example:

> During a period of resistance within a group of "high functioning" adults, I began the session by designating corners of the room to represent particular feeling states. In an attempt to better understand the nature of the resistance and to facilitate active expression, I indicated that one corner was permeated with rebelliousness, another with anger, another fear, another depression. Group members were to go to whichever corner they wished, but once in that corner they were to express only the designated feeling. They could switch corners as often as they chose. It was interesting to observe the corners particular members chose, how engaged and seemingly relieved they became, and how the playfulness that was intermingled with the powerful expressions seemed to bring about some distance from the feelings and gradually some shifting. After some rounds of witnessing and of joining the interaction in various corners, I asked the group to rename the corners. We did several rounds, each time getting more specific and closer to the heart of the resistance, and eventually to a transformation of it.

Over the years, I have worked with very resistant groups, including acting-out adolescents and severely depressed adults. My approach with adolescents

entails engaging their healthy and age-appropriate rebelliousness as a way of bypassing their resistance to treatment (Emunah, 1985, 1995). A power struggle is averted by the playful manner in which aggression is permitted and mobilized, as well as contained, within the dramatic arena. This is a paradoxical approach (Erikson, in Haley, 1973; Minuchin, 1974) in which the client's resistance is used in such a way that resisting actually becomes cooperating. Given the similarities between acting-out, which is dramatic in nature, and acting, the former can be converted to the latter so that the acting becomes conscious (Blatner, 1996), inviting a self-observing ego to monitor actions and make choices.

Similarly, the passive and depressed states common among many adult psychiatric patients can be incorporated into the dramatic activity. In a game in which one person leaves the room while the others decide on a mood that the whole group will display when the person returns and attempts to guess the group mood, patients frequently suggest enacting the feelings of being depressed, tired, or lonely. The feeling states are thus acknowledged and actively expressed; paradoxically, the clients simultaneously gain a sense of success at their acting abilities and a degree of distance from the enacted mood. In addition, methods geared toward a high level of nonthreatening interaction reduce resistance with such a population. Success in breaking through the isolation that many of these patients experience creates a shift in their depressive state, releases some energy, and transforms their passivity into activity within the session.

Little resistance is encountered in drama therapy with younger children, for whom play, including dramatic play, is part of their natural mode of self-expression. However, in work with children whose childhoods have been interrupted by traumatic or painful experiences, embodied role play can be threatening. At the beginning of therapy, more distanced play, involving the use of objects (e.g., puppets or dolls) rather than one's own body, can reduce resistance. In individual drama therapy with such children, the action-oriented therapist may first invite the child to make a sandtray (Lowenfeld, 1939; Kalff, 1981). Dramatic activity is introduced over time, gradually and unobtrusively. Static sandtray depictions progress to storytelling connected to the trays, at which point the therapist give voice to a character in the story as the client, serving as director, feeds the lines. Eventually, the child will give voice to his or her characters, and before long, the therapist and the client will be able to dramatize the story together. The therapist's role shifts from witness to fellow player, and the heightened action in the session tends to increase emotional expression, clarify symbology, and facilitate the assimilation of new learning.

The relationship between the therapist and the client is always at the heart of therapeutic work and is the primary factor that diminishes the client's resis-

tance to action-oriented work. In group work, the relationship between group members is also a crucial element in sustaining the participants' involvement and commitment to the treatment process.

Transference and the Client-Therapist Relationship

Transference and the nature of the client-therapist relationship are affected by the fact that the drama therapist actively participates in the process, especially in the early stages of group work. Even if the drama therapist does little or no direct self-disclosure, her or his active involvement and interaction enables clients to experience the therapist more fully as a fellow player, a fellow human being. Moreover, the therapist will often play roles in the clients' dramas, especially in the context of individual therapy. Generally, the drama therapist has a more varied repertoire of roles in the session than does the psychodramatist, who is typically in the role of director throughout the process. The sense of fluidity in the relationship between drama therapist and client as they weave in and out of various play modalities and roles somewhat minimizes the tendency to form a fixed transferential relationship.

In drama therapy, the therapist sees the client in a multitude of roles, both in and out of dramatic scenes, which gives the therapist an expansive and complex view of the client's inner and outer worlds. The therapist's capacity for deep empathy is heightened by witnessing live enactments revolving around the client's struggle and pain; that, of course, is equally true in psychodrama. Kipper (1992) cited the importance of truly sensitive, caring, and empathic relationships in therapy. In group drama therapy, such empathic relationships are also developed and fostered among group members.

Even though transference is not as accentuated in drama therapy as in verbal psychoanalytic psychotherapy, it is nonetheless a carefully examined therapeutic factor. In group drama therapy, the multileveled responses that group members manifest toward one another are given equal consideration with the transferential relationship to the therapist. At any given moment within a group process, multiple interrelationships are in operation. Transferential feelings can often be playfully expressed or more directly explored through role play. For example, a client and a therapist may reverse roles or dramatize some of the dynamics in the transferential relationship.

Dramatizations that occur within the sessions, unrelated to transference with the therapist, can also evoke or accelerate underlying transferential issues. The drama therapist needs to pay careful attention to the client's responses, particularly after she or he has engaged in evocative role plays, for example, role playing the client's mother or lover. Romantic feelings can develop between group members as a direct result of playing a fictional scene in which they were romantically involved. Dramas, when enacted with authenticity and integrity,

seem quite real, and participants experience each other in new ways and contexts within the dramatic arena. Three important tasks for the drama therapist are the establishment of clear boundaries between dramatic scenes and real life, a process for de-roling the participants, and methods of helping clients become conscious of their emotional responses to enactments.

Clients are often best able to express concerns regarding their relationship with the therapist through metaphor and enactment. That is especially true for children. For example, a 6-year-old emotionally disturbed boy began repeatedly placing a drama therapy intern in the role of wife. In their improvisations, he obsessively insisted that she stay in bed while he cooked, went to and returned from work, and ran errands. Finally, it became clear that to this boy a wife symbolized someone he could keep forever. As a husband, he could be the one to come and go, explore his growing world and identity, and always have someone to come back to—an experience he unfortunately had not had with his actual parents. When he began that repetitive role play, he had just become aware that the intern would be leaving.

Transference naturally surfaces more fully during in-depth individual drama therapy than in brief work or group therapy. The following extract is an example drawn from individual drama therapy with a $2^1/_2$-year-old boy, Tory, who had been removed when he was 2 from his severely physically abusive, biological mother and placed with a nurturing foster mother. His biological mother, however, was attempting to be reunited with him, and he had just started having supervised visits with her. The day before our session, his foster mother had been informed that before long, Tory might be returned to his biological mother.

> Tory, usually so playful, active, and eager in our sessions, was silent and still. He appeared sad and would not speak. I laid out a paper and crayons for him. As had become a custom in our sessions, he scribbled lines, and then quietly identified them as members of his world: his sister, his foster mother and siblings, etc. For the first time since we had begun this scribble game, his foster mother was omitted from his scribble picture. I asked him why "Nana" was not in the picture. He said nothing but leaned against me and before I knew it he had crawled into my lap. "Are you feeling sad and scared today?" I asked softly. He nodded ever so slightly. "And in need of comfort?" Again the subtle nod, as though that much movement was all the energy his little body could muster. We continued this interaction of my asking him questions that I imagined articulated what he was feeling, and his nodding or shaking his head to give me feedback. Suddenly I felt his hands opening my shirt and his mouth reaching toward my breast. Shifting positions, I said, "You want to nurse, don't you?" He nodded. "You want to be held and cared for and be a baby again, with a mommy." More nodding.
>
> Gently, I stood up, and took him to the shelves of toys, where we picked up a toy bottle. Supporting him again in my arms, I held out the bottle to his mouth, and

> for about five long poignant minutes, he sucked the nipple of the empty bottle. I continued speaking to him, softly, and awaiting his nods. When he would shake his head, I would modify my words until he offered the nod that indicated I had gotten it right. And then I spoke some statements that I thought may be important for him to hear. These utterances revolved around how much he deserved to be held and loved, what a good special boy he was, how his foster mother loved him, how his biological mom also loved him even though she had had trouble taking good care of him, how lovable he was, and how he was going to be receiving a lot more love in his life.

Tory's tranference had been dramatically manifested in that session. Although I could not really be his mother (nor nurse him), I could be a temporary surrogate mother and by using the toy bottle as a prop, indicate that we were playing at mom and baby—just as we had pretended in dramas in prior sessions. Moreover, the pretending, or playing out, was also serving real needs, and allowing, as far as is possible within the therapeutic context, actual nurturance and some moments of a corrective experience.

My own countertransference was evoked, involving maternal feelings and the desire to give this deprived child so much more than is possible within the limited confines of the therapeutic relationship. However, even within the boundaries of the therapeutic context, a boundless sense of care and empathy can be conveyed toward a client in need. The dramatic arena enables these boundaries to be respected and expanded simultaneously. Within role and play some of the most real healing occurs.

The Use of Metaphor and Role of Interpretation

Scenes in the early stages of the Integrative Five-Phase Model tend to be metaphoric, symbolic, or fictional. The metaphoric realm enables the expression of emotions, themes, and issues that the client might not be able to tolerate expressing directly. Unconscious material is also expressed and grappled with through symbolic and metaphoric play and enactment. Children in particular reveal their inner concerns metaphorically. Metaphoric play serves not only a communicative function but also a healing one. Dramatic play, according to Erikson (1950, p. 222), is "the most natural self-healing measure childhood affords."

Inherent in the dramatic mode is a sense of freedom and permission to imagine, create, invent, and experiment with roles and situations that are outside one's real-life reach. In drama therapy, it is important to support and enhance that experience of limitless possibility. Premature interpretation is at best inhibiting; at worst, it can destroy the healing essence of the dramatic mode. Interpretation, however, can also be an integral part of the therapeutic process. The question is not whether to incorporate interpretation but when to do so. The Integrative Five-Phase Model attempts to clarify for the drama

therapist the issue of timing. In the third and fourth phases, interpretation is a significant component of the therapeutic process, whereas in the first and second phases, interpretation is rare.

Before interpretation is incorporated, the drama therapist is nonetheless observing and noting patterns in the client's dramas. Such patterns include recurring roles, dynamics, responses, themes, as well as styles of role playing. At the same time, it is important that the drama therapist not make simplistic assessments or analyses but stay in the present, supporting the client's dramatic work and avoiding any hasty conclusions. Even when patterns do become clear over time, interpretation must be carefully timed and framed. As in any therapeutic arena, it is best to facilitate the client's own capacity for insight.

Within the metaphoric realm, the drama therapist can offer the client a great deal of support and empathy. When a child claims that her doll is very sad, the therapist can offer the doll understanding, or comfort, or can ask the child about the doll's sadness. Even better, the drama therapist can help the client play out a scene related to the doll's feelings. The drama therapist can also challenge a client within the metaphoric realm. For example, when an adolescent revels in assuming the role of a powerful drug dealer, the therapist can interview him about both positive and negative aspects to his life or could direct a scene that takes place at a future point, when the dealer lands in prison.

The meaning of the scene and the best way of intervening gradually crystallize as the scene is played out. In this sense, the drama therapist is very much a theatrical director, helping to draw out, develop, embellish, and transform the raw material of the scene. As the scene unfolds and expands, its nuances and complexities emerge, and with time its therapeutic significance is revealed—for example:

> A group of adults in a psychiatric day treatment program, many of whom were grappling with self-abusive behaviors, began one session bantering about an imaginary planet. Helping them develop their ideas, I interviewed them about this ideal planet, which the group named Glockenspiegal. Soon we moved from discussion to dramatic enactment. One person in the group played a newcomer from Earth who was being given a tour of Glockenspiegal. There were special eyeglasses that helped one to see more broadly, a cleansing machine that rinsed off the overwhelming emotions Earthlings enter with, and gentle explanations of how on Glockenspiegal there is no violence or child abuse toward others or toward one's own self. Sadness existed, but "there is a sweetness to the sadness," and tears are honored.
>
> After the extended enactment, the group members sat in silence, clearly moved by the poetry and vision they had co-created. I sensed too some letdown at their return to Earth, to reality. "We have just traveled," I said, "to an incredible place. And like all traveling, there are things we take back with us, that continue to

> affect us, that we carry within us as we return home. What is it about Glockenspiegal that you can bring back with you to Earth?" Their responses created a bridge between the two worlds/planets, between fantasy and reality, between the wished-for and the possible. The discussion sustained some of the poetic tone that had been established in that session, at the same time that it became a way of helping the young people to integrate the experience they had just had.

Experiences within the metaphoric realm can be just as "real" and as powerful as those that deal directly with actual life events. It is amazing how much clients register symbolic or metaphoric play, even when interpretation is not involved; the unconscious absorbs and sorts multilevel meanings, even when the conscious mind is unaware of those meanings.

Levels of Intervention

One means of intervention in drama therapy is through the direction of improvisational enactments. The drama therapist intertwines theatrical and therapeutic skills in determining the most beneficial ways of developing the enactments. An exciting aspect to the direction of scenes is that the theatrical and therapeutic needs usually coincide. That is, direction from an aesthetic perspective will often elicit deeper psychological content or lead the scene toward deeper expression or resolution. Moreover, directing from a therapeutic perspective will often result in a more effective theatrical creation.

In intervention, the dramatic techniques that are frequently used by both drama therapists and psychodramatists include role reversal, doubling, and playing with time.

- Role reversal helps the client to experience a different perspective, expand role repertoire, or achieve some distance.
- Doubling helps the client to become aware of, and express, underlying feelings or thoughts, and also to experience the support of others.
- Playing with time, analogous to Moreno's future projection, enables the client to explore consequences or outcomes when a scene is "fast forwarded" to the future. It also can deepen insight or understanding when a scene is "rewound" to the past.

Another intervention in drama therapy involves adding or eliminating characters from a scene. In general, the addition of characters adds scope and new perspective, whereas the elimination of characters deepens the scene; the former tends to increase emotional distance and the latter to decrease emotional distance. An intervention that I frequently use is repetition. I apply that intervention when the objective is to decrease emotional distance in a scene. Without interrupting the client's concentration, I ask the client to repeat a line that was spontaneously uttered in the scene. The line or words are generally emo-

tionally charged or particularly significant. Sometimes I direct the person to continue the scene, using only that line.

Interventions must always be used intentionally. Role reversal, for example, should not be used at a point when helping someone achieve a greater connectedness to a role or emotion is needed because that intervention would probably result in increasing distance. Repetition of an emotionally laden line should not be used with a fragile client who has already reached his or her tolerance point of emotional expression.

In drama therapy, interventions interweave dramatic and verbal modes. As I previously stated, there tends to be a progression in the course of treatment toward increasing the integration of the verbal, along with a greater emphasis on insight and interpretation. In the later stages of treatment, however, multilevel dramatic interventions remain primary. Dramatic, action-oriented approaches help the client to stay emotionally, physically, and sensorially connected to the content of the personal material.

The drama therapist's interventions tread between focusing on interpersonal and on intrapsychic dynamics. Often the work begins with interpersonal issues, such as relationships with partners or parents, and progresses to dramatizations revolving around the identification of emotions or to dramatic scenes in which one addresses oneself. At other times, the work begins with feelings or internal dynamics, such as a sense of loss or a need to be more autonomous, and then progresses to more concrete enactments dealing with particular relationships or practicing new behaviors.

Drama therapists and psychodramatists are often challenged to find creative ways that meet the multiple, diverse needs that arise in a group. The more closely tailored the work is to the unique group or individual, the more effective the outcome. The drama therapist is constantly incorporating and devising methods that match the point within the therapeutic journey at which clients are engaged. One can often initiate processes that contain some combination of the familiar and the surprising as a way of simultaneously "joining" the group in territory they know well and engaging their curiosity and excitement. In the following example, psychodramatic scene work is preceded by a playful, creative process specially designed to address particular challenges.

> Mid-way through a 2-day intensive training program that I conducted in Israel with a group of graduate psychology students, I struggled to find the right means of dealing with the following disparate issues that were present in the group. First, I was working with a group of 30 people—too many people for an intimate group process. In addition, the group was composed of a number of clear subgroups. The entire group had not worked together before, and there was little sense of group cohesion or trust, although that trust did exist among the subgroups. Second, I sensed both a desire by the participants to experience "deeper level" work and, at the same time, a palpable fear of, and resistance to, this deeper, more emotional, and personal work. Third, the group had a tendency to chat

in the middle of both lecture and experiential work, which was distracting to me. To the participants, that was clearly a culturally familiar and normal behavior that only slightly interfered with their overall level of concentration.

During my stay in Israel, I had noticed that everyone was walking around with cellular phones. In Tel Aviv, people, along with their ringing phones, swarmed into cafés. During the class lunch break, I rearranged the room, placing six tables, with varying numbers of chairs around each table, throughout the room. When the participants meandered back to the training session, I immediately invited them to our café. I suggested they sit with those they knew best in the class. Smiling, they gladly joined their circle of friends around a table. Then 30 pairs of eyes looked at me expectantly. I said, "Now, take out your cell phones!" There was a moment of silence, and then a roar of laughter. Delighted and rather shocked because teachers usually told them to put their phones away, those with cell phones, which was most of the class, brought their phones to the tables. I told them that when our scene began, each table would be engaged in a discussion about phone calls they wanted to make but were afraid to do so. No actual calls would take place at this stage, and the conversation might be as much about why they would not make a given a call as about why they were tempted to make the call. As the scene began, I assumed the role of waitress; in that way I could oversee and playfully interact with each group. After a few minutes I suggested that their orders to the waitress become metaphoric, asking for what they needed to feel more willing or able to make difficult calls.

After gaining a sense of the group's, as well as particular individual's, emotional readiness and ego-strength to deal with some of the work to follow, I directed one person at each table to make a phone call (dramatized, of course, with the phone turned off). The members of the protagonist's table became either auxiliaries, doubles, or actively supportive witnesses of the scene, and the larger group sat further back as audience.

The phone calls were painful. One woman called her husband to express her fears about their deteriorating marriage; another called his mother, by whom he felt suffocated. The scenes progressed, beyond the initial phone calls, to deeper levels of personal exploration and emotional expression. For example, one woman, who began with a phone call that conveyed her confusion and anxiety at being a new mother, later enacted a scene revolving around her desire to be a child herself. Familial and cultural pressures had led her to "grow up too fast," and now she felt resistant to assuming the full-fledged "grown up" responsibility of parenting. There were many facets and levels to her extended scene work, including a very poignant interaction with her long-neglected child-self.

By the end of the day, the group was astounded at how far they had come, both in their individual work and in the larger group cohesion that had developed through witnessing others' scenes. There was a sense of universality as people identified and resonated with one other's struggles. The final hour of the day involved dramatic, ritualistic processes with the entire group working together.

The café format had enabled the training group members to interact intimately with their own natural cohort, in a familiar, albeit pretend, environment. Side chatter, appropriate for a scene taking place in a café, was called

for, rather than disallowed. The discussion about calls they were both drawn to but were afraid of making facilitated the external expression of their concurrent desire for and resistance to deeper therapeutic work. One might call that episode homeopathic drama therapy!

Rather than fighting obstacles, drama therapists design strategies that draw forth whatever is present. They construct processes that match, heighten, and eventually heal or transform the struggles and issues of particular individuals, groups, and cultures.

Conflict and Difficulty Among Group Members

Conflicts and difficulties within groups can often be examined and resolved through action-oriented, dramatic approaches. For example, role reversal is a simple but effective method of helping clients step outside of their own experiences and into someone else's experience and perspective. A simple replay of a conflictual occurrence can be effective. For example, when two 13-year-old boys entered a group after fighting, I asked them to replay what had transpired between them. Backtracking in order to reenact what had preceded the fight enabled them to achieve some awareness about what had triggered each of them. The scene was interrupted by many "freezes" and pauses, which provided safety, containment, and distance and also triggered a blow-by-blow (no pun intended!) examination of each moment. In the replay, I again froze the scene just before the point at which one boy had physically struck the other. Through monologues and the use of doubles, we explored each boy's internal feelings and associations at that moment, and later we strategized, with the rest of the group's help, alternative behavioral responses.

The drama therapist continually exercises creativity in devising strategies for work with unusually difficult situations. The following example begins psychodramatically, but the incorporation of specially tailored distancing devices helps the work progress more effectively.

> José and Gary, two men in an adult drama therapy group in the community, were increasingly antagonistic toward one another. They chose to ignore each other, but the tension between them had been mounting for weeks and was now affecting the entire group. I decided to confront the matter in a drama therapy session. I tried directing simple dialogues between them and then having them reverse roles to experience and communicate the other's perspective. I also tried doubling, in which each became his own inner voice and later became the inner voice for the other. Each process seemed to result in little change. The depictions of the other were superficial and subtly denigrating. Once the role plays ended, José and Gary immediately resumed their own rigid positions. I realized I had to find a different strategy.
>
> I asked José and Gary to chose someone in the group to play/represent them. By now everyone in the group was familiar with each of their positions and

demeanors. José chose Carmella, and Gary selected David, both trusted members of the group. I told Carmella and David, playing José and Gary, that they were about to enter a mediation session. The scene was to begin with them sitting in the waiting room of a therapy office.

I then told José and Gary that they were to assume the roles of cotherapists who had been working together for years. Their next appointment was a therapeutic mediation between two men in conflict. When they were ready, they could call the two men into their office and begin the work.

The ensuing scene was amazing to watch. Carmella and David played the roles of José and Gary accurately and respectfully. José and Gary fully embodied their new roles as cotherapists. They worked together gracefully, collaboratively, and skillfully, drawing forth their clients' concerns and feelings, offering feedback and their perceptions of the clients' attitudes and perceptions. Finally, with my side-coaching, they examined possible steps toward resolution.

When the scene ended, José and Gary, still half in their roles as cotherapists, spontaneously shook hands. A moment later, their roles fully shed, they hugged. I could feel, if not hear, the collective sigh of relief from the larger group. José and Gary had clearly benefited from the increased distance the scene afforded them—the experience of working with, rather than in opposition to, the other; of being empathically "mirrored" in the sensitive role playing of fellow group members; and of having to come up with their own prescriptions for what to do. All they had to do now was follow those self-designed, collaboratively concocted prescriptions for solving their problem.

Spirituality in Drama Therapy

In ancient and non-Western cultures, drama, healing, and spirituality were inseparable. In contemporary drama therapy practice, these three strands are once again joined. Through dramatic ritual, which is a main source and aspect of drama therapy practice, clients can express, contain, and digest the myriad experiences that arise during treatment. The nonlinear, nonverbal language of ritual facilitates the expression of untranslatable, complex, multilevel feelings. Ritual is used particularly at the close of a session and of a treatment series. A sense of awe arises as clients undergo a process that involves uncovering layers, accessing the unconscious, discarding masks, coming to know and care for themselves and others in a profound way, and transforming pain into art. Ritual is a way of reflecting, containing, and celebrating the transformative journey.

Even aside from the use of ritual, there are moments that spontaneously arise during both group and individual drama therapy and psychodrama that move both client and therapist out of the realm of the ordinary and into a spiritual domain. My experience with a young client illustrates this point.

Latisha, a 10-year-old client living in a foster home after being removed from her physically abusive and severely neglectful family, was afraid of the dark. But in

one session, which took place close to Halloween, she turned off the lights in the room and then closed the shades and curtains. I understood the gestures to symbolize her willingness to confront the darkness, her fears, and also her growing trust in me, in herself, and in the process of our work together.

In the blackened room, she asked to light candles. We sat down by the two candles. Then she said, "Let's say prayers." I think the hallowed atmosphere that she had created reminded her of church. I said, "Yes, let's. Let's make up our own prayers." She was still and quiet but more attentive and present than I had ever seen her.

R: Are we going to say our prayers out loud?
L: No, in our mind, and then we blow the candle out.
We started saying the prayers "in our minds."
R: (Whispering) Do you want to share our prayers, maybe in whispers?
L: OK. You go first.
R: I pray that children of the world don't get hurt anymore.
L: I pray that my Mom and Dad will get back together.

I could hear Latisha's sigh intermingled with her breath as we blew out the candles. It was the first time she had voiced that longing. Latisha suggested we light the candles again and stand up. This time she whispered, "I wish my whole family would be back together."

In recent sessions, Latisha had begun to manifest a degree of acceptance of her foster family. I was amazed at how she was now also able to disclose her suppressed desire for her abusive biological family and to express her ambivalence and confusion. The ritual of candle lighting-praying-candle blowing went on, and Latisha continued voicing, in the prayer format, stifled longings.

We blew out the candles for the last time and stood in silence in the dark room. Then Latisha declared, "Now we sing." She began to sing *Amazing Grace*. I joined her. In the still, blackened, prayer-filled room, this beautiful, wounded 10-year-old African American girl and I sang in unison the most spiritual song I know, a song about salvation and renewal. The context was therapy, but what I think Latisha and I experienced was the sacred.

It was through following my young client's lead and trusting her instincts and her natural inclination toward healing herself, that a spontaneous ritual emerged. When we later sang together in darkness, I was reminded how much our work, at the center of which is the connection between therapist and client, recalls the human spirit and touches the soul.

Conclusion

The range of Moreno's work is broad and far-reaching, catalyzing and influencing many fields, including group psychotherapy and the creative arts therapies (Blatner, 1997). Of all the creative arts therapies, drama therapy is obviously the most closely aligned with psychodrama. Many drama therapists

and psychodramatists draw a clear line between the two disciplines. In this article I have attempted to present a model of drama therapy that purposefully incorporates psychodrama in latter stages of a developmental group process. The model emphasizes group interaction and cohesion, elements that provide the foundation for the eventual intimate, psychodramatic work. The clinical examples in the article relate to group cohesion, choice points revolving around the group versus the individual, and conflict and difficulty among group members. I also discussed a playful, paradoxical, and dramatic approach to dealing with resistance.

One of the most cited differences between psychodrama and drama therapy is the focus of drama therapy on metaphor and the incorporation of fictional enactments. I have examined the use of metaphor and the role of interpretation from the perspective of an integrative model. Whether dealing with imaginary, symbolic, realistic, or actual situations, the drama therapist develops scenes with a theatrical as well as a therapeutic sensibility and combines the aesthetic with healing strategies through the levels of intervention.

The client-therapist relationship, an empathic, dynamic therapeutic relationship, is at the heart of drama therapy and psychodrama and is a fundamental part of all the clinical examples in this article, particularly the final example in the section on spirituality. Spirituality is an area that is not often discussed within the field of psychotherapy, but drama therapists and psychodramatists have long been rekindling the ancient link between art, healing, and the sacred.

Drama therapy and psychodrama are both active approaches to psychotherapy that use dramatic processes. When the two disciplines join forces, in a systematic and integrated fashion, the client embarks on a therapeutic journey that is extremely rich and layered. In a sense, the client is both clothed in colorful costumes, offering an array of new possibilities, and also bared as she or he unravels and reveals core issues. In the context of a therapeutic relationship, the raw material of the client's imagination and real life is creatively concretized and gradually transformed. The therapist's artistry in interweaving the essential elements of drama therapy and psychodrama helps the client to become an artist empowered to express and master the raw material and to generate new sources for renewal.

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