

Where is the Therapy in Drama Therapy  
When Working with Children  
with Severely Disruptive Behavior?

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## Abstract

Where is the therapy in drama therapy when working with children with severely disruptive behavior?

Cindy Gaffney

There are two main themes discussed in this paper. The first is one drama therapy student's growth process over the course of her last academic year. The second theme deals with using drama therapy effectively with different populations and how she learned to adapt drama therapy best to suit her specific clientele of children with severely disruptive behavior. The paper explains how drama therapy can exist on a continuum which moves from drama being therapeutic in and of itself to clients being cognitively aware of the issues in their life which are causing them difficulty. There is an explanation of how goals were re-evaluated to better serve the specific population. In working with this group, there was a new understanding about how to approach therapy. Important themes were the use of boundaries and containment, play, planning, and acceptance and advocacy.

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## Chapter 1

### **Where is the therapy in drama therapy when working with children with severely disruptive behavior?**

*“Success is not a place at which one arrives but rather ... the spirit with which one undertakes and continues the journey”*

*(Alex Noble, 1998, in Simpson's Contemporary Quotations).*

Over the course of the last year (1999-2000), I have learned a great deal about my specific population (children with severely disruptive behaviors), drama therapy, and what it means to be a drama therapist. I have also learned a great deal about research and how best to tailor your research to follow your own personal learning process. My personal process was a very important part of my development as a future drama therapist and I thought that I would be remiss if I did not include it in any explanations of my work with my clients. Due to this fact, I have chosen to do my final year-end research paper describing my changes in attitude and how they effected my development. As a student of drama therapy, I have used one specific question to help me to focus my education: “Where is the therapy in drama therapy?” and it soon became my battle cry. I found that this question does not have one clear, correct answer, but that it is different for every therapist. The answer depends on the individual therapist, their personality and style. As well, the specific population greatly influences the working method of the therapist.

My practicum site this year was in an institutional setting with children, ages six to eleven. All of the children who participated in the programs were referred due to their disruptive behavior, both at school and at home. The unit worked under one main



psychiatrist who oversees the progress of each client. There were a number of different professionals and students who worked as part of the team within this unit. The professionals included: a psychiatrist, psychologists, teachers, a social worker, an occupational therapist, art and music therapists, student drama and art therapists, nurses and child-care workers. The programs instituted by this unit included drama therapy, art therapy, family therapy, school, 'gym and swim', and social skills training.

The clients were split into three different groups with a set number of six participants in each age group. Every day, these children went to school for half their day or three hours, on the unit, and the rest of the time was devoted to group and individual therapeutic activities such as drama, art or music therapy. When the participants were not in therapy, the child-care workers worked with them on social skills, community building and homework. Once a week, usually in the evenings, each participant had family therapy. Participants also saw the occupational therapist on occasion. The occupational therapist was also responsible for any specific testing, both cognitive and physical of each client. There were meetings, once a week, where all of the professionals could quickly review each child. As well, once a week, a different child was chosen to be discussed in depth. The professionals in these ITP (Individual Treatment Plan) meetings were responsible for discussing the progress of each client and developing a plan for the future. This unit continues all year long but the student therapists only participated during their school year.

I worked with three different groups of three but, for the purposes of this paper, I will be focusing on the middle age group (ages ranged from 9-10). One of these children has been diagnosed with attention deficit hyperactivity disorder and conduct disorder. The other two have been diagnosed with oppositional defiant disorder. As I began to work at my practicum site, I became frustrated with my inability as a drama therapist. As my work progressed, I felt that I was not doing “therapy” with these children. I had been struggling for the first part of year because they were having difficulty fully participating in the session. (A number of group members were asked to leave the sessions on a number of different occasions.) I did not think that it was possible to built a cohesive group with these children that would be able to offer its group members the kind of support necessary to safely explore any issues which might arise in the therapy. I realized I had been too hard on myself. I thought that the therapy came in only when we were working towards making big life changes. I thought that I had been failing because there was no evidence of a great deal of change within my group members. I came to realize that children are not able to do “therapy”, as I understood it, but that they were able to work using metaphors.

There are two main purposes to this paper. The first is a discussion of the therapy in drama therapy and the second is an account of my personal development as a therapist.

Due to the length of this paper and the nature of the practicum site, there are a number of limitations. One limitation is that I will not be discussing therapy as it pertains to adults. Another limitation is that the therapy process was only for a limited amount of

time, one academic year. The group size placed limitations on the generalizability of the information. There were only three group members and therefore this paper can only be seen as a description of the process. Another important fact to mention is the use of medication in the treatment of these various disorders, especially attention deficit hyperactivity disorder (ADHD). In the institutional setting that I worked in, medication was an important part of the process, but there are more detailed reviews of the effects of medication on these various disorders. The usefulness of medication in the treatment of these disorders is not a focus in this paper.

## **Chapter 2 My Dilemma**

As I began my work and my journey, I was feeling inept and very insecure. I had the benefit of having one year's worth of experience which had been fairly successful. Unfortunately, this success could be due to the fact that I had a partner or it could be that the population was well suited for this type of intervention. There was a possibility that the success was not due to anything that I had done. I decided to model my work after dramatherapist Sue Jennings' theory of embodiment, projection and role (EPR) because I thought it would be best suited for work with children.

### **What is EPR?**

Ann Cattach (1996) quotes Sue Jennings describing the play of children evolving through three developmental stages from early infant experiences to the complex dramatic play of the young child. These three stages are: embodiment play, projection play and role-play. It seemed important for me to use this method of working with these

children because it allowed them to experience each previous level before continuing on to the next. It is possible that, due to a lack of a nurturing environment in their infancy, these children might not have experienced embodiment play, which might effect the levels that follow.

Embodiment play refers to the first level of development when children are still exploring their own bodies and then using their bodies to explore the world around them. This exploration makes children aware of their five senses: sight, smell, hearing, taste and touch. The use of the five senses leads to a new awareness of the sensations that they cause in the body. This, in turn, helps each child to become more connected to their own bodies. Children, then, can better interpret these new body sensations as emotions. Emotions and body sensations have always been closely linked to one another. There are a number of common phrases that show this link. When people are sad and they cry, they are said to “have a lump in the back of their throat”. When people are nervous, they have “butterflies in their stomach”, their “hands shake” and they “break out in a cold sweat”. When people are scared, it raises “the hair on the back of their neck” or they are said to have a “hair raising experience”. Lastly, is the phrase “breathless with anticipation”.

Embodiment play, developmentally speaking, occurs first in babies. It can be seen when babies move their hands around and play with their toes. Exploring the body and its physical movements leads to new experiences of body sensations. Children who are a little older can begin to experience the difference between tensions in the body and

relaxation. Being in a more relaxed state can help to facilitate their self-awareness and help them to be more receptive to their sensations and emotions.

Embodiment play seemed to be advantageous for these children for a number of reasons: The first is that helping these children to be in better touch with their bodies and senses might help them to be aware of their emotions. This, in turn, might help them to be more connected to their emotions and it might help them to be more self-aware. Secondly, exploring the body and how it functions might help these children to have more direct control over their impulses and movements. Giving them a sense of control over their own bodies seemed to be a fundamental step towards healing. Lastly, a number of the embodiment activities can help to facilitate groundedness. Several colleagues suggested to me that helping these children to be more grounded would help them to be less active.

Some examples of activities in drama therapy that can help to facilitate embodiment play are: playing with slime, dance/movement, experimenting with physical movement, using a blind fold and feeling objects to guess what they are, playing with various musical instruments, listening to music, building sculptures out of fruit and then eating them, and any other sort of activity which can help clients to explore their bodies or their senses.

The second developmental level is termed projection play. According to Jennings, projection play begins when the child starts to explore the world around him.

This leads to encounters with toys and other objects. Symbolic play occurs when children begin to understand that these toys represent things in the real world. Once the child has learned that, they then can continue to learn that anything can be used to represent a specific object. Ann Cattanach (1996) described this as playing “...in the “as if” mode: ‘Let’s play as if the chair were a car’” (p. 6).

Projection play in drama therapy can be encouraged through a number of different activities: drawing, transforming an object, plasticine, sand trays, puppets, finger puppets, mask work, stories and story telling. Projection can be progressive as it leads from two dimensions, as in drawing, to three dimensions, as in plasticine, sand tray figures and puppets. Stories and story telling can occur at the end because they seem to be the most natural lead in for role-play.

The third developmental level is role-play. It is a natural progression after projection because it moves from using objects “as if” they were something else to “pretending” to be someone else. According to Ann Cattanach, at about age four, children can begin to play socially with other children. In their role playing, they can create make believe scenarios and discuss and agree upon their roles: “You be the cop this time, and I’ll be the robber”. Role-play can be used in drama therapy in the following activities: improvisation, psychodrama, script work and re-enactment of stories, both pre-existing and client authored. “Psychodrama is a form of therapy and education that uses a wide range of action methods to examine subjective experience and to promote constructive change through the development of new perceptions, behaviors and

connections with others” (Callahan, 1989, p. 102). For a more thorough explanation of psychodrama see Blatner’s (1996) book, Acting-in: Practical Applications of Psychodramatic Methods (3<sup>rd</sup> Ed.).

The group that I have chosen to feature in this paper has only three members, two boys and one girl. To ensure their confidentiality they will be referred to, in this paper, as Mark, Steve and Sally.

Referrals to this specialized unit came from a variety of places. The three members of this one specific group each came from a different referral agency. According to the records, Sally was referred to this unit by social services because of unpredictable and aggressive behavior, at home, to her family and at school towards peers. There had been a great deal of family difficulties which ended with the total withdrawal of the mother from the family. Then, Sally was moved to live with a foster family. Sally had a lot of anger, hopelessness, insecurity, anxiety, fear of abandonment; she was an emotionally needy child. She also had trouble interacting with peers.

Mark was referred to the unit by a psychologist from community services because of aggressive behavior at home and at school. Mark also had family difficulties and suffered from fear of abandonment. He showed signs of intense anger and sadness. He had problems with authority figures and he had some learning disabilities as well.

Steve was referred to the unit by his schoolteacher and the O.P.D. (outpatient department) team because of hyperactivity and aggressivity with adults and children

demonstrated at home and at school. The files stated that Steve seemed very angry, threw temper tantrums, often swore and was rude. While Steve still lived at home, his family life was not very stable. There are often loud noises, arguments and it is usually active, disorganized and chaotic.

Once the children are on the unit, it is up to the child-care workers to refer them to drama therapy. These three children were chosen because they were all thought to have a talent for dramatics. There is an important quote from Josiah Dodds that sums up the type of work that is done in this institution:

“Often children are brought to a mental health professional with a primary symptom such as bed-wetting, learning disability, or attention deficit and also with associated feelings of incompetence, shame, depression and negative self-image. In these cases the approach could be twofold: (a) direct intervention on the symptom (e.g. bell and pad for bed wetting, remedial teaching for the learning disorder or medication for the attention deficit) and (b) psychotherapy with play techniques to help the child change his/her concomitant feelings and attitudes” (Dodds, 1985. p. 23).

All of these children have very specific psychological considerations to take into account. Sally had been diagnosed with attention deficit hyperactivity disorder and conduct disorder. Steve had been diagnosed with conduct disorder and they were going to test to see if they could rule out learning disabilities. Mark had been diagnosed with oppositional defiant disorder but they wanted to do some testing to rule out attention deficit hyperactivity disorder and learning disabilities. Attention deficit hyperactivity disorder (ADHD) has only been officially diagnosed in Sally but it was suspected in Mark. All three of these children showed signs of ADHD. They all had difficulty paying



attention for extended periods of time and taking turns. They were all easily distracted. Steve tended to run excessively and Mark talked excessively and often interrupted. In the past, they all had difficulty complying with the controls placed on them by authority figures. Steve and Mark both showed poor impulse control. Sally and Steve both had been diagnosed with conduct disorder but again there are several features of this disorder which persisted with each member of this group. They all showed aggressive tendencies towards their family and their peers. They all needed work on their ability to have empathy for others. Both Sally and Steve had severe temper tantrums. They all had anxiety for a variety of reasons. One of the group members has had a history of stealing. I noticed Mark's oppositional defiant behavior when he deliberately annoyed people and when he was annoyed by others. All of these disorders can be linked to low self-esteem and inconsistent parenting which had apparently occurred to all of these group members in the past.

Armed only with my previous experience, a little bit of research on their histories and disorders, and a few techniques that I had in "my bag of tricks", I went to meet with my groups. The first session was very important for me to observe and assess the group members.

In this first session, I was able to determine that this group was very creative and enthusiastic. They also seemed to be better able to control some of their behaviors than my other two groups. They also seemed to be better able to function as a group. After this first group session, I was pleased with the way that the session had gone and I had

high hopes for this group and its future. I also noticed that there was a bit of tension between two of the group members Mark and Sally. One of the group members, Sally, mentioned a text entitled *The Caterpillar and I*, that they had been working on in school. (For a copy of the text please refer to Appendix A, page 72.) She said that it was about a butterfly. She asked if we could use it in one of the groups. I told them that I would see if we could use it. In between the first and the second session, I went to their schoolteacher to find the text in question. I then decided to spend the next session focused on this text. I figured that if it was a topic that they were all familiar with and they all seemed to connect with it, why not use it? It seemed like a lovely metaphor.

The second session I structured around this text. I was a little surprised that one group member had the text memorized because this was not a requirement of the initial assignment either from the English teacher or myself. After reading the text, I lead them through the developmental stages of the caterpillar changing into a butterfly. I then asked them to draw a picture of their favorite part of the development. I was a little shocked that all of the pictures they had drawn had to do with the cocoon stage of the life cycle. To me, this was their way of expressing the fact that they all need to be held and contained. (Containment and boundaries will be discussed later in this paper, on page 45). I thought that they all needed security, safety and protection. They all had had difficulties with their families in the past and they needed some time to help heal those wounds. It was interesting to me because I think that this was also the stage of the life cycle in which they all seemed to be. They were all working towards some change and they were not sure what that change would look like once it was finished.

I noticed that in this group, the two boys would do an activity together and leave out the girl. During this session, she became upset and she regressed to a much earlier stage in her development. She began to suck her thumb, pout and cry. She could not stay in the group. She left the group to go back to the unit. I was shocked by the speed at which this transformation happened and the intensity of her reaction. There was very little I could do to help her because it happened so fast. I also felt that it was a failing on my part that she was not able to stay in the group. I thought that her departure was due to the fact that there was not enough safety in the group and that she did not feel contained.

During the third session, all of the group members spent a great deal of time and invested a great deal of energy into building some masks. Once they were built, each individual had an opportunity to use them to tell a story. One of the stories was about a ninja turtle breaking free of its egg. Another story was about the gargoyles and the fact that they are frozen during the day. Both of these stories had strong, confident characters. The last group member pretended to do a very quick juggling act with imaginary balls. All of the participants were willing and able to contribute to each other's stories. At the time, I was disappointed because I did not think that the group members were projecting their feelings into the masks.

During the fourth session, on October 22, there were two themes: sibling rivalry and neediness; I was really able to see the roles that each group member play in the group. There was often a competition for the position of leader within the group and often this struggle ended with the same individual, Mark, as the leader. There was one member,

Steve, who was usually very passive. We started this session by using the instruments. Playing the instruments gave each member of the group an opportunity to be in the spotlight and to be the center of attention. It also allowed these children to express themselves without words, without repercussions for being either too loud or too violent. There was also no way to be wrong when using the instruments, so it helped to add to their feeling of self-esteem. There was some grabbing and a bit of a competition over the instruments. I was able to get this group to discuss and decide who would go first and who would go second. I tried very hard to ensure that all of the members of this group were treated fairly.

Next, we explored some costumes that I had brought with me. They were a little bit on the scary side because this session was very close to Halloween. I started by having their characters move around the room and experimenting with different ways of moving. Once I saw that they were not invested in the building of these characters, I suggested instead that they could think of a story which would involve their character. I figured that if they could not fully invest in the character, perhaps they could project their feelings into a story. This was the second time that stories were used and they seemed comfortable with the process. They seemed more interested in putting their stories into action than in telling them. I learned that stories should be agreed upon and they should have a clear ending that is understood by everyone. After I reminded them about being safe and doing any fighting in slow motion so as not to hurt one another, Mark told the first story. It was quite violent, angry and scary. The main character was the king of the dead. The king of the dead attacked a farmer who was just minding his business one day.

The queen of the dead then attacked the king of the dead and they fought. The king of the dead then ran away. When the farmer came to, he then attacked and killed the queen of the dead and received part of her power. Then the king of the dead and the farmer fought and the farmer lost. He was killed and the king of the dead received the queen of the dead's power. Then the farmer came back to life. The farmer and the king of the dead fought again. This time the farmer won and ended up becoming the new king of the dead. This was symbolized by the farmer taking the king of the dead's cloak.

This story continued for a little while longer with people fighting, dying and coming back to life. I had to remind Mark to find an ending to his story. He was able to but it did take some time. I think this shows Mark's impulsivity. He would rather go with his impulses and continue the story rather than just finishing it. Looking back, I realized that I should have de-rolled these characters after this story. De-rolling refers to when an actor finishes enacting a role and relaxes into a more natural state. The characters were violent and angry characters, which probably had some influence in the next story.

The next story was Sally's. She wanted both boys to be farmers. She started by killing one of the farmers. Then she captured the second farmer. Then the first farmer, Mark, came back to life. Again, this shows Mark's impulsivity and the fact that I should have de-rolled the first story. They both started to hold and frighten the second farmer. They moved him from one corner of the room to the other and to put him in pretend shackles. I interrupted to ensure that Steve was all right. He said that he was and the

story continued. Then the farmer was beaten to death. I asked if this is the way that she wanted her story to end and she said that it was fine.

After this second story, I made sure that these characters were shaken out and de-rolled. I also thanked Steve for being such a wonderful victim and I asked him if he was ready to tell his story. He decided that he did not want to do his own story. I was a little worried about this. I have to ensure that they all feel that they can participate in the group as much as possible. Instead, he wanted to play "What time is it, Mr. Wolf?". I asked the group and, once it was agreed, we played. Unfortunately, this is an example of how Steve often was passive in the group. I decided to have them do more work on their own, so that I might encourage him to participate. I also decided that I would do some story building using the Mooli Lehad method described in Sue Jennings' Dramatherapy II (1992), so that each person would have their own story and they could have a clear ending to them. This method of story building has six specific pictures that are drawn to help the author to tell a story. For a better description of this technique, please refer to the book, Dramatherapy II, (1992), edited by Sue Jennings. Once again, I was very hard on myself, that I had not de-rolled the two characters in between the two stories. I also questioned the level of safety in the group. Perhaps the last group member would have told his story, if he had felt safe.

The next session was only a few days before Halloween. To encourage the feeling of safety, I wanted group members to be able to create their own safe place. I had the group build houses which they could pretend to live in and feel safe. The two boys joined

together to build their house and left the girl on her own. Once the two houses were built, I asked the group to do an imagery exercise in which I stressed the importance of safety in the house. Then, I asked them to continue with the story. The story became about invading each others' houses and anger. The characters the group had built seemed to change from people to animals. The two members of the group, who were most often arguing with each other, ended up casting themselves as a dog and a cat. Then, there were a number of intrusions into the others' camp and there was more fighting. Then, they asked me if I thought that they could break down the houses. I said that it was okay with me, if it was okay with everyone in the group. The group agreed and the houses came down. After I stressed the fact that the story should have an ending, the story ended with more fighting, more killing and coming back to life. I had started out with the best of intentions, to encourage them to feel safe within the group and within the space. Unfortunately, any sense of security they may have felt was lost when they broke down the houses.

The next session I decided to allow each group member to do his or her own story. I wanted to have no competition about who would be telling the story and the direction that story would take. I also wanted to give the passive member of this group his own space to participate without having to follow the "leader". Using Mooli Lehad's story-building method, I was pleased that each member of the group was able to create their own story. This allowed each participant to project into his or her own personal story.

The next session was spent enacting stories. Originally, I wanted them to re-tell, in action, the stories that they had written last session. Instead, the stories were a little different. One group member did not want to tell her story and I did not force her. The other two stories were about Pokemon, a popular child's game. One was written that way, last session, and the other one was invented during this session. Both authors seemed to enjoy the powerful feelings of these characters. I wondered that if Sally had felt safe within the group, she might have told her story.

The next session, the eighth session, was a little less structured than the other sessions. This session we were playing with slime and with the sand-tray toys and doing a little bit of embodiment work. (Slime is a thick goeey substance which is slippery to the touch. Slime is used in drama therapy to help participants become aware of their bodies and senses). I realized after the session that there was not enough structure in this session and I should be more vigilant in containment and fairness. I believe that because I had so much faith in this group I thought that they could handle it. There were quite a few moments where the participants thought that it was not fair. I should have seen these moments and I should have been prepared for them. One of the themes of this group really became apparent to me. There was a very strong feeling of sibling rivalry on this day. There was a competition for the toys and an inability to share. There was also the very strong feeling of neediness. There were lots of toys but there would never be enough for them. Once again, I took this personally and I felt guilty about my inadequacy.



The next session, I brought plasticine to the group. I had hoped that they could create a plasticine creature, project a little bit of themselves into it and then tell a little story using the creature as a main character. When the group heard that I had brought plasticine, they were very unimpressed. They said that they had been using plasticine all week and that they did not feel like using plasticine any more. I, of course, panicked a little bit, but I was able to find two or three different activities that they could do instead. The group rejected each of these as well. I did have other material there but I got the distinct impression that nothing I did would have been enough for them. The overall feeling of this group was sort of melancholy. I think that they were thinking about the end of the year and termination. I think that they were feeling a little lost and uncared for. I do not think that I could have made them feel cared for, that session.

The next session was our tenth session together and I tried to make up for the fact that I did not bring enough materials in our last session. Unfortunately, this meant that the group was over stimulated. One of the group members had a great deal of difficulty focusing on one thing because there were too many things to do. It was also interesting to note that even with all of the materials that I had brought, it still did not seem to be enough. They were not able to share the resources. There was also a bit of a competition to use the many resources that were there. Again, the feeling of neediness came up quite strongly. There were two very important themes occurring in this group. The first would be a sibling rivalry and the competition for love and attention and the other theme would be neediness. These two themes seem to go hand-in-hand. I do not think that there would be a sibling rivalry, if they felt that they were getting enough love and attention in

their lives. Their neediness was due to their real need in their lives. Unfortunately, I was there to try to give them a different experience from their real lives and I did not think that I had done it.

In our eleventh session, I brought back the plasticine because I knew that this group could use it very well as a projective technique, and that they would be able to tell a story about the work that they had created. Each child created a sculpture in plasticine. Mark created a family of penguins and a green creature, which resembled a cactus. The story that he told had the cactus looking creature push the baby penguin into the water. The mother penguin and the brother penguin worked very hard to save the baby. Sally created a family of geese in plasticine. These geese were very close to one another and they were following each other in a row, with their beaks resting on the backs of the one in front of it. Steve created an egg on a leaf and a snail. His story was about the snail eating the egg, getting sick, dying, coming to life, eating the egg and dying again. There was a little bit of conflict in this group as one of the group members accused the other of copying. As well, there were difficulties due to the perceived lack of materials. However, the group was able to deal with the shortage and share the resources.

The next session, which was the last session before Christmas, we had an opportunity for a nice closure of the group for the coming break. I provided the outline of three separate Christmas trees for them. I thought that each person could decorate their own Christmas tree however they wanted. Then, each child could give themselves a present. I had hoped that this would be used as a projective technique for them to express

their hopes and dreams and to nurture themselves. They each seemed excited to decorate their trees and they all gave themselves some presents, but they did not want to share what they were. We went on to blow some wish bubbles, where each bubble blown represented a wish. Finally, I brought them a basket, full of beads, to build a bracelet. They each could draw out a bead, one at a time, which would represent something about the group. Afterwards, they could string all of the beads together and wear it as a bracelet. In this way, I figured they could create for themselves a transitional object, which would remind them of the group.

This is where I was left at Christmas time. I did not think that my groups were safe or supportive. The group members were breaking rules, teasing each other, calling each other names and there was a great deal of tension between the group members, both individually and between the sexes. As well, there had been a tendency to put Sally in the role of scapegoat. Most of these issues I took personally; I felt that it was my fault that they did not feel safe, that they were still breaking the rules, and that they had failed to come together as a group to be supportive of one another. I believed that I had not enforced the boundaries or provided enough containment.

At this point in time, I was not very confident in my knowledge and ability as a drama therapist. I always questioned if I was helping them and how I could have helped them more effectively. I did not think that I had been able to connect my theory with my practice. I was still lost in what it was that I was supposed to be doing. I was not sure how to help them. I was painfully aware of these shortcomings and I knew that I had to

find a way to proceed. I saw all of my difficulties as “mistakes”, and I was harsh on myself, rather than learning from them. I knew, then, that what I was lacking was a working definition of therapy.

### **Chapter 3**

#### **My central question: Where is the therapy in Drama therapy?**

At this time, therapy to me meant sitting and talking through problems.

Traditional talk therapy was what I was most familiar with, and it usually works by sitting and talking. After all of the work that I had done so far, I could accept the fact that therapy does not have to encompass talking, but that leaves the problems. I felt that I would only be doing therapy if there was one specific problem that needed solving. This was my working definition of therapy: one problem with one solution. If we could look at each problem separately and work out a solution for each individual problem, it would just be a matter of time before we had dealt with all of the issues in their lives. As well, therapy would then have a definite ending. It would be clear to everyone involved when the therapy would be no longer required. Problems, by my definition, were anything that hinders the client from being everything that they can. So therapy is anything that helps the client to progress towards their desired outcome which, in this case, was work on specific behaviors and family issues. But I was not working on any of these issues and I did not see the possibility of getting a cohesive group together, to succeed at working through some real problems. Was I doing therapy with these children? Was I doing drama therapy? If so, where was the therapy in drama therapy? Was I helping?

I did not see any progress with my clients at all. I even thought that because of my incompetence, my work with my clients could be injuring my clients. I was not living up to my expectations as a therapist. I was not helping my clients to be more aware of their problems and to deal with them in therapy. This was my expectation as a therapist. I wanted to be able to deal with all of their issues in a very concrete way. This led to an incalculable amount of frustration and stress. I was failing as a therapist and I was not even sure why. I was frustrated with my supervisors because they were not helping me to go where I needed to go. I knew where I was and I knew where I wanted to be, but there was no map and no help to show me how to get there. To continue on in my journey, I needed some direction. Little did any of us realize that where I thought I needed to go and where I actually needed to go were two very different places.

#### **Chapter 4** **Answering the questions**

Over the Christmas break, Christine Novy, my supervisor gave me an assignment, to answer three questions. What am I doing? Where is the therapy? What have I achieved? These are the answers that I gave to her then.

##### **What am I doing?**

Therapy usually implies treatment of disorder, disease, or defect. This makes this question difficult to answer because I am not, technically, doing “therapy” with these children. Treatment usually implies curing and I am not trying to “cure” them or their disease. There may be better ways of dealing with their specific problem. It is the belief of the Douglas Hospital that an effective way to help children suffering from ADHD is

through the use of medication. So, if I was not trying to “cure” their disorders, what was I doing and where would I start? I could start with building a better group and helping the group members to be more cohesive and, at the same time, to determine the best way that I could help them within my specific modality, drama therapy. If I could not “cure” their disorder, then perhaps I could help them to deal with the various effects of their disorder. I could help them to adapt and to succeed in their lives *despite* the disorder.

### **Where is the therapy?**

There is therapy in being creative. I could encourage these children to experience the pleasure of being creative. Once they had learned to be more creative, they could carry this over into their everyday lives, which might give them another method of dealing with any problems that might arise.

Due to the fact that these children had not done very well in school and have often been expelled from several schools, their self-esteem was very low. There is therapy in being able to succeed. Encouraging them to succeed in various activities could help them to increase their self-esteem. By helping to increase their self-esteem they would be better able to deal with their lives.

There is therapy in being listened to. A number of my clients just needed time to be heard and to be understood. Due to their age, however, it was not always easy for them to communicate their feelings on topics. It was my job to provide useful metaphors for them to express various themes. It was important for them to have the space to

communicate and explore different topics. I could give them a positive outlet to express their feelings and to help them to vent their frustrations.

There is therapy in exploring various specific problems that these children might experience in their lives. This is an important point, but it is not the single most important part of therapy. Solution-based therapy is just one method that I could use to help these children. I needed to realize that we had to build a relationship in which they could feel safe enough to bring specific issues forward. This is done through various games, which require improvement and are easily mastered (for example, hitting a balloon up into the air). Start small, easy and playful at first, to help build a relationship. Having fun together helps them to establish a safe and trusting play space, which then allows them to become a more cohesive group and to begin to work through some of their specific issues. As well, I needed be aware that it was not my job to solve these problems for them, but to help them to be able to deal with these problems on their own. I had hoped to help them to become better problem-solvers so that they could react differently in various situations. I had hoped that I could give them an alternative to their defiant and disruptive behavior, which was their most prevalent response.

### **What have I achieved?**

It is true, as it is with most beginning therapists, that I set some high standards for myself. While I had not quite achieved these high expectations, I had made some progress with all of these groups. The goals that I set for all of these groups were:

- to create a safe, supportive environment

- to increase self-esteem and self confidence
- to increase communication skills

The first goal, which I thought was going to be the easiest to achieve, was proving to be the most difficult. These children were not yet ready to be supportive of one another. They were also having a great deal of trouble trusting one another. There was a great deal of animosity in these groups, which stemmed from their lives outside the drama therapy sessions. It might be possible to achieve this goal, but they were going to require the rest of the year to work on it.

The second goal was important, but it did not speak to the huge deficit that these children had in this area. They were still hurting from the fact that they could not learn and participate in school the same way that other children did. This was a very large deficit to overcome. I did not make huge strides in this area, but I continued to work on it. This was probably the most important benefit that these children could receive from drama therapy.

Lastly, these children learned a little bit more about communication. One of the things that I had been trying to stress in these sessions is that it was unnecessary and detrimental to call each other names. Again, I realized that these children had not fully learned this skill, but I still had time to help them work on it. As well, I gave them a space to explore their creativity and to relax a bit. There were fewer pressures “to produce” in drama therapy than there were in school.



After reflecting on the first half of the year, I was feeling a little more positive about my work with these children, but I still did not think that it was enough. I wanted to be doing more for them. Looking back, I realize that I was suffering from the most common syndrome experienced by beginning therapists: rescuer's syndrome. I thought that I could solve all of their problems and fix their lives.

## **Chapter 5**

### **My Realization: Drama Therapy as a continuum**

#### **Change**

The first and most important issue for me was to determine what therapy is. I needed to know what I was working towards first, before I could even begin to think of a plan of attack. Then one day in January, by coincidence, I read this quote by Brenda Meldrum (1993). "The distinction between 'therapy' and 'therapeutic'. A therapeutic experience is one through which a person comes to feel a greater sense of herself and her abilities, while a therapy is a specific form of intervention in her life whose aim is to help bring about change" (p.70). What I was doing or attempting to do with my clients was all linked to the idea of "change". What I had been trying to do was to bring about life changes. My goals were set impossibly high. I also realized that I could not change my clients in any way. All that I could do was to give them tools to help them cope with their lives. This quote was so important to me because it showed me that perhaps I was not wasting my time after all. I realized that I was not doing therapy as she states it. It was not possible for me to change these children. Until now, I was trying to treat these children, with the understanding that treating them would relieve them of their symptoms.

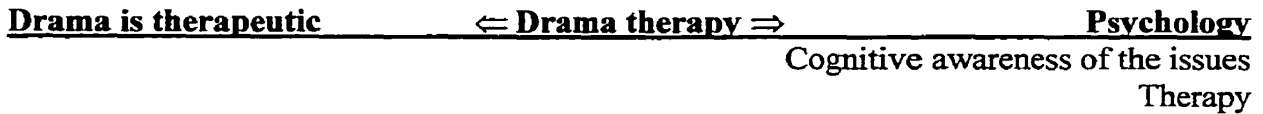
Ultimately, I had hoped to “cure” all of my group members of the various disorders which they presented. Obviously, treatment for these children is possible, but “curing” them is not. Children with ADHD will always have ADHD and the best thing that I can do for them is to help them to live with it, adapt, develop, improve attitudes and behavior.

Children with conduct disorder and oppositional defiant disorder will also always be at risk due to their disorders. Once again, these disorders can not be “cured”, but the opportunity exists to help them to control their behavior. In the case of the conduct disordered child, the possibility exists to help them to be more empathetic and to be more aware of other people’s feelings. For the oppositional defiant child, the possibility exists to become more socially aware.

I realized that what I had considered "not doing enough" was exactly what these children needed. It was better for them to, in Brenda Meldrum’s words, “feel a greater sense of herself and her abilities”. What I had been trying to do and what I should be doing was to increase their self-esteem. Behavioral issues were the reason that they had been expelled from the schools and that they were in the day program, but the underlying self-esteem problems might be leading to these behavioral problems. They might have been acting "bad" because they felt bad. I realized that the purpose of the therapy was not to change their behaviors, but rather to help them to deal or cope with their life. In the end, I realized that I could not change them at all. What I could give them were tools so that they could deal with their lives in the future.

This realization led me to investigate the topic further. I began to have discussions about it with my on site supervisor, Irene Gericke. Together we discovered that drama therapy exists on a continuum:

### **A Continuum**



(Figure 1: A continuum of drama therapy)

On one end of the continuum, there is the idea that simply doing drama and being creative is “therapeutic”. On the other end of this continuum is cognitive awareness of the issues or problems which occur in people’s lives. Children are seldom able to reach this cognitive awareness. Drama therapy can move up and down this continuum depending on the population and the goals of the therapy. Part of why I felt like I was not doing therapy was due to the fact that we were not discussing the problem directly and we were not mentioning feelings very often. I had to first realize that it was not necessary for our sessions to have this focus because they were not developmentally able to become cognitively aware of their feelings. Children do not have the necessary self-awareness and language to discuss issues that might arise in their lives. I began to see that working with children was significantly different than working with adults. I did not need to know where the therapy was in drama therapy, all I needed to know was how best to work with my groups and what was therapeutic about the work that I was doing with this specific population. I therefore changed the working title of my paper to “where is the therapy in drama therapy when working with children with severely disruptive behavior?” My

drama therapy groups were therapeutic because they provided an opportunity for the participants to be listened to and understood. As well, being in the drama therapy group gave my clients an opportunity to practice and succeed at listening, communicating, and interacting with their peers.

**Where do I fall on this continuum?**

After this realization I was able to see my work in a more positive light. I always knew that just doing drama and being creative was therapeutic, but I did not see that as being very impressive. For these children, with such low levels of self-esteem, this was a wonderful place to start. The purpose of therapy with children is to help them to build a strong “self”. I also realized that just giving them attention was a wonderful change for some of them.

It was very important for me to realize that I was, in fact, doing therapeutic work with these children, but still I felt that this was not nearly enough and that I could be doing more. So I began to think of how I could begin to move further up the continuum. Two different ideas came to me then, quite quickly. The first was that any work that I did should take into account the specific needs of my population. The second was that I should reconsider my goals for these children.

**Chapter 6**  
**Therapy is population specific**

Still, at the heart of all of my learning has been this one overriding question: “where is the therapy in drama therapy?”. As my work continued, this question even

changes to show my development. I did not need to know the answer to this question, I did not need to know where the therapy was; I just needed to know how it related to my particular population. As John Casson (1998) put it in his article entitled Dramatherapy: A Heterodoxy not an Orthodoxy: “[w]hat is the best method for this particular client/group at this time?” (p. 23). My question then changed to: “where is the therapy in drama therapy when working with children with severely disruptive behavior?”. I realized that with any population that I chose to work with, I would have to re-evaluate how best to work with them and how I could best help them using my chosen modality, drama therapy. According to the National Association for Drama Therapy (1994), drama therapy achieves the therapeutic goals of symptom alleviation, emotional and physical integration and personal growth, using dramatic and theatrical activities. To be able to do this, I found it imperative to establish what specific symptoms each child was suffering from and how each child needed to grow. By researching the various disorders, I was able to find a starting point, a base line to start from. Then, I was able to look at each child and assess how they were similar or different from the descriptions of their disorders.

### **Special needs for population**

#### **Attention deficit hyperactivity disorder (ADHD)**

A child with ADHD is “...unquestionably bright and gifted, impulsive in his actions towards others and oblivious to their feelings, energetic to the point of exhaustion, yet hopelessly uncoordinated on the playing field, friendly - even charming- to adults, yet regarded as a “loser” by his peers” (Henley, 1998, p.2). This quotation implies that social

skills are an important part of the deficits. “The incapacity to accurately interpret, and then follow, established rules required in social or school situations often results in interpersonal conflicts with authority figures or peers.” (Henley, 1998, p.3) The group on which I have chosen to focus has members with aspects of both ADHD and oppositional defiant disorder. The diagnosis criteria listed in The DSM IV Training Guide for Diagnosis of Childhood Disorders (1996) has two main divisions: attention and hyperactive-impulsivity.

“Attention-deficit/hyperactivity: Diagnostic criteria

A. Either (1) or (2)

(1) Six (or more) of the following symptoms in **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

**Inattention:**

- (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or activities
- (b) often has difficulty sustaining attention in tasks or play activities
- (c) often does not seem to listen when spoken to directly
- (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- (e) often has difficulties organizing tasks and activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- (h) often easily distracted by extraneous stimuli
- (i) often forgetful in daily activities

(2) Six (or more) of the following symptoms to **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

**Hyperactivity**

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in classroom or in other situations in which remaining seated is expected
- (c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- (d) often has difficulty playing or engaging in leisure activities quietly

(e) often “on the go” or often acts as if “driven by a motor”

(f) often talks excessively

**Impulsivity**

(g) often blurts out answers before questions have been completed

(h) has difficulty awaiting turn

(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder)” (p. 144).

According to the DSM IV (1994), children who exhibit symptoms of inattention usually will avoid activities which require close concentration and sustained self-application. “In social situations, inattention may be express as frequent shifts in conversation, not listening to others, not keeping one’s mind on conversations, and not following details or rules of games or activities” (American Psychiatric Association, 1994, p.79). Symptoms of hyperactivity include: fidgetiness, squirming in one’s seat and talking excessively. Impulsivity characteristics include impatience, difficulty delaying responses and seeming to not think before they act. Impulsive children also “fail to listen to directions, initiate conversations at inappropriate times, interrupt others excessively, intrude on others, grab objects from others, touch things they are not supposed to touch, and clown around” (American Psychiatric Association, 1994, p.79). “Associated features...may include: low frustration tolerance, temper outbursts, bossiness, stubbornness, excess and frequent insistence that requests are met, mood liability,

demoralization, dysphoria, rejection by peers and poor self-esteem” (American Psychiatric Association, 1994, p. 80). Children diagnosed with ADHD usually have lower IQ scores and are usually behind in their intellectual development.

In two articles by David Henley (1998 & 1999), he describes how he developed a socialization program in a therapeutic camp setting from children with attention deficit hyperactivity disorder. “The mission of the camp was to develop, through therapeutic and expressive group activities, social capacities in children suffering from varying degrees of asocial or anti-social behaviors” (Henley, 1999, p. 41). He used art therapy, videotaping and playback to help these children focus on relations with peers, schoolmates, family, and friends, as well as issues related to the children’s perceptions of self-concept and self-esteem. “One of the salient conclusions gleaned from this data is that aggressive or impulsive behavior related to hyperactivity and social anxiety can be channeled and transformed into socially constructive forms of self-regulation through facilitated creative endeavor” (Henley, 1999, p. 40).

### **Conduct disorder**

The diagnostic criteria for Conduct disorder listed in The DSM IV Training Guide for Diagnosis of Childhood Disorders (1996, p. 150) is as follows:

#### “Conduct Disorder: Diagnostic Criteria

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

#### **Aggression to people and animals**

- (1) often bullies, threatens or intimidates others



- (2) often initiates physical fights
- (3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
- (4) has been physically cruel to people
- (5) has been physically cruel to animals
- (6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- (7) has forced someone into sexual activity

**Destruction of property**

- (8) has deliberately engaged in fire setting with the intention of causing serious damage
- (9) has deliberately destroyed others' property (other than by setting fire)

**Deceitfulness or theft**

- (10) has broken into someone's house, building, or car
- (11) often lies to obtain goods or favors to avoid obligations (e.g., "cons" others)

**Serious violation of rules**

- (13) often stays out at night despite parental prohibitions, beginning before age 13 years
- (14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
- (15) often truant from school, beginning before age 13 years"

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 year or older, criteria are not met for Antisocial Personality Disorder.

Children with conduct disorder, according to the DSM IV (1994), have little concern for the feelings, wishes and well being of others. They may have very little empathy, lack appropriate feelings of guilt or remorse and they may be callous and reckless. "Self-esteem is usually low" (American Psychiatric Association, 1994, p. 87). They might have poor frustration tolerance, irritability, temper outbursts and blame others for their misbehavior. There is usually a history of school suspensions or expulsions. Children with conduct disorders usually have lower than average intelligence. "Virtually all cases diagnosed as conduct disorder will meet the criteria for oppositional defiant disorder; however, the latter diagnosis is not made if a diagnosis of conduct disorder had

been established” (Rapoport & Ismond, 1996, p.152). This means that all of the members of my group had the symptoms of oppositional defiant disorder.

### **Oppositional defiant disorder**

A child with oppositional defiant disorder usually has low self-esteem, mood liability, low frustration tolerance, and may swear excessively. He often has conflicts with parents, teachers and peers. The behavior of a child with oppositional defiant disorder is best described by in the DSM IV (1994):

“Negativistic and defiant behaviors are expressed by persistent stubbornness, resistance to directions and unwillingness to compromise, give in, or negotiate with adults or peers. Defiance may also include deliberate or persistent testing of limits, usually by ignoring orders, arguing and failing to accept blame for misdeeds. Hostility can be directed at adults or peers and is shown by deliberately annoying others or by verbal aggression (usually without the more serious physical aggression seen in Conduct Disorder)” (p. 91).

The diagnostic criteria for oppositional defiant disorder listed in The DSM IV Training Guide for Diagnosis of Childhood Disorders (Rapoport & Ismond, 1996, p. 154)

is as follows:

“A. A pattern of negativistic, hostile and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

- (1) often loses temper
- (2) often argues with adults
- (3) often actively defies or refuses to comply with adults’ requests or rules
- (4) often deliberately annoys people
- (5) often blames others for his or her mistakes or misbehavior
- (6) often touchy or easily annoyed by others
- (7) often angry and resentful
- (8) often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 year or older, criteria are not met for Antisocial Personality Disorder.”

These three disorders: attention-deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder often go together (Kazdin, 1997). Studies show that children with conduct disorder also meet the criteria for oppositional defiant disorder. In fact, some researchers believe that oppositional defiant disorder is a precursor to conduct disorder. Henley (1998) states that 44% of children with ADHD also have been diagnosed with oppositional defiance disorders. There were a number of similarities in the behaviors of the three members of my group, which meant the treatments should be similar as well.

### **Treatment**

According to Eric Taylor (1994), when treating ADHD, a number of important factors should be taken into account while devising a treatment plan: biology, family, school and peer groups. As well, aggression, learning abilities and emotional life should be investigated. “The overriding goal of treatment is to foster normal development...To approach this goal, there are several aims: to reduce hyperactivity, treat coexisting disorders, prevent or treat disorders of conduct, promote academic and social learning, improve emotional adjustment and self-esteem and relieve family distress” (Taylor, 1994, p. 299). According to Kazdin (1997), there are four promising treatments for conduct disorders: cognitive problem-solving skills training, parental management training, functional family therapy and multisystemic therapy. Cognitive problem-solving skills training involves re-learning interpersonal problem-solving skills. These include:

- perceptions and expectations about others' actions
- creating new ways of handling social situations
- awarenesses of the consequences of one's actions on others
- methods to obtain a wanted goal (e.g., making new friends)

Children can be taught these skills in a step-by-step fashion. Parental management training involves training the parents to implement new rules and limits at home. They are also shown new ways of identifying and interpreting behaviors. They are taught positive reinforcement and then given an opportunity to practice these new skills.

Functional family therapy deals with teaching the family more effective ways to communicate and negotiate. They then can discuss any specific problem and its possible solutions in a clearer manner. Multisystemic therapy is a family-system based approach to treatment. The family works to build a more cohesive, strong and supportive unit. This approach recognizes the importance of the family in the child's development, but it also investigates the environment surrounding the child.

Treatment at the institution where I did my practicum covered most of these key areas. Patients were offered a number of different methods to help treat their disorder. Children spent half of their days in a school setting, where they could practice their educational skills. The other half of their day was spent in various types of therapies and with other group members. Family therapy was a critical part of the process.

## **Change**

Another important aspect of therapy, which I had to come to terms with, was change. The children with whom I was working were there due to severely disruptive behavior. However, the underlying causes of these disruptive behaviors could be due to low self-esteem, poor social skills or a need for attention. The focus of the therapy, then, was not to change these disruptive behaviors but rather to help diminish the causes, by increasing self-esteem, improving social skills and giving them attention. This realization required that I re-evaluate my point of view on change. Previously, I had the intention of treating, or even curing their disorders. The focus of therapy in this way of thinking is to change their behaviors. After re-evaluation, I realized that there was no cure for their disorders and that they would be better served by learning social skills and coping skills which could help them deal with their lives. I could give them the tools that would allow them to succeed. In this line of thinking, change occurs more slowly but it is more beneficial for the client in the long run. Taking these facts and the needs of the specific population, I concluded that I really needed to re-set the goals for my groups to something more realistic and beneficial.

## **Chapter 7 Re-setting goals**

Ann Cattanach, during one of her lectures to our class, stated that it was imperative to define the subject and the goal of therapy. Without this working definition we are just wasting our time, “playing” around. All of the research that I had done on the specific populations led me to realize that the most important focus of my work with this

population should center around interpersonal skills and group interaction because this was the source of their greatest deficiency. It seemed to me to be the place where they could receive the most benefit.

### **Group building skills**

In re-setting the goals for my groups, there were two main points to focus on: the self and participation in a group. My supervisors always talked about seeing change in baby steps in drama therapy. I needed to lay these baby steps out so that they were reachable. I also had to look at the problem from another perspective and use all of the information that I had learned so far about the population. As well, I needed to look at what I was changing and how I could achieve these changes using drama therapy. Setting new goals would more accurately reflect the little baby steps of change that occur over the course of therapy. A majority of the research that I had done on my population (ADHD) stated that a major problem area is in social interactions. A group setting provided the perfect opportunity to allow them to practice and succeed at these skills. The changes I determined that I should be working on and that I felt were reachable through drama therapy were:

- learn to participate, as part of a group
- enhance social interactions
- increase communication skills
- improve listening skills
- negotiate with others

- learn to share the therapist's attention
- enjoy being creative

**Drama therapy accomplishes these goals by:**

- allowing the opportunity to succeed, which helps to increase self-esteem. This can be done through games, which allow participants to improve with practice, and activities, which encourage success.
- teaching these children to be in a group together and succeeding at that. Each session this skill is built on and improved. They learn better, more effective ways of being in this group. Being in the drama therapy group gives them an opportunity to practice and succeed at listening, communicating, and interacting with their peers.
- helping them to get in touch with their bodies and senses. By using various embodiment activities the children can have the experience of succeeding and exploring their senses and how they relate to the world. Drama therapy helps them to be more self-aware and expressive.
- providing them with an opportunity to communicate their feelings through metaphors. Very often, this group will use the metaphor. The next step for this group is to start exploring various solutions to problems that occur within the metaphor. An example of this would be if a story about an abused little girl ended with a helpless, hopeless feeling, the child could be encouraged to change the story so that the little girl could ask a trusted adult for help. If the metaphor is that the little girl in the story is the storyteller, then by helping the character in the story, the storyteller might see how to help themselves.

- providing an opportunity to be listened to and understood. Due to the cohesive nature of this group, they are able to listen to others in the group and they can be supportive.
- Practicing listening skills when directions are given and followed. As well, group members are encouraged to listen to one another in the group.
- encouraging creativity.

### **Individual goals**

This means that a perfectly appropriate goal of therapy can be increased self-esteem because the lack of this is greatly hindering the client. Increasing self-esteem also increases their resilience. Not all problems can be named or are so clear-cut. So one of the most important aspects of therapy is determining the goals of the therapy and deciding the suitable end results. So am I doing therapy if I am just working on self-esteem? Yes, if it seems as though this is hindering their daily functioning. Therapy with this group occurred slowly. I was trying to work on their self-esteem by giving them many different activities that they could do successfully. I was trying to listen intently to any story or emotion that they showed in their characters. Most importantly, this group progressed in their ability to relate to their peers. There were a lot fewer instances of name calling and bickering in this group. Most of my work with this group was providing them with several different metaphors into which they could project their feelings. This gave them an opportunity to express their feelings in a safe way. Without the use of the metaphor, they might not have had another appropriate outlet for some of these emotions.



Fortunately for me, an opportunity for me to express these new goals was provided by the hospital. They required that I create a treatment plan for all of the children with whom I was working. This let me express my new goals and it also allowed my to re-visit each child and devise an individual treatment plan. The first thing that I determined was that there were three goals which were common to all three of the group members. These individual goals were:

- improve self-esteem and self confidence
- improve self expression
- improve self awareness

I felt that all of the group members could benefit from improvements in these areas. I also felt that drama therapy would be an excellent way to help them meet these goals.

#### **Individual Treatment Plan for Sally:**

Sally was very enthusiastic, helpful and energetic. She was a very supportive group member and she would often offer to work with other members of the group. She seemed to enjoy working on her creativity and gave a number of suggestions as to various activities. Sally was able to express some of her sad feelings using the metaphor. Her past family life had been very distressing and she needed a space to work through some of the pain in her history. (“Working through” an issue refers breaking it down, exploring it and examining it thoroughly to fully understand it.)

**Therapeutic goals for Sally in drama therapy:**

- improve listening skills
- introducing an internal nurturing parent. (This phrase refers to one of Renee Emunah's four objectives in drama therapy. This objective uses the belief that deep inside a client there is usually a wounded child. Emunah tries to show her clients that they can help themselves by focusing on the best parts of themselves. "In dramatherapy, once the client has heard and internalized the love and acceptance of others towards the child within, he is ready to give this love and acceptance to himself." (Emunah, 1994, p. 122)).
- continue to use the metaphor to express her feelings

**Drama therapy accomplishes these goals by:**

- helping her to express feelings, using various projective techniques, such as: characters, musical instruments, masks, stories, plasticine, puppets and artwork.
- learning to take turns and listen to others in the group
- having the therapist ally herself with the wounded child, and modeling acceptance

**Individual Treatment Plan for Mark:**

Mark was very cheerful, energetic, happy, enthusiastic, helpful and playful. He was often the leader of this group. He often worked very well in the group setting. He was very supportive and he tried to include other group members in his work as often as possible. He seemed to enjoy working creatively and had offered a number of suggestions.

### **Therapeutic goals for Mark in drama therapy**

- be more accepting of others and their weaknesses
- improve his control over his impulses
- getting along better with others
- learn to share the group's attention and focus
- improve his patience

### **Drama therapy accomplishes these goals by:**

- allowing him the opportunity to practice and succeed at acceptance
- allowing him the opportunity to practice control of his impulses
- allowing him to practice turn taking and listening to others in the group and modeling of patience by the therapist

### **Individual Treatment Plan for Steve:**

He seemed to enjoy succeeding at the various games that we played. Steve was a little on the quiet side and often contented himself with following the others. He seemed to enjoy succeeding at the various running games that we play (e.g., What time is it, Mr. Wolf?).

### **Therapeutic goals for Steve in drama therapy:**

- taking his own initiative
- be more accepting of others and their weaknesses
- improve his patience
- controlling his impulses

**Drama therapy accomplishes these goals by:**

- allowing him the opportunity to practice and succeed at acceptance
- allowing him to practice turn taking and listening to others in the group and modeling of patience by the therapist
- giving him opportunities to work and create things on his own and to be accepting of his work
- allowing him the opportunity to practice control of his impulses

**Chapter 8**  
**How I learned to work with this population**

There were four important things I learned about therapy with these children. The first was the importance of boundaries and containment for this group. The second was the use of play in the therapeutic process. The third was the importance of planning. Lastly, was the importance of acceptance and my ability as an advocate for these children. These were other things that I had to keep in mind, along with the individual and group goals.

**Boundaries and Containment**

The use and testing of the boundaries was an ever-present difficulty in the group. The conflict revolved around the children's need to test the boundaries and my need to make them feel safe and contained. Haim G. Ginott (1976) provides six statements as a rationale for the use of limits in individual and group play therapy:

- (1) Limits Direct Catharsis into Symbolic Channels: Setting limits help to provide a socially acceptable means of expressing their desires through puppetry, modeling, painting and playing.
- (2) Limits Enable the Therapist to Maintain Attitudes of Acceptance, Empathy, and Regard for the Child Client: Setting limits allows the therapist the capacity to remain in a position to offer unconditional positive regard.
- (3) Limits Assure the Physical Safety of the Children and the Therapist in the Playroom: The safety and well being of the clients should be of paramount importance at all times. Without an awareness of the clients' safety, it would be difficult to maintain a trusting relationship.
- (4) Limits Strengthen Ego Controls: "By accepting the child's feelings and preventing his undesirable acts, the therapist reduces the child's guilt and at the same time turns his wishes in the direction of reality controls. Thus the child comes to accept and control impulses without excessive guilt" (Ginott, 1976, p. 282).
- (5) Some Limits are Set for Reasons of Law, Ethics, and Social Acceptability: Behavior in the playroom should not exist outside of normal socially acceptable behavior.
- (6) Some Limits are Set because of Budgetary Considerations: Limits should be set so that breaking expensive toys would not be allowed due to the expense of having them replaced.

All three of these children had difficulties with their family relationships in the past. Children's misbehaviors are thought to be aggravated by the lack of parental controls placed on them at home. "An inadequate, disorganized, chaotic environment

might cause a child to simulate such behavior due to resultant anxiety” (Rapoport & Ismond, 1996, p. 148). As their therapist, it was my job to see that they had an experience of containment, which might help them to:

- experience a fair authority figure
- succeed at choosing to follow the rules
- feel safe and secure
- learn to control their own behaviors

The first point, experiencing a fair authority figure, was very crucial for the progress of the therapy. All of these children had difficulty complying with the controls set by authority figures in the past. This probably led to anger, frustration, helplessness and mistrust of the authority figures on the part of these children. As a therapist, it was my job to give them a different experience. To do this, I had to ensure that all of the boundaries, in the form of rules, were very well understood and fair.

My first task, at the beginning of the year, was to explain to them that rules were necessary, and which rules would be required, so that everyone knows what is expected of them and they know how to behave.

“Both in therapy and in life, children need a clear definition of acceptable and unacceptable behavior. They feel safer when they know the boundaries of permissible action. Therefore, limits should be delineated in a manner that leaves no doubt in the child’s mind as to what constitutes unacceptable conduct in the playroom” (Ginott, 1976, p. 283).

Rules are also necessary to ensure all of the group members' safety. I also learned that, with this population, it was more important to clearly explain the rules before they were broken, rather than to have to resort to a type of punishment afterwards. Punishment, as I learned, was not necessary, and it probably hurt the therapeutic relationship. It was crucial to make all of the group members understand that they could choose not to follow the rules. All that this meant was that they were not prepared to participate in the drama therapy group or the activity that we were doing. If a group member chose not to participate, for any reason, there was a spot for him or her to go to. In my case, this spot was indicated by a blanket on the floor which was an idea taken from Ann Cattanach (1996, p.160).

The group's first experience with the rules was very early in the group where the rules were introduced and discussed. For my sessions, there were only three simple rules:

1) Freeze: Whenever I said the word freeze, every member of the group had to stop whatever it was that they were doing and create a frozen statue.

2) Listen to instructions: This rule meant that they should pay attention to any explanations for activities that I would give and then to follow out these instructions to the best of their ability. If they ever had any questions about the explanations, they could ask me to explain them further.

3) No violence: This rule included both physical violence (e.g., hitting, kicking and punching) and verbal aggression (put downs, name calling, and swearing).

I tried to reiterate the rules as often as I felt it was necessary. As well, I had to ensure that these rules were adhered to as precisely as possible. It was important for these children to see that authority figures can do what they say they will do and be consistent. I also stressed the importance of these rules for their own safety, as well as the safety of the others in the group.

Once these children realized that I was an authority figure who was fair, could be trusted, and was interested in their safety, I think that they began to feel more safe, secure and trusting of me as a therapist. About half way through the second semester, I began to notice that there were fewer arguments and fighting among group members. This new atmosphere allowed me to provide a number of opportunities to explore their feelings in a projective manner.

Lastly, experiencing consistent, fair, understandable and safe boundaries provided by myself as an external locus of control might lead them to start to internalize this control. This might allow them to better control their own behaviors. "...[L]imits are conducive to the development of self-discipline; through identification with the therapist and the values he personifies, the child achieves greater powers of self-regulation and self-command" (Ginott, 1976, p. 283).

## **Play**

One of the more crucial things that I learned was the importance of play in therapy with children. Through play, the child first makes sense of his world and starts to give it



meaning. Ann Cattanach (1995), stated that there were "... four basic concepts that facilitate the play and contain the process to keep the children safe:

- 1) the centrality of play as the children's way of understanding their world;
- 2) that play is a developmental process and, in therapy, the children move back and forth along a developmental continuum as a way of discovering and exploring aspects of identity;
- 3) that play is a symbolic process through which the children can experiment with imaginative choices aesthetically distanced by the creation of this other playing reality from the consequences of those children in "real" life;
- 4) that play happens in its own special place and time, and this playing space is a physical space and a therapeutic space. This is the transitional space between children and therapists, the space to define what is "me" and "not me," the space where our creative life starts" (p.224).

Since play is such an important part of the child's life and it is how they help to make sense of their world, it would make sense for the therapist to join the child in that world. It is very important, therefore, for the therapist not to give the child's play any adult meaning. All the therapist can do is to suggest that the children put part of themselves into the play. In the case of a story, the therapist can ask the child to make a story where one of the characters is similar to someone in their life or where the situation is the same as what is happening in their life. In this way, the therapist can encourage the child to create their own metaphors about their life. Using these metaphors in a playful way then gives the child the opportunity to explore his or her life from a safe distance, and view it from the eyes of this new character or situation which is similar to them, but not them. Distancing in drama therapy refers to the ability to feel what a character might be feeling, but to still remain detached enough to reflect on it.

Returning to my continuum momentarily (Figure 1, p.28), I learned that therapeutic work with children had to remain on the side of "drama is therapeutic" rather

than moving forward towards “psychology”. Children are not often capable of having introspective discussions about their emotions. They are not cognitively able to, nor do they have the proper language. They can, however, use play to explore the various issues in their lives and to look at solutions within the context of the play.

### **Planning**

I also learned that drama therapy is not just a collection of different dramatic activities. Each session requires a certain amount of planning which takes into account the amount of cohesion within the group, its developmental level and how that relates to the EPR model I was using (see p. 4), each individual’s separate tastes and therapeutic needs. Upon reflecting back on my first semester’s work, I realized that I had not been taking these factors into account. I realized that I had spent a majority of my time working with roles, whereas this group probably could have benefited more from a more gradual progression through the first two levels of embodiment and projection. Developmentally, this group was not advanced enough to benefit from the therapeutic use of roles yet. They were not secure enough in their own selves to start to embody other people’s roles. The only thing I had focused on was the lack of cohesion in the group and I should have been planning new ways of group building. By setting individual goals, I was able to plan my different choices in a little less arbitrary way. I could choose my different activities with a specific therapeutic purpose in mind.

## **Acceptance and Advocacy**

The last important detail I learned about therapy with these children is the importance of acceptance and advocacy. These two ideas have to do with the building of a more positive opinion both for themselves and for others in their lives. Acceptance is the unconditional positive regard and attention that I could give them directly. This helped them to learn that there were other methods of getting attention rather than acting out. Everyone needs to feel good about themselves and drama therapy offered them the opportunity to succeed at something. I provided them with the space necessary to be themselves. I gave them a new way of thinking about themselves: "The drama therapist was the first person who saw me as a creative individual." Advocacy was my opportunity to help others see the individuals and their progress in the drama therapy group. In the form of written reports, verbal reports and certificates, I was able to communicate to the interested people in their lives the positive qualities of the child. It was my task to help show that the child was a well-rounded individual who was not "all bad, all of the time". I also tried to help to instill a sense of hope.

The second half of the year at my practicum site went a lot better. I was able to interpret my work with these children in a more positive light. I actively tried to add more play into my work. I spent more time thinking about and planning sessions. Various activities were chosen with therapeutic goals in mind. With a clearer map in hand, I continued on my journey. The following is a description of just a few of the second semester's sessions, chosen because of their significance and value.

My first session back after the Christmas break, we played a number of games to get back into the swing of the drama therapy group and to have some fun. I was hoping to help to release some tension that may have accumulated over the break. It is fairly well known that holidays can be a very stressful time for some people. We played one game of dodge balloon, which is a game that this group invented earlier in the year. We also played “What time is it, Mr. Wolf?” and leapfrog. We also played a game called “Grandfather”, which was taught to us by one of the group members. It was very similar to “What time is it, Mr. Wolf?”.

Our fourteenth session together was spent using the musical instruments and using small plastic toys to help tell a story. It was also the first session with my new set of goals and my new awareness. With this in mind, I planned to have more time for self-expression. I started by having each member choose any instrument they wanted and to use that instrument in any fashion that they saw fit (short of breaking it). One of the group members did not feel up to this activity and practiced his self-awareness and communication skills to state that he had a head-ache and that he would feel more comfortable if he were allowed to leave the room during this activity. After negotiating, the group decided that it would be permitted. The other two remaining group members proceeded with the activity, but it was half-hearted and short-lived. I believe that due to empathy and consideration for the other group member, they reduced their time.

Once the other group member had been welcomed back, the second activity was introduced. I was very careful that all of the resources were shared out as fairly and as

precisely as possible. Each person was allowed to choose one plastic animal at a time for as long as they wanted, or until all of the animals were chosen. This allowed the process to be as fair as possible. They each then spent time organizing a story to tell with their chosen animals. Mark's story, once again, had a theme of older animals taking care of the younger animals. Sally's story was about birds building a nest out of flowers. Her stories seemed to have a reoccurring theme of careful and loving house or home building. Steve, who complained of the headache earlier, did not seem invested in this activity and he was unable to tell a story.

The power of drama therapy can be seen in this instance, because these children were able to use this projective technique to communicate their feelings indirectly through the situation in the story. I think that both of the two individuals who were able to participate in this activity expressed their hopes, dreams and desires for their lives. I realized that if I was looking for it, it was possible to recognize each child in the stories that they told. I also realized that these sorts of moments were occurring in my sessions last semester, but that I had not been able to see them.

In our fifteenth session together (I think it is important to note that I had missed the previous week with them due to a holiday), I had brought a number of different art materials so that this group could build their own puppets. We had used puppets just once before with this group. They were able to project some of their feelings into them and they seemed to enjoy working with them. As well, I provided each group member with a box so that if they each wanted to build their own puppet theatre, they could. The

group was very eager to get right to work building their puppets. They looked through the box of material that I had brought with me. Once again, Steve was not happy with the materials that I had brought. He seemed to be in a bad mood in general. The other two worked well, building their puppets. Sally wanted to build her puppet using a balloon. I said that that was fine, but that she should only use one so that everyone should have enough. After a while, she said that she wanted to use three. I said that that would be fine as long as there were enough for everyone to have three. Mark put her down by saying that she knew that she was only to use one, but she had to go and use three. I said that it was fine because there were still enough there for them all to use. Then Mark suggested that we get the recycling box out so that we could use the various materials there to build their puppets. The group went as a whole to get the box out and Sally dove in the box to get at the materials. They all then spent time to get some material out to use in the building of their puppets. Steve was very quiet and he was just wrapping one small box. Sally kept collecting different pieces of material to include in her story. There was a brief argument about taking art supplies.

The group worked happily on their own for most of this session, with only the occasional sniping back and forth which had come to be normal for this group. I often noticed that the boys seem to scapegoat the girl.

Then it was time to go. I told them that we did not have time to set up the puppet theatre because they were not finished working on their puppets and that they should put away their work, clean up and sit in a circle. Sally got very upset at this saying that I said

we would have time to make the puppet theatre. I explained that we would have time, next session, to finish building their puppets and to build the theatre. The clean up went fairly well, with only a few sideways comments made in Sally's direction. Mark mentioned a few times that he was a little uneasy with the fact that he was not sure that I would bring back his work. I assured him that I would.

Then it came time to sit in a circle to bring down the magic box. (The magic box is a technique created by Johnson (1986), described in Acting for Real (Emunah, 1994, p.232). This closure ritual has participants take down an imaginary box (often hidden in the ceiling) open it, and take out of it or place in to it, any hopes, fears, dreams, aspirations and emotions the client want to. These items are then kept safe until next session, where the box can be re-opened.) I asked all of the group members to help. Only Sally was willing to help. We brought the box down and Sally opened it. I asked the two boys if they had anything that they wanted to put into the box. They both said no. Then Mark and Sally made a quick face at one another that I did not see. A few more angry comments were exchanged, which led up to Sally getting up and retreating away from the group. I asked them both to calmly explain their side of the story. Steve was obviously in support of Mark. This ended in Sally leaving the room. Upon her return, the argument continued until Steve confronted Sally and they started to push one another, hence breaking my rules. This ended our session and we went upstairs, back to the unit. Once there, it was decided that there would be a further discussion of their behavior on Monday, because the session was late Friday.

There are a few explanations as to why this blow-up occurred. The first is that it could have been anger at me for leaving them for one week, while I was on my holiday. It also could have been anger at me for allowing Sally to break the rules and to get more than her fair share. If the balloons were a metaphor for my attention, she got what she wanted, whereas the others did not, and there could be a fear that there might not be enough to go around. This is a very clear example of how vigilant I had to be with my fairness. I thought that it would be enough that there were enough materials for all of them and that they all could have access to them when they needed them. Unfortunately, all that they saw was that Sally was getting more than her fair share. Another possible explanation for this blow-up could have been issues from outside the sessions, which seems to lead to Sally being cast as the scapegoat and me seemingly taking her side.

In our sixteenth session, we had an observer: my academic supervisor, Christine Novy. There was not enough time last session for them actually to work with the puppets. I wanted to give them an opportunity this week to work with the puppets that they had created. Puppets are useful because the client can project into them the characters that they wish to portray. More than that, they can tell a story of what these characters might be doing. There were a few comments made by Mark about the fact that there had been a fight between the other two members of the group last session. He tried to push the issue but the other two were not letting it get to them. I told him that that was in the past and that he could just let it be.



We started by bringing out all of the various puppets that they had built in the previous session. I made a special attempt to show them that I had done what I said I would do and taken care of all of their puppets and that they were all returned to them safely. I especially wanted Steve to feel as if his work were just as important as every one else's. I gave them an opportunity for the group to finish creating any puppets that they still needed and to create a puppet theatre out of the boxes I had brought. I had hoped that Steve would take the time to build a few of his own puppets. He did spend a little bit of time trying to think of ideas for puppets. He spent a great deal of time working on making a door in one of the boxes I gave him. Sally spent her time preparing for her story in one corner of the room. Mark spent his time working in the opposite corner to her. Steve worked in the center. Sally wanted to use the black cloth in her puppet show, so did Mark. I decided that, rather than give it to one person rather than the other, I would not let either one of them use it. As the time went on, Mark asked if Steve wanted to help with his story. Steve agreed that he did want to help. Mark explained a little bit about how he thought his story might want to go. He wanted to do a story about the mail being delivered and how there could be two mailboxes, one for Steve and one for him. He asked Sally if she wanted to be in it as well. She suggested that she could be the mailman and she would deliver the mail. This is a wonderful example of this group's improved skills in social interaction, communication and negotiation skills.

They continued to work on setting the scene for the story. Mark and Steve continued to cut holes in the boxes so that they could serve for mailboxes. Sally took down the work that she had been setting up so that she would have a great deal of mail to

deliver. I asked her if she wanted to tell her story. She said no because she would be helping them. I did not want to interfere too much because it is very admirable that they were able to work together this week.

The story went fairly quickly. Mark and Steve used the puppets that Mark had created in the beginning, but as the story went on Mark would talk as himself. Steve did not talk a great deal. Sally delivered anything and everything that she could get her hands on. Mark thought that it would be funny if the mail were to land on his head. The story ended with Mark collecting all of the mail and placing it in another box. Mark closed up this second box and he addressed it to his Uncle Keith in another town. (This was also a nice way to clean up.) Mark asked Sally for her help in spelling the words for him.

After this, we spent a little bit of time to de-role. Sally was very curious about the extra bag that I had brought for them. I had told them that we would have some time at the end of the session to play with it. The story had taken a great deal of time but I decided that it was very important for me to keep my word and let them play with the noisy slime. (Noisy slime is slime which, when pushed down on, creates a rude noise which these children thought was humorous.) We put out the mat and they played with the slime. They all seemed to enjoy it. There was some question about who would get to use the orange slime. I decided that the best way to deal with this problem would be to let them all have a turn with it. This worked quite well. There was not a great deal of time for them to play with the slime so I told them that we could use it again, next

session. Once again, it shows the importance of being fair to all of the members of the group, equally.

Next, we brought down the magic box. Mark had the inspiration to use the magic box that they had created in the story. I did not see a problem with this because it was a prop used in this story which they had created themselves as a group. Steve did not want to put anything into the magic box. Mark and Sally put the mail into the magic box. We did a quick tapping and the group went back upstairs to the unit. Tapping refers to a quick closing ritual which had the children knock, pat or rub the floor to communicate a message. I realized later that I should have mentioned how well they had done. Every once in a while, I should have encouraged them and given them some positive feedback, particularly as this session was such a large improvement over their last day's session.

At another session, March 10, I specifically organized the session so that they could work on their social interaction, communication skills, listening skills and negotiation skills. There was a little bit of excitement as they saw the new equipment that I had brought with me. I explained most of it to them. I then asked them to come into a circle. I started by discussing the fact that next week, some people would be coming and that they wanted to view the group. The group negotiated and discussed their opinions and it was decided that the observers would be allowed to watch next session.

Then, I asked them to show me a statue of what they did over their spring break. Sally did a statue of herself playing Nintendo. The other two group members did not

want to create a statue. We then played Crow's nest. Steve only seemed half interested in the game. He was lagging behind the other group members. He did not appear interested in the game. During the course of the game, it became apparent that there was tension between the group members. This group has always had bad feelings that seem to come and go. Tensions seemed high during this session. I did not like the tone of the game so I decided to be flexible and to go onto something else.

Next, I wanted the group to help set up an area so that we could build a minefield. Sally and Mark were willing to help but Steve sat in the corner. The two other group members were able to work together to create a rectangle on the ground, in tape, and to spread out a number of obstacles inside the rectangle. Then, they were each to put on a blind fold and the other one was to talk them through the minefield. As a fair method of choosing who was to go first, I had them pick a number between 1-10. Mark was closer. Sally got a little upset because Mark got to go first because "He always gets to go first". I told her that I had done it as fairly as possible. The group successfully crossed the minefield. They communicated to every member, in their turn, how best to navigate their path. Steve even chose to re-join the group and take his turn. Although this activity was successful, it was apparent that this group still needed practice with communicating. After cleaning up, we moved on to play with the noisy slime. To finish the group, after cleaning up the noisy slime, we did our usual tapping ritual and went back to the unit upstairs.

At this time, Mark had shown sufficient improvements in both his conduct and his behavior to be reintegrated back into regular school. He was no longer able to attend the drama therapy sessions.

One method of projection that I found to be very effective for this group is the use of finger puppets. On May 10, we spent the whole session using puppets. I started the activity by having each group member pull the puppets out of the bag, one at a time so that everyone could see all of the choices. Once this was done, I allowed each group member to choose one puppet with which they would like to work. Taking turns, they each chose a total of five puppets. Steve's story was a funny story about a lion telling on himself to the principal. The principal was wearing a bee on his head and stated that he would "bee" right back. His story ended with a rousing rendition of "We are family", sung by all five of his finger puppets. The story that Sally told had an underwater theme. The story was about a smaller fish and a very scary and mean octopus. The smaller fish was afraid of the bigger octopus and after discussing it with a few of her friends, she decided to kill the octopus by tricking it into eating some poisonous food. She told the octopus about some nice food and brought him to a stingray. The octopus then ate the stingray and died. Sally then said that was how the fish outsmarted the octopus. After cleaning up, we did our quick tapping and went back to the unit.

Given another opportunity to reflect on my second semester's work made me realize that re-setting the therapeutic goals was beneficial for me as well. In re-setting the goals, it allowed me to be clearer about my purpose as a therapist. When I could break

my goals down into smaller, observable, definable pieces, I was better able to determine how to reach them and how to assess when they were achieved. Re-setting my goals also allowed me to take some pressure off of myself. Earlier in the year, I had assessed my work by what I was unable to accomplish. In the second part of the year, my assessments were based on where the client was and how best to proceed from that point forward. There was not the same sense of judgement that I had felt earlier because there was no “right or wrong”, just an observation of the group’s current level and an opportunity to move ahead. It took away a lot of the responsibility I was feeling and placed it in the hands of the group members. Once again, I could not “change” these children, I could just show them various tools so that they could help themselves.

## **Chapter 9 Conclusion**

Over the course of this last year, I learned a great deal about the specific population I was working with and the needs of working with children. I learned that it was necessary for me to imagine drama therapy as a continuum. It was important for me to accept that drama, in and of itself, can be therapeutic and that if I were doing nothing else, just by doing drama I was helping my clients to heal.

At another critical point, I had to explore my definition of change and how that effected my work. I also had to look at making more reasonable goals for change. It was important to see that I was not responsible for changing their lives completely. I realized

that I could not “cure” these children and that I had to break down my goals for them into smaller, more realistic goals.

After re-setting the specific goals for this group, I learned better ways of working with them. I learned the importance of boundaries and containment. For children who may have not had a great deal of containment in their life, this was crucial. It helped them to feel safe and to relieve anxiety. It also helped to build a sense of trust between the children and myself. I also learned the importance of play in therapy. Play is central to how the child understands the world and therefore, its place in therapy is paramount. I learned how to play while still maintaining strict rules and limits. There was a balance between the two which had to be maintained. I also was able to spend more time choosing the various dramatic activities, specifically in regards to their therapeutic merit.

Lastly, I learned the importance of acceptance and advocacy. Part of my task as a drama therapist was to teach the children with whom I worked that I accepted them. This group may have experienced acceptance for the first time. This could go a long way towards building their self-esteem. Another part of my task as a drama therapist was to show the other central caregivers in the child’s life this acceptance and to advocate for a new acceptance and understanding of the child.

A large part of my process was finding my limitations. First, I had to learn that I could not “cure” these children. The disorders that they were suffering from would always be a part of their life to various degrees. Then, I had to consider that I could not

change these children at all. It was just my task to help them to live and cope with their disorders. I realized that it was not possible for me to rescue these children and to save them from their lives. Looking back, I can clearly see how I was suffering from rescuer's syndrome, and the negative consequences this caused. I had such a strong feeling of responsibility towards helping these children that it actually impeded my progress. By looking only at how far I had to go and not the specific path that I was going to take, all I was able to see was the incredible distance. Instead, by focussing on the little steps taken along the way, I could celebrate each little success with the children.

My journey to becoming a drama therapist has been a very difficult one but a very rewarding one as well. John Casson (1998) said it best when he stated: "I believe that fundamental to training is the enabling of trainees to find their own style" (p. 23). He saw that there was not one correct way to train drama therapists because there are just as many different types of drama therapists as there are methods to train them. It is important to note, however, that every drama therapist in training has to succeed at his or her own process, and in his or her own rhythm in order to find his or her own style.

This paper has helped me to bring together and reflect on everything I have learned over this last year, both as a student and as a therapist. I would like to think that this paper will help other students who might follow me. It could give them an opportunity to see the process that I went through and it would give them a guideline to follow in their own personal development.



I do not pretend to know all of the answers and I am not an expert in this field yet, but, more than anything, I have learned that it was each individual's process and journey that was important and not just the final destination.

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## Appendix A

### The Caterpillar and I

Group: Caterpillar, caterpillar.  
Where can you be going?

Child: Just across the garden path  
Where the grass and trees are growing.

Group: Caterpillar, caterpillar.  
Why do you go there?

Child: To build a house around myself  
And spend the winter there.

Group: Caterpillar, caterpillar.  
What, when winter's done?

Child: I think I'll be a butterfly  
And sail out in the sun.

(Dramatize the poem. The caterpillar walks, spins, sleeps, flies.)