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Melanie Pollock
mpolloc2@lesley.edu

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Exploring the Benefits of Developmental Transformations (DvT)
with Adults on a Short-term Psychiatric Unit

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Melanie Pollock
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Tomoyo Kawano
Abstract

This exploration aimed to explore the benefits of the drama therapy method, Developmental Transformations with adults on an adult inpatient short term unit. Five sessions of developmental transformations were lead by two drama therapy clinical interns as part of the expressive therapies group offered to patients. The group was open to any patients that were not actively psychotic and participation was voluntary. Patient responses and group leader responses to each session were recorded in a journal and artistic responses were also created. The findings fit into four themes: joy, inhibition vs. freedom, danger vs. safety, and distress tolerance. This exploration demonstrated the value in developmental transformations on a short term adult psychiatric unit, as an intervention for improving mood, practicing distress tolerance, and reducing maladaptive patterns of cognition, emotion, and behavior.
Introduction

In working on a short-term psychiatric unit for adults, this writer noticed several areas of need in terms of treating patients. This writer noticed a lack of playfulness, joy, and laughter on the unit within the group setting and instead saw repetitive themes and ruminations that would occur within groups. While the themes that the groups covered such as stigma, support, self-esteem, addiction, distress intolerance and so on, were important to the patients and likely an essential part of treatment, this writer noticed a difficulty in patients accessing the skills that were being worked on. While current treatment methods such as dialectical behavior therapy (DBT), work on these issues, they do not allow the patients to play with these themes or have substantial and palpable practice with the skills. Particularly this writer noticed a difficulty tolerating the uncomfortable, whether it was emotions, thoughts, or situations, which would often cause patients to leave group or to shut down within group. Furthermore, the current research with this population, including but not limited to the works such as that of Chiu, Hancock, and Waddell (2015) and Forrester and Johnson (1995) confirm that rigidity and inflexibility are common difficulties with this population, and moreover emphasize the need for increasing flexibility through playful means. Noticing this need for playfulness, and this need to play out themes and practice flexibility, this writer saw DvT as an alternative psychotherapy method that could possibly benefit the patients as well as expand upon the current psychotherapy methods used. Therefore, this exploration aimed to discover potential benefits of Developmental Transformations (DvT) on a short-term inpatient psychiatric unit with adults.

Literature Review

In order to further understand why this method would be beneficial on an adult short term psychiatric unit, it is important to look at the literature. The following will explore three
types of literature: literature that relates to the theories behind DvT, literature about current methods used with this population and how they connect to DvT, and literature on current uses of DvT and its benefits with a variety of populations. In looking at the varying research, this writer aims to explore how DvT can benefit this population and to highlight the importance of this investigation.

The Processes of DvT

To understand the value of this exploration, it is important to first look at the theory behind Developmental Transformations (DvT). DvT theory is grounded in the concept that life is intrinsically full of instability (Johnson, 2009). In DvT, these instabilities are believed to be the source of suffering; “DvT posits that it is the intolerance of ambiguity and incompleteness that leads to many maladies in the individual, family, and society” (Johnson, 2013, p. 31). Through the use of playspace, embodiment, encounter, and transformation, this suffering can be relieved (Johnson, 2009).

Playspace. The therapy happens within what is called the playspace. The playspace “is a mutual agreement among the participants that everything that goes on between them is a representation or portrayal of real or imagined being” (Johnson, 2009, p. 8), it is the “container of the entire therapeutic action in Developmental Transformations” (Johnson, 2009, p. 8). The play in DvT “consist entirely of dramatic, improvisational interaction between the therapist and client in which the therapist is an active participant in the play and intervenes through his/her own immersion in the client’s playspace” (Johnson, 2009, p. 1). Within the DvT playspace, the concept of safety often arises. It is important to be clear that DvT is not intended to be “safe”, but rather it intends to “focus on building self-confidence and capacity to remain balanced in unbalanced situations” (Johnson, 2013, p. 32). While DvT follows ethical guidelines for
“safety”, there is no intention for participants to be promised safety. Instead, participants are given permission to experience a lack of safety within a therapeutic space and with the support of a therapist (Johnson, 2013). Life does not promise safety and in order to prepare patients for the reality of the world and what they will experience, neither does DvT. Therefore, the goal is to help them bear the fear of harm by promoting the patient’s “courage, rather than safety” (Johnson, 2013, p. 35).

**Embodiment.** Within the playspace, participants also must be embodied. Embodiment is the way in which one experiences being in their own body; it is the state of being where mind and body connect, and “consciousness infuses substance” (Johnson, 2014, p. 72). Embodiment can be disrupted by certain life experiences, such as trauma, in which there can be a “feeling like one cannot live another second in this body” (Johnson, 2014, p. 72) or “complete dissociation where one has exited the body” (Johnson, 2014, p. 72). In order to work towards DvT’s aim of tolerating instability, and for allowing one to have a restorative and therapeutic experience, one needs to be present within their own body. Therefore, before the transforming, or encountering can occur, the goal is to bring the patients into a state of embodiment.

**Encounter.** In addition to being embodied in the playspace, the encounter also needs to occur. Encounter is the place where each embodied person interact with and experience the other (Johnson, 2013). As Johnson (2013) says, “If I am a source of turbulence, interacting with another source of turbulence greatly increases my sense of instability” (p. 46). Encounter is what one does anytime they interact with another in the world, and within the playspace it is essential to encounter other in order to have a restorative relational experience.

**Transformation.** When one is embodied and encountering another, there is an opportunity for a relational and personal repair (Johnson, 2013). DvT relies on transformation
for this effective change. Rather than sticking to themes and images presented, DvT encourages transforming them. There is no script or guide, and role and story is not held to a higher importance (Johnson, 2013). Since each person is going to feel attached or want to hold on to different images or themes that arise, there is a constant challenge for the group to adapt and transform (Johnson, 2013). Important to the idea of transformation is the concept of varielation. Varielation is “movement back and forth across a divide of difference” (Johnson, 2013, p. 50-51), it is a “dance between repetition and variation” (Johnson, 2013, p. 51). Varielation is a natural part of conversation and other interactions that one may have on a daily basis. DvT utilizes varielation to promote exploration and transformation.

Ultimately, “DvT is the transformation of embodied encounters in the playspace” (Johnson, 2013, p. 38). As Johnson (1991) discusses, suffering occurs from distortion in development, particularly in the areas of constriction, rigidity, and negativity. Many patients on the unit suffer from depression and anxiety, and their affect is constricted, rigid, and negative. DvT’s focus on spontaneity, embodiment, transformation, and play, can be seen as the counterpart to those areas of suffering (constriction, rigidity, and negativity), thus lending itself to be a helpful therapy tool.

**Play Therapy**

As DvT relies on play, it is important to explore the underpinnings of play and how it works as a therapeutic tool. DvT utilizes play’s purpose in human development, allowing a way to confront the uncomfortable and difficult, and allowing for the experiences of joy, humor, and excitement (Dintino, Steiner, Smith & Carlucci Galway, 2015). Play, as it is used in play therapy is found to aid in catharsis, self-expression, self-esteem, self-regulation, stress management, positive emotions, and so on (Schaefer & Drewes, 2014). Play has been shown to
“stimulate the neural structures in the brain and is critical for normal development” (Homeyer & Morrison, 2008, p. 211). According to Homeyer and Morrison (2008), this neurobiological understanding shows how using play therapy can help those who experienced some sort of trauma in development, by working on a neurological level. While play is helpful for children and adults who have experienced early developmental trauma, it goes beyond that. As Kelly says, “Adults need to play. We are working creatures, we are bonding creatures and we are playing creatures” (as qtd. in Olson-Morrison, 2017, p. 175). Understanding how play positively impacts one’s neurobiology and aids in therapeutic experiences for adults as well as children, supports the idea that DvT, a method that relies on the use of play, could be beneficial for adults in inpatient care.

Laughter. Within the concept of play, while not explicitly laid out by DvT theory, another early developmental process that is highlighted in DvT is laughter. Yim (2016) states that laughter therapy helps reduce anxiety and feelings of depression, and assists in improving interpersonal relationships. Yim describes one important theory of laughter relating to arousal. This theory states that “stress increases arousal, while laughter is able to reduce stress by easing arousal and tension” (Yim, 2016, p. 244). In terms of mental illness, stress is increased in a hospital setting as well as when one has anxiety or depression, and thus so is arousal. Laughter, such as that encouraged in DvT, reduces this arousal, ultimately relieving some stress. Freud (as cited in Yim, 2016) also discusses that laughter “reduces negative emotional responses or unpleasant feelings” (p. 244).

In looking at the effects of laughter, many connections can be made to the goals of DvT. DvT is designed to increase one’s tolerance for change and instability, improve interpersonal connections, increase psychological well-being, and so on. Similarly, laughter has a positive
effect on interpersonal connection, reducing stress/depression, elevating pain tolerance, and promoting psychological well being (Yim, 2016, p. 245). Since DvT often generates laughter, it can be argued that this method of treatment will also have similar benefits to laughter.

**Current Methods of Treatment**

Currently the treatment methods used on the unit include but are not limited to: psychotherapy (particularly DBT), and expressive therapies. DvT not only aligns with these methodologies, but moreover, as this writer will argue, enhances and reinforces the benefits of them.

**Psychotherapy.** Psychotherapy is a popular method to help treat those suffering from mental illness, and DvT aligns, and according to Johnson (1991), is a form of psychotherapy. From Johnson’s (1991) perspective, suffering occurs from distortion in development, particularly in the areas of constriction, rigidity, and negativity (Johnson, 1991, p. 286). Johnson (1991) believes that psychotherapy addresses these distortions by helping clients to “experience their own becoming, own freedom and limitations, as human beings. Instead of constriction, the goal is to expand the range and depth of experience through catharsis of suppressed feeling and encouragement to live out previously disallowed aspects of life” (Johnson, 1991, p. 286-287).

The hope is to increase flexibility in adaptability, tolerate ambiguity, and achieve acceptance of history and current circumstances (Johnson, 1991). DvT is particularly aligned with the goals of psychotherapy in that they are extensions in “methods of freedom” (Johnson, 1991, p. 287). In other words, DvT expands upon the concepts such as free association and active imagination which psychotherapists use to assist clients (Johnson, 1991).

One of the most common forms of psychotherapy treatment on the unit, is Dialectical Behavioral Therapy (DBT). DBT emphasizes acceptance and being mindful, or in the here and
EXPLORING THE BENEFITS OF DVT

now (Swales, 2016). This focus on the here and now is similar in DvT, in that there is a focus on staying present and allowing for transformation and flexibility in each moment, not holding on to past moments or future ones. A DBT therapist aims to validate the client, and to ultimately find the underlying truth in what is being said (Swales, p. 166). Similarly, a DvT therapist aims to join the client and follow their themes, and stay present with them, observing and playing with what the client is truly bringing to the playspace, whether explicitly stated or held in the body (Johnson, 2009). In DBT, it is thought that suffering arises from “a combination of pain and non-acceptance of the pain” (Swales, 2016, p. 168). This idea of non-acceptance of pain causing suffering is similar to the idea in DvT that suffering is caused by non-acceptance of change or turbulence.

Expressive therapies.

Authentic movement. Expressive therapies such as authentic movement have utilized this concept of freedom as well (Johnson, 1991). Authentic movement, a form of dance/movement therapy relies on similar principles to DvT. In authentic movement, “the mover focuses on internal experience and responding to that experience, rather than on the shape or direction of the movement” (Musicant, 2001, p. 18). Authentic movement allows for the “emergence of the unconscious” (Musicant, 2001), which is vital as “the relationships between conscious and unconscious, physical and symbolic...has potential as a healing, integrative process” (Musicant, 2001, p. 25). In addition to the emergence of the unconscious, authentic movement also discusses the importance of the patient internalizing “the attitude of openness and non-judgmental acceptance that characterizes the external witness” (Musicant, 2001, p. 25), and how this internalization leads to a patient’s stronger sense of self, including a more compassionate and curious attitude towards the self (Musicant, 2001, p. 26). It can be
argued that a similar experience can occur in DvT as a patient internalizes the openness and spontaneity of the therapist and the group, they may ultimately be able to show that openness and compassionate attitude toward themselves and their experiences.

**Expressive arts therapy.** In addition to freedom, other expressive therapies have been shown successful with this population, and align with some of the important DvT processes, further supporting its use with this population. In a study done to explore whether group expressive therapy can improve mood on an acute care unit, they found that expressive arts therapy groups helped to shift patients’ mood. The study utilized an open studio-based expressive therapy group, open to anyone on the in patient psychiatric unit, though not required. The group would start with a music warm up and then encouraged to “participate in whatever way they were inspired” (Chiu et al., 2015 p. 37), some would continue with musical instruments and singing, others would dance, some would utilize the arts materials that had been laid out, and others would watch. The main focus of the intervention was “flexibility and being in the “present moment”” (Chiu, Hancock & Waddell, 2015 p. 37), and the transformative nature of the communal space.

As Chiu et al. (2015) describe, there was a mood shift, which was found to be a result of a few different factors including: increased understanding and acceptance of the self, transformation of stigma and creation of community, and a safe environment where imagination and self-expression can be explored. By offering a playful space, it was found that “patients opened up their inner world and shared it with others in familiar and unfamiliar ways” (Chiu et al., 2015, p. 41). When this opening up of the self occurred, more acceptance of the self could come, and this would allow for a shift in mood. This is similar in DvT in that there is an offering of an open playful space in which the group has to tolerate the familiar and unfamiliar,
and explore the self more. It can be argued that this “playful opportunity” (Chiu et al., 2015, p. 41), exists in DvT as well and therefore could also be an intervention to help shift mood. Moreover, Chiu et al. (2015) discuss how in their study the facilitators entering into the space with the patients, bringing acceptance, allowed for everyone to be “seen and heard as valued creators” (p. 41), transforming stigma and creating “true human connection within a community” (p. 41). Additionally, the authors point out that many patients entering into units such as this, experience a sense of isolation and stigmatization, and this expressive therapy experience allowed those experiences to transform. Likewise, in DvT, the therapist always enters into the space with the patients and they are creating and transforming the play together. Similar to Chiu et al.’s study, the experience in group DvT also forms this sense of community and ignites human connection, which can also lead to de-stigmatization and reduced feelings of isolation.

Lastly, as Chiu et al. (2015) describe, those suffering from mental illness “are often highly sensitive, creative, and imaginative” (p. 41), and with this isolative experience of being hospitalized, their “imaginations could fuel their illness” (p. 41). This means that being isolated and being imaginative, could cause one’s imagination to focus on the illness and on the negative thinking and low mood that may accompany it. However, “the group experience offered them an avenue into their senses, their imagination and their self-expression within a facilitated, safe environment with others” (Chiu et al., 2015, p. 41). Group DvT similarly offers a contained and communal environment, in which imagination can be explored. Therefore, it could similarly benefit the patients as a transformative space for their thoughts and feelings.

**Using DvT: Expanding Upon Current Treatment Methods**
While DvT addresses similar needs as DBT, expressive therapies, and psychotherapy, it provides a mode of doing so which utilizes movement, sound, gesture, and dramatic character, allowing it to expand upon those methods. Furthermore, the current research on this method, as well as other drama therapy methods which rely on similar concepts as DvT, support the exploration into DvT’s benefits with this population. For example, in looking at DvT’s use on a similar short-term inpatient care unit, it was found that DvT can strengthen patients as well as units as a whole. Forrester and Johnson (1995) found that using play as a distancing tool from real world situations, allowed for self revelation and that the “positive humorous creative and spontaneous contents within each patient reassures them that they are not completely worthless or dead” (p. 128), and they can gain some agency over their experience of their illness. Furthermore, they found that “Laughter, relief, equanimity, and the connection are often the by-products of this type of dramatherapy group” (Forrester & Johnson, 1995, p. 128). Ultimately they find that DvT is effective at creating a “‘greater tolerance of oneself and relief from anxieties generated by rigid interpersonal stances’” (Forrester & Johnson, 1995, p. 128).

Schnee’s (1996) research into DvT with the homeless and mentally ill found similar results relating to tolerance of overwhelming feelings. Additionally, Schnee (1996) found that DvT allowed participants to play out group themes and find predictability and consistency.

DvT’s use with adult populations is also furthered in Butler’s (2012) research on DvT and Schizophrenia. Butler discusses the ability DvT provides for patients to experience emotions that they may not typically express. In DvT, “the therapist encourages the clients to go to extremes, enhancing the discrepancy and distance and giving them the chance to more fully embody the experience” (Butler, 2012, p. 90). The idea being that if one can experience and embody an emotion in the playspace, they may be able to bring that emotion into their real life.
Butler describes that “DvT can aid in motivating clients to participate in treatment and to be more active in the recovery process” (p. 90).

In looking at the research, it is clear that DvT is a potentially beneficial method for short-term adult psychiatric care in that it aligns with the population’s therapeutic needs as well as supports and expands upon current treatment methodologies.

Methods

The following section outlines the details of the DvT method and how it was used for this exploration.

Participants

For the purpose of this exploration, a DvT group was held on an inpatient unit in a large psychiatric hospital in Massachusetts. Currently, on this unit, there is an expressive therapies group every day. Within this group, DvT was implemented approximately once per week, maintaining the title as expressive therapies. This exploration utilizes five sessions held over the course of a few months. Due to the nature of the site, no one patient participated twice. On the unit being explored for this paper, the population consists of adults ages 17-65+. The diagnoses on the unit vary, though Bipolar, Major Depressive Disorder, Anxiety disorders, Substance use disorders, Borderline Personality Disorder, PTSD and developmental trauma are most common. Moreover, the reasons for hospitalizations vary including but not limited to suicidal ideation, manic or depressive episodes, medication stabilization, and suicide attempts. Despite the varying reasons for being on the unit and the varying diagnoses, there are many symptoms and presenting problems related to mood impairment that patients report having in common. These include but are not limited to: hopelessness, sadness, worthlessness, low self-esteem, loneliness,
self-harm or self-destructive behaviors, impaired social relationships, irritability and/or agitation, shame, and guilt.

Facilitators

This group is led by this writer, a third year drama therapy student and second year clinical intern, and a first year clinical intern, also a drama therapy student. The group is entirely co-led, though the leaders take turns running warm-up and starting the main body of the exercise. Closure and discussion is run together.

Method of Observation

In order to track progress, this writer took notes on both group leaders reactions/observations after each group as well as comments made by the participants during the discussion at the end of each group. Additionally, this writer created a piece of visual art representing their experience of each session, as well as one for the overall experience of this exploration.

Procedure

Warm-up. To begin each session, the two co-leaders would warm themselves up for leading the session. In the beginning this was done through their own 15 minute developmental transformations. One important image that came up was the two co-leaders imagining holding a ball with the faces of two experienced DvT practitioners on it, and taking a piece to carry with them as hope to emulate their knowledge and experience. With each new session, and limited time to warm-up, the co-leaders would exchange a version of this image, usually through a form of giving each other a small imaginary piece of the ball image to hold onto.

Following this warm up, the co-leaders would announce the start of the group via the speaker system on the unit. Additionally, they would walk around to personally invite the
patients who were visible on the unit to participate. Once in the room, a “check-in” would take
place in which each participant would say their name and how their day has been and how they
are feeling in this moment. Then, it would be explained that the group that day was going to be
a form of drama therapy called developmental transformations. It was explained that the name
may sound complicated and overwhelming, but that it is an activity full of play and fun. The
nature of the site is that groups are voluntary and often patients are allowed to come and go if
needed. Due to this fact, as well as the idea that it is important in DvT to both enter and exit a
playspace together, a group expectation needed to be established. The expectation was
described that if they chose to leave, that choice was respected, though patients were
encouraged to instead practice naming their discomfort and staying in the room. It was also
asked that if they stayed, that some level of participation was necessary, and observation would
be discouraged. One of the two co-leaders, would then encourage the group to stand up and
make a circle. Once there, the group was asked to check in again with how they were feeling,
this time with a sound and movement, that would be repeated back by the group. One of the
leaders would start to demonstrate. After this was done, the group would continue to pass
around a sound and movement to the person next to them, though this time it could be any
sound and movement they wanted. Sound and movements would continue to be passed around
in this manner, sometimes slightly altering how the movement was passed. For example, the
exercise may change from passing it to one’s neighbor, to going in the middle of the circle and
passing it to everyone. Once the leaders felt that the group was warmed up and feeling more
embodied and comfortable, they would make eye contact in order to agree to move on to the
next part of the activity.
Main activity. Once everyone was warmed up, the leader would ask the group to reach their arms up and imagine a curtain above them. The leader asked the group to describe the curtain and guided them through imagining what the curtain looks like, feels like, is it heavy or light. Etc. The leader then guided the group to grab the curtain and on a count of three lower the curtain to the ground together. The leader then asked the group to look inside and name things that they see in the imaginary world. Once the group appeared ready as determined by the leader, they were guided to imagine entering through the curtain, to close the curtain behind them, and push the curtain back to make a bigger playspace. Once in the imaginary space, the group leader would follow the group in free play, using the group’s ideas and free association to let images and play develop. The leaders utilized several tools to guide the play and to ensure the therapeutic nature of the exercise.

As Johnson describes, there are several stages that a group or individual goes through when participating in DvT. Starting with free play, a stage “in which the client and therapist play together relatively spontaneously, getting to know each other, exploring various roles and relationships” (Johnson, 1991, p. 292). The next stage is confrontation, where the more personal material begins to reveal itself and certain themes are repeated over and over, and the therapist begins to confront these personal themes. Next, is the impasse stage, when these personal themes are now being actively avoided. Often in this stage play can become boring or repetitive. Lastly, is the stage of remembering in which the impasse stage is broken through, and often there is a release of emotion and energy. Finally, is the integration stage, in which these personal themes are being owned by the client; this stage often involves a sense of reclaiming parts of the self and finding acceptance.
Due to the nature of a short term unit, patients often only participate in group once or twice. During this exploration, no patient came to DvT more than once. This means that the method usually stays in the initial free play stage. This stage usually does not have a lot of personal material come up, but instead more “the stereotypical stuff of everyday life: characters from soap operas, refrains from commercials” (Johnson, 1991, p. 292). The newness of the group and of the method for the participants means that it generally stays in the realm of superficial content, and as Johnson (1991) says are more a stage of “purging the self of unnecessary material…” (p. 292).

**Closure.** The closure exercise used in this group was a typical DvT structure of exiting the playspace using the curtain that they entered the playspace with. In order to close the playspace and distinguish and differentiate from reality, the group is asked to find the curtain they used to enter the playspace and hold it behind them. Then, the group was asked to name all the images, things they liked, words, themes, that came up in the playspace and to imagine placing them in the middle, leaving them in the playspace. Once the group has no more images to name, the leader asks everyone to step back out through the curtain to leave the playspace, close it in front of them, and on the count of three as a group, push the curtain back up. Then the leaders ask the group to shake out/off all those feelings and thoughts and have a seat. While typically in DvT, the processing of the session occurs within the play, for the purposes of this exploration, a discussion was held at the end of each session. This is mainly due to the inexperience of the leaders with this method and therefore they felt that processing may not always occur within the play if their guidance is not that of an expert. The discussion allowed for some of the processing that could not occur during the play to still occur. During this
discussion, the group was asked what the process was like, from there the discussion followed whatever the group brought up and their needs in that moment.

**Results**

This exploration explored the benefits of DvT on a short term psychiatric unit.

Information on the benefits was collected in three ways: notes on both leaders’ observations of each session, notes collected during post-session discussion with patients including patients’ responses to the activity, and lastly one of the leaders’, this writer’s, art responses to each session. The information that was observed is organized by session. For the purposes of discretion, Leader 1 will refer to this writer, and Leader 2 will refer to the other group leader. Patient responses were written in summarized bullet point form in a notebook by Leader 1, and did not contain quotations from the patients.

**Session 1**

**Patient responses as recorded by leader 1 during discussion.**

- Felt like a kid again
- Forgot I was in a hospital
- Want to hold on to laughter
- Forgot I could laugh
- Stayed through discomfort-accomplished it
- Worried about bringing up inappropriate themes
- Feel supported by friends, glad we did it together

**Leader 2’s response.** This group was exactly what I imagined DvT would be like, in the perfect scenario. The patients were playful, uninhibited, and shared how fun it was to connect with their child-like sense of play. The patients allowed to face whatever impulses arose, and we
made it work.

Leader 1’s response. In this session, everyone was so playful. I saw people who had never come to group, or who were known as difficult and rude patients, laughing and playing. This group was fun and during it, I felt very exhilarated and could see the patients’ moods lifting. It was a distinct change in affect from start to finish of this session.

![Artistic response to the first session.](image)

*Figure 1.* Artistic response to the first session. This picture represents the excitement, chaos, and joy experienced by this writer in the first session. The image of the spring represents the energy shift and the change in mood that this writer noticed during the session.

Session 2

Patient responses as recorded by leader 1 during discussion.

- Had fun
- Felt unsafe
- Felt very uncomfortable
- Uncomfortable but I did it
- Forgot I was in hospital
- Felt safe despite it being scary

**Leader 2’s response.** This group was scary, and a good reminder for me of the unit we were on and the patients we were treating. Patient J was completely fine, and minutes later was rocking back and forth and going into detail about her mother's funeral, telling us how dissociated she felt. After this, we always checked that no one on the unit was actively psychotic before running DvT. I learned how powerful and intimidating this work can be, and how quickly a switch can flip for these patients. We are doing some delicate stuff.

**Leader 1’s response.** This session was extremely difficult. During this session there was a patient that was exhibiting some psychotic features, mainly delusions about where she was, as well as signs of dissociation. However this was unknown to us before starting. During the session, this person did not want to participate but observe and usually this is allowed on the unit so we allowed it. After a while, this person chose to join the play however did not enter the playspace and exit the playspace with the group. While she seemed regulated during the session, during the discussion she began crying and felt that she was “very unsafe.” Once group ended, she continued to talk to us and her delusional thinking as well as dissociative symptoms became quite apparent. Afterwards, I felt very frustrated and felt that we did not hold the space. Throughout this whole session I had a knot in my stomach and felt incredibly anxious. This session was when I realized how important it is to be mindful of who is in the group, that DvT may not always work, and that it is important to practice and become an
experienced practitioner.

Figure 2. Artistic response to second session. This picture represented the knot that leader 1 felt in her stomach, as a result of the anxiety and disorganization of one of the patients within the group.

Session 3

**Patient responses as recorded by leader 1 during discussion.**

- Felt uncomfortable
- Stayed through discomfort
- Awkward
- Tough to be creative
- Had to pay attention and stick with it, difficult
- Very uninhibited
- Fun, new, frustration
- We are all different levels of engagement but helped each other

**Leader 1’s response.** During this session, I was very worried about people leaving. I felt
that the discomfort level of the group was high and there was a pressure to contain that. I noticed that my predictions about who would stay and who would leave were wrong. Some left that I thought would stay and some stayed that I thought would stay. Most important for me during this session was a man on the unit that had been extremely depressed, with slow psychomotor abilities, and a very blunted affect, smiled and participated. He would not get up from his chair, but he played and occasionally smiled.

Figure 3. Artistic response to third session. This picture represents the moments where DvT can alter someone’s current baseline, and for just a small moment, change can be seen.

Session 4

Patient responses as recorded by leader 1 during discussion.

- Forgot in hospital
- Stupid at first then okay
- Dangerous group to come to
- Uncharacteristically up/don’t want to be cheered up
• Liked it- my illness is plan oriented, when I have no plan I freak out. Freeing
• Play/hope felt like betrayal. betrayal to be better/have fun/be silly
• Fun, but worried about what themes I brought up
• Distracting from out there

**Leader 2’s response.** This group was great! We had some difficult patients in the room, but just met them where they were at for the entire time. I found that encouraging them to bring things from their lives into the play was very useful. One patient loves nature, and he introduced this idea that leaves were surrounding all of our feet. Another patient who is very hesitant to be playful, and quick to resistance, loves skateboarding. I asked her if she could teach us all how to skateboard, and after that she was completely in the play. Sometimes the patients arrive in the playspace at different moments, even after we’ve all entered as a group. You have to continue to welcome them throughout the session.

**Leader 1’s response.** During this session, I noticed the ability of DvT to open up creativity and to give an outlet to play with themes that maybe feel unplayable in real life. For example, one girl who had some intrusive violent thoughts as well as expressed some mania, had been feeling very bad about herself for the thoughts and for her lack of behavioral control due to mania, as she had disclosed to her team and therapists. Yet during the session, she had an opportunity to play with those intrusive thoughts and be allowed to have a little behavioral disinhibition and that it was okay within the safety of the space. This session, I was very aware of the dichotomous nature of heavy themes and “dangerous” themes existing with joy and laughter.
Figure 4. Artistic response to the fourth session. This picture represents the dichotomous nature of the danger and joy existing in the space.

Session 5

**Patient responses as recorded by leader 1 during discussion.**

- Fun
- Forgot where I was
- Felt creative
- Felt like a kid
- Stayed through discomfort
- Felt connected to others, thankful for them

**Leader 2’s response.** I see this group as a pretty normal DvT group on the unit, with the patients that we have. The patients were hesitant, and needed guidance from the facilitators throughout the group with regards to topics addressed in the playspace. They were unlikely to bring ideas and impulses to the group on their own. But they allowed themselves to be playful
with the concepts that we introduced. The play moved forward mostly by us asking questions
directly to patients that required some kind of creative response. We then ran with whatever
answers they gave.

**Leader 1’s response.** This last session I noticed the power of play and laughter to
relieve mood and relieve stuck patterns. A woman on the unit had been very stuck, reported
never feeling happy, difficulty focusing and smiling, felt she had lost interest in everything, and
had difficulty being creative and answering questions. However, during the DvT session, I
noticed her laughing and playing and that she was able to come up with creative ideas.

![Figure 5](image)

*Figure 5.* Artistic response to the fifth session. This picture represents the energy that comes
from participating in DvT and watching as a glimmer of that energy could be noticed on even
the most depressed of patients.

**Themes**

After observing and looking at the observations, this writer organized the information
into prominent themes. These themes highlighted both the benefits and the potential detriments
of this method on an adult short term psychiatric unit.
**Distress tolerance.** Distress tolerance was a theme that came up during these sessions. Comments about staying in the room despite being uncomfortable, or feeling good that they were able to do it even though it was awkward, demonstrated a sense of distress tolerance. Moreover, both group leaders made note of the discomfort they felt coming from the patients and in the room and that they stayed for the full group anyway.

**Danger vs. safety.** The theme of danger vs. safety came up a lot during the exploration. Comments about feeling a sense of safety while being playful, or that they felt very supported by the group, indicated that safety was a prominent feature of the exercise. However, the reverse of this also came up, in which some people reported feeling a lack of safety, or reported the “danger” of the exercise and in feeling vulnerable. The leaders also made note of this talking about the importance of safety and containment they observed, and how creating safety was an important part of group. This creation of safety over danger was observed to be related to fostering a sense of support and non-judgement, as well as ensuring to properly enter and exit the imaginary playspace.

**Joy.** The idea of experiencing joy was also expressed throughout these sessions in different ways. This joy was reported as: feeling happy, having fun, laughing, liking the activity, and smiling. Both therapists also commented on the apparent shift in mood and affect upon participating. For example, patients who had a low mood and flat or blunted affect prior to group, were found smiling and laughing, a noticeable shift than their typical presentation on the unit.

**Distraction.** Within joy, arose the theme of distraction. One of the most common patient responses after the activity was that they forgot they were in the hospital. The activity and nature of the exercise allowed them distraction from being hospitalized. In addition to forgetting
they were in the hospital, another common comment was that they were able to not ruminate, that the negative thoughts and feelings were stopped for a short time. Lastly, it was described that it took a great deal of focus to participate and that they felt they could not be distracted by other thoughts and feelings.

**Freedom vs. inhibition.** Lastly, a theme of freedom vs. inhibition was identified throughout this exploration. Many patients reported feeling like a kid again, and being playful. As one patient said, “this was very uninhibited.” The activity was described as playful and difficult, and many patients described the feeling of discomfort. Both leaders made note of observing patients getting out of stuck patterns, such as negative thinking. As one patient made note, her illness has to do with control, and this exercise gave her safety to not be in control, she said it was “freeing.” Additionally, there was mention of feeling guilty for bringing up certain themes, or odd for trying to avoid certain themes. The leaders noticed patients opening up throughout the play, and acting in ways different from their typical presentation, and being more uninhibited, as well as patients feeling a sense of freedom to play out those thoughts, feelings, and behaviors in a contained place.

**Discussion**

This exploration examined the benefits of DvT with adults on a short term psychiatric unit. Previous research indicated that DvT had the potential to be beneficial for this population but research using this exact method was limited. The findings from this exploration indicated similar results to that found in the literature, finding that the emergent themes (distraction, distress tolerance, danger vs. safety, joy, and freedom vs. inhibition), demonstrate three key benefits: improving mood, distress tolerance, and as a way to break up stuck patterns of thought, feeling, and behavior.
Improved Mood

One of the key findings of this study is that DvT has the potential to improve one’s mood. This mood improvement was linked to distraction from life stressors, creation of community and support, decreased isolation, feelings of accomplishment and strength, and an experience of joy. As Chiu et al. (2015) discuss, hospitalization can be isolating and stigmatizing, not to mention the patients are usually there due to a crisis in their life, often a suicide attempt or suicidal ideation. Therefore, this brief distraction from these problems can provide a temporary relief from the pain of those thoughts. The findings also indicate that DvT helped create a sense of safety and community support within the group. Again, when isolation and stigmatization are common issues (Chiu et al., 2015), this creation of safety and support can provide a shift in mood that otherwise does not occur on the unit. Additionally, laughter improves mood (Yim, 2016), as does play (Chiu et al., 2015) and thus the reports of laughter and playfulness are also indications of improved mood.

Distress Tolerance

In addition to improved mood, it was also found that DvT was beneficial for practicing distress tolerance. Not all patients who stayed, felt “safe,” some even reported feeling a sense of danger or vulnerability. However, these patients stayed, and tolerated their distress during the activity. The findings show that DvT supports DBT theory, and the practicing of mindfulness or focusing in the “here and now” in order to tolerate distress. Patients and therapists noticed the way in which this skill can be practiced in DvT in an active way.

Decreasing Maladaptive Cognition, Emotion, and Behavior

Lastly, DvT was found to be beneficial for decreasing maladaptive cognition, emotion, and behavior. As Johnson (1991) discusses, suffering occurs from distortion in development,
particularly in the areas of constriction, rigidity, and negativity (p. 286). This indicates that patients in acute psychiatric care, who are suffering, may be constricted, rigid, and negative. The findings indicate that patients experienced a sense of release by letting go of rigid patterns, negativity, and constriction, and instead practicing being uninhibited. As DvT theory emphasizes, healing occurs from being able to be in the here and now and allowing spontaneity to exist--tolerating the instabilities of everyday life. The practicing in DvT of improvisation, spontaneity, and transformation, allows for lowered rigidity, and increased adaptive thinking, feeling, and behaving.

**Limitations**

There are a few key limitations to this exploration that are important to mention: the participants observed and the experience and bias of the group leaders. In terms of the participants, the group was not required, therefore the patients observed in this exploration were voluntarily participating. This means they were willingly engaging in the exercise, which may skew the results. Those who voluntarily came and left were not interviewed and therefore their reasons for leaving are unknown. Those who did not attend were also not interviewed. Additionally, the site is not racially or culturally diverse, with majority of patients being white, so there is no way to tell if there would be any cultural differences or implications for the results. Furthermore, while patients of varying gender identities, sexualities, and socioeconomic statuses did participate, majority were cisgender, heterosexual, and middle class. Both leaders were white and English speakers, and so patients who did not speak English often left group due to lack of communication, which again may have an impact on the results. Additionally, while play may exist across cultures, it may differ in its use and its cultural implications, another factor that may have an impact on participants and thus on the results.
Additionally, the group leaders are both students and not certified DvT practitioners. While the students have both practiced DvT in school, and took a course on DvT, their experience is still limited. The limited experience of these practitioners may have an effect on the results as their ability to guide the patients through play and spontaneity may not have been as successful.

Moreover, while this writer has no conflict of interest, there is a potential bias involved in terms of what information is presented and recorded. While the writer attempted to record and write patient responses, they are not direct quotes. Thus, the recordings of patient responses could be skewed due to misinterpretations on behalf of this writer. Johnson (1991) says that the unhelpful counter-transference responses of therapists during DvT include: closing off options in role play, introduction of unrelated material, lack of acknowledging reality, or an “empathic lapse” (Johnson, 1991, p. 298) in which the therapist misses an important issue, image, or theme that the patient presents. Of note, this writer recognizes that due to her own discomfort with impasse, sometimes her or the other leader would bring in unrelated material to try to encourage play within the group. Moreover, this writer acknowledges that due to lack of experience, all of these unhelpful situations arose at some point during the exploration.

Lastly, during some of the sessions, the leaders emphasized that it would be fun and help with distress tolerance. The leaders encouraged patients to stay through distress. Due to these actions of the leaders, patients’ responses may have been influenced.

Implications for Clinical Practice

The findings that DvT benefits patients on a short term inpatient psychiatric unit, has important indications for future clinical practice. The criticism towards using DvT short term would be that there is less time for patients to begin to incorporate the improved mood, distress
tolerance, and spontaneity, into their everyday lives. The working through of difficult themes and vulnerabilities does not have as much time to be explored. However, this exploration shows that there are indications for usefulness of DvT even in short term work, mainly: temporary sense of joy, increased understanding of one’s potential to tolerate stress, and a momentary escape from ruminations and negative thinking. Despite the short term nature of acute hospitalization, DvT is an excellent way to create community, break ruminative cycles, provide some joy, and show them their potential to tolerate suffering.

In addition to the benefits, it is important to understand if there are any concerns regarding using this method short term. Since DvT is usually practiced over a longer period of time, there is a risk in short term work that patients may be left feeling more vulnerable. As said above when working longer term, the patient has more time to accept vulnerable feelings and process difficult themes. The risk here is that the patient isn’t given appropriate time to process and learn. As DvT therapy suggests however, this risk is an essential element for therapeutic transformation. It is through these moments of danger, and the potential for harm, that relationships and the self can be repaired.

As Johnson (1991) highlights, there are several stages of DvT, starting with free play, a stage “in which the client and therapist play together relatively spontaneously, getting to know each other, exploring various roles and relationships” (p. 292), moving onto confrontation, impasse, remembering, and finally, integration. While any of these stages may arise during a session, in this exploration, the experience was mostly contained in the initial free play stage. Staying in this stage can provide a safer approach to DvT for short-term work. It allows the focus to remain on play, improvisation, spontaneity, and roles, in order to help improve mood
and practice distress tolerance, without going into more difficult themes, with no time for transformation.

**Conclusion**

While this exploration had some limitations, it demonstrated the ways in which DvT could benefit adults on a short term psychiatric unit. There is often a goal in short term inpatient treatment to contain patients in order to discharge from the hospital. As a result, a method such as DvT which may be perceived to be too “dangerous” or lacking “safety,” or perhaps even lacking the time to practice in this setting, is sometimes avoided. However, as this paper explores, there are benefits to the ambiguity and lack of “safety” that DvT utilizes and thus the method should continue to be explored and practiced within the inpatient setting.
References


