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Developmental transformations with Alzheimer's patients in a residential care facility

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ABSTRACT

Developmental transformations (DVT) is presented as an effective therapeutic modality for individual and group work with Alzheimer's patients. Effectiveness is defined for this population and validation therapy is outlined as an established paradigm for working with demented individuals. DVT is presented, including basic premises and previous literature on its effectiveness with non-demented elderly. Theoretical connections between validation therapy and DVT are explored, as are areas in which DVT moves beyond validation to access areas of remaining competency for the demented and to elicit the symbolic expression of psychological and existential issues. Adaptations for using this method specifically with Alzheimer's patients are described, limitations are acknowledged and areas for further exploration are proposed. Case material is presented throughout.

Due to advances in nutrition, medical technology and other social and environmental factors, more people are living into their elder years than ever before. Advancing age is the single greatest risk factor for Alzheimer's. One in eight people over the age of 65 and 50% of those over 85 suffer from some form of dementia. According to the National Alzheimer's Association (2007), 5.1 million Americans are estimated to have Alzheimer's and this number could reach nearly 16 million by the year 2050 (p. 6). In the United States alone direct and indirect costs of Alzheimer's and related dementias amount to more than $148 billion annually (p. 14). This disease affects individuals of all racial and ethnic backgrounds and socio-economic classes. Furthermore, it not only affects those who suffer from it directly, but also places an enormous psychological and financial burden on friends, family members and caregivers. Alzheimer's disease is a significant mental health issue, the impact of which will only increase over the next several decades as the baby boomer generation reaches their elder years. As such, it is necessary that we begin to develop more effective therapeutic strategies to meet the unique psychological needs of this rapidly growing clinical population.

The intention of this paper is to present one such method – a form of drama therapy called developmental transformations (DVT) – as an effective therapeutic modality for individual and group work with Alzheimer's patients. I will begin by defining effectiveness in the context of this population. Validation therapy will then be presented as an established paradigm for working with demented individuals. Following that, I will outline developmental transformations, focusing on basic premises underlying the method as well as previous research on its effectiveness with non-demented elderly. Connections between validation therapy and DVT will be explored, as well as ways in which DVT moves beyond validation to access areas of remaining competency for the demented and to elicit the symbolic expression of psychological and existential issues. I will also discuss specific adaptations that must be made in using this method with Alzheimer's patients. Case material will be presented from my own work with this population at the Irene Swindells Alzheimer's Residential Care Program at California Pacific Medical Center in San Francisco. In closing, limitations of this method as well as areas for further exploration will be discussed.

Effectiveness

Within the field of psychotherapy, effectiveness is generally defined through observable and/or subjectively reported improvement in the patient's life circumstances and well being throughout the course of treatment. How then is effectiveness to be measured for Alzheimer's patients who suffer from a degenerative and ultimately fatal disease, who do not have the capacity for insight into their illness, and who cannot track their own experience beyond a brief segment of time? As improvement, per se, is no longer a viable therapeutic goal, clinical interventions are generally aimed at increasing the quality of life of those who suffer from Alzheimer's disease.

The following is a list of specific therapeutic objectives which have been adapted from goals outlined in the validation therapy

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literature (Feil, 1985, 1989, 1991, 1999, 2007) and further developed through my own work with this population. Therapeutic goals for Alzheimer's patients include: (1) increasing positive affect, as evidenced by more frequent smiling, laughter and positive remarks, (2) decreasing negative affect, as evidenced by less frequent frowning, crying, negative remarks, combativeness and aggressive behavior, (3) increasing interpersonal interaction, as evidenced by more frequent displays of eye contact, sitting upright, participating in group activities and initiating interaction with others, (4) decreasing isolation and inward withdrawal, as evidenced by less frequent refusal to participate in activities, sleeping during group, dissociation and blank or distant gaze, (5) affirming personal strengths, identity and sense of self, (6) facilitating a greater sense of community and interconnectedness, (7) providing appropriate cognitive and sensory stimulation to maintain current levels of functioning, (8) facilitating physical movement to maintain current levels of bodily awareness, endurance and flexibility, (9) providing a safe container for emotional expression—especially for processing grief and loss, (10) supporting patients in processing unresolved conflicts and/or trauma from earlier developmental stages, (11) providing a creative outlet for the symbolic expression of death anxiety and other existential concerns, and (12) providing emotional support and psycho-education for family members and caregivers. Currently, the principal approach for treating Alzheimer's patients is validation therapy.

Validation therapy

Validation therapy is a method for communicating with elderly people who suffer from Alzheimer's and related dementias. It was developed by social worker Naomi Feil during the 1960s and 1970s. Prior to her pioneering work, the primary approach to work with demented elderly was called reality orientation. As its name suggests, this method involved ongoing efforts by family members and caregivers to reorient the Alzheimer's individual to consensual reality. During her work at the Montefiore Home for the Aged Feil discovered that the goal of reorientation was not only unrealistic but also led to greater withdrawal, vegetation and hostility among the patients that it purported to help (Feil, 1983, 1991, 1999). Thus she developed a new method for communicating both verbally and non-verbally with demented elderly.

In validation therapy, the therapist uses empathic listening, emotional and physical mirroring and therapeutic touch to join the demented person in their own reality. All verbal and non-verbal communication by the Alzheimer's patient, no matter how nonsensical or illogical it may seem, is viewed as an attempt to facilitate interpersonal connection and as an expression of that person's internal experience of reality. As such, in working with Alzheimer's patients, the therapist accepts the client fully and without judgment, listens empathically, joins in their reality and names the emotional undercurrent of their communication (Feil, 1989).

For example, Jane, a 95-year-old Alzheimer's patient, suddenly shouts: "Where's my mother? She said she would be here by now!" A therapist working in a reality orientation model might respond by saying "Actually your mother passed away many years ago. You're 95 years old, so your mother could not possibly be alive." However, a therapist working in a validation model might respond by saying "You've been waiting for your mother for a long time, haven't you? It's very hard to be disappointed by the people that we love. It can make you feel very sad and angry. Is that how you feel right now?" The reorientation response would be likely to elicit greater confusion and anxiety whereas the validating response holds greater potential for Jane to feel seen and understood, and to express her feelings more fully, leading to decreased confusion and anxiety.

Utilizing Erikson's stages of psycho-social development, Feil (1985) proposed a final stage of life after integrity versus despair which she calls resolution versus vegetation. In this phase the demented elderly person retreats into the past to process unresolved conflicts from earlier life stages. "As naturally as the adolescent rebels for identity, the disoriented old clean house before death" (p. 92). Feil (1985, 1989, 1991) suggests that this stage of resolution versus vegetation occurs only in the population now called the old–old (those 80+) and that this stage was not previously identified because never before in history have so many people survived beyond the age of 80. Although validation therapy cannot restore cognitive functioning, it is considered effective in helping to slow, and in some cases even prevent, progression into the state of vegetation which occurs in the final stages of the disease (Feil, 1983, 1985, 1989, 1991).

Returning to the previous example, the validation worker might view Jane's comment about her mother as related to the absence of primary attachment in infancy or perhaps a pattern of disappointment experienced in intimate relationships throughout her life. As such, Jane's behavior would be viewed as a means of purging unexpressed feelings of loss, grief and anger related to this unresolved psychic conflict. Theoretically if the therapist can consistently provide a supportive container for the expression of these unresolved feelings and conflicts, then the patient will be less likely to withdraw into isolation. In effect, she will be moving toward resolution rather than vegetation (Feil, 1983, 1985).

In her work with elderly suffering from Alzheimer's and related dementias, Feil found that empathic validation leads to an increase in positive affect as evidenced by more frequent smiling, sitting upright and reaching out to others, as well as a decrease in negative affect as demonstrated by less frequent swearing, biting and scratching. She also found that dormant speech returns, social roles within the group reemerge, social interaction increases and group members begin to express common concerns and feelings (Feil, 1989, p. 90). In a 1972 study the charge nurse at the Montefiore Home reported that those residents who participated in the validation group were less anxious and less demanding of nursing time than those who did not participate (Feil, 1985, p. 101). A 1973 study further demonstrated that permanent change can occur in the demented elderly, though it is slow and fluctuates from day to day. After 6 months in a validation group participants "became less incontinent; speech improved; less crying, hitting, pounding, more smiling, talking, helping others; more awareness of external reality; more interaction outside of group meetings; greater contentment" (Feil, 1983, p. 62). Feil (1991) also found that the validation group lead to reduced anxiety, improvement in activities of daily living, increased attention span, improved gait, a decrease in ego-centricity and stimulation of memories of former social and familial groups (p. 112). Moreover, validation therapy consistently led to less burnout and more positive interactions for the family and caregivers of demented elderly (1991, 1999).

These remarkable results have stood the test of time, and validation therapy is now recognized across the globe as the principal therapy for elderly suffering from Alzheimer's and related dementias. It has provided a basic framework for therapeutic communication with the demented elderly, thus facilitating the necessary conditions of safety, trust, containment and empathy that are essential for any therapy to take place. As such, validation has paved the way for the application of play therapy, sandplay and various forms of expressive arts therapy to this population as well. One such form, which is particularly well-suited to the unique needs of Alzheimer's patients, is a type of drama therapy called developmental transformations.

Developmental transformations

Although a complete discussion of the theory and practice of DVT is beyond the scope of this paper, I will attempt to outline its basic intentions and premises. For a more thorough exploration I encourage the reader to see Johnson (2000). Developmental transformations, created by drama therapist David Read Johnson, is a highly improvisational form of drama therapy which seeks to free individuals from the inhibitive psychic structures which prevent them from being fully present, spontaneous and creative in their daily lives (Johnson, 2000). These psychic structures are loosened through a process of mutual play between therapist and client(s). Essentially, DVT is a dramatic and embodied form of free association. Emphasis is placed on the present moment, which is continually transforming and giving way to new images and forms. However, rather than discussing these emerging images, memories, feelings, thoughts and ideas, therapist and client(s) play with them through sound and movement, improvisation and role play, as well as structured and unstructured dramatic scenes.

In DVT all dramatic exploration takes place within what is called "the playspace". This is the term for the mutual agreement between therapist and client(s) that everything occurring between them is a representation or portrayal of reality. The playspace has three conditions: (1) mutuality: all participants recognize that what takes place within the playspace is pretend, and they agree to play together interactively, with a shared sense of imagery and theme, (2) discrepancy: there is an aesthetic or theatrical quality to all action within the playspace, which serves as a reminder that the action is pretend, and (3) restraint against harm: although we may play with representations of harm, no actual physical or psychological harm can occur within the playspace. In DVT it is not the therapist, but rather the playspace itself which serves as the container for the clients' psychic material. The function of the therapist is to facilitate, maintain and expand the playspace. As the playspace expands, the unplayable becomes playable. That is, psychological material that was previously too overwhelming to address gradually becomes more tolerable for both client and therapist (Johnson, 2005).

At the core of DVT is the fundamental paradox that something can be simultaneously real and not real. During a DVT session therapist and client(s) inevitably play with very real and often disturbing feelings, experiences, memories and desires. However, it is precisely the mutual agreement that "this is all pretend" which allows client(s) the freedom and the safety to express those aspects of themselves which would otherwise be either denied, repressed or too emotionally overwhelming to acknowledge.

Current literature on developmental transformations with non-demented elderly

Although there has been little written thus far on the efficacy of developmental transformations specifically with Alzheimer's patients, it has been demonstrated as an effective therapeutic modality for work with non-demented elderly (Johnson, 1986; Johnson, Smith, & James, 2002; Smith, 2000). Through participation in the DVT group the elderly come to experience increased tolerance for themselves and others, as well as decreased anxiety as rigid interpersonal structures are loosened. The group also provides a temporary transitional space through which integration can be achieved between the elderly patient's past and present sense of identity, as well as between their internal world and the external world of the nursing home (Johnson, 1986).

According to Johnson et al. (2002), the three central concepts of developmental transformations – embodiment, encounter and transformation – are all directly relevant to the major concerns with which the elderly are confronted. Embodiment immediately calls to mind one's relationship to his or her body, thus raising fears of physical deterioration, vulnerability, incontinence, illness and death. In addition, for those elderly who have lost mobility due to a stroke, amputation or other condition, embodiment may bring about feelings of loss around movement which was once joyful and is now painful and restricted. The element of encounter raises feelings related to one's relationship to others. For the elderly this can bring up concerns about isolation, loss of loved ones and intimate partners, fears of becoming a burden, as well as feelings of being unseen, marginalized or forgotten. For those elderly suffering from Alzheimer's disease encounter can also raise feelings around the loss of recognition of others and even the self. Finally transformation serves as a reminder of the need to mourn what has been lost, to accept the inevitability of change and to confront the fear of the unknown: tasks which all become increasingly pertinent as one nears the end of life (Johnson et al., 2002).

Smith (2000) also views developmental transformations as an embodied form of existential psychotherapy for the elderly, in which clients are invited to play with issues of death, freedom, isolation and meaninglessness. She feels that "the tendency among healthcare workers in nursing facilities to avoid issues of death and other existential concerns can lead to misguided attempts to direct the clients to think about positive things, no matter how superficial or untruthful this may be for the clients" (p. 321). I have observed in my own DVT groups that the participants' energy and interest rise noticeably when the play focuses on themes that are actually relevant for them, such as loss, death, confusion and disorientation. This point will be illustrated through a case example derived from a DVT session with seven Alzheimer's patients.

> "You know I... it... oh dear, it was a... Mmm... oh, you know the, uh... um, the..." We all listen patiently as Iris continues. "Oh dear, I've lost it. It was a 'c' word." "Oh no!" I shout playfully. "Our dear friend Iris has lost a 'c' word! Does anyone see a 'c' word lying around here somewhere? Quick! Check under your chairs!" We all lean down and start searching around our seats for the missing word. "I guess it flew away," I say. Donald begins to flap his arms and we all join him, embodying the words as they fly away. "How are we going to catch them?" I ask. Donald cowers playfully and says: "Don't catch me!" I melodramatically sneak up and place my hands on his shoulders. "Gotcha!" I exclaim as he screams playfully. The group offers different ideas for how to catch the words. Together we pull down a giant word trap and some word food to put inside of it. Suddenly Iris shouts: "This is such a messy way to do this! Shouldn't the leaders be handling it?!" "You're right, Iris," I reply. [Referring to my co-facilitator] "We're supposed to be in charge here! We should be the ones taking care of this problem... Oh wait, I think I see one!" I stand up and leap across the circle clasping my hands together around the imaginary word. I look inside my hands, gasp, then show the contents to Iris. "Is this the one you were looking for?" "You smooshed it!" she retorts. "Oh dear, I'll have to be more gentle then, huh?" My co-facilitator and I continue leaping around the circle catching words to the delighted laughter of the group members. With exaggerated care and tenderness I scoop up an imaginary word that had come to rest on Rose's knee and offer it to Iris. "I don't want that one either!" she says with an irritated tone. I kneel down before her. "Iris, I bet what you want is for them to stop flying away in the first place, huh?" Silence. "Yes... That's right..."

In this session we play with some very real and disturbing aspects of Alzheimer's disease: confusion, memory loss and expressive aphasia. The participants no longer have the observing ego function which would allow them to discuss their symptoms ver-

bally, yet they are still able to play with the experience of the symptoms through an embodied image within the playspace. The energy and flow during this point in the session were incredibly high, which I attribute, as stated earlier, to the fact that we were playing with real, relevant aspects of their experience. The difference, however, is that in real life this experience is one of frustration, shame and anxiety. Yet within the playspace we are able to transform it into an embodied image around which they are able to cultivate some humor and acceptance.

Connections between validation therapy and developmental transformations

Philosophically, the main connection between validation therapy and developmental transformations is their absolute and unconditional acceptance of the subjective reality of the individual client. DVT conveys this in its "commitment and respect to the client's inner world" (Johnson, 2005, p. 6). Feil (1993) expresses this in her first three principles of validation: "(1) All people are unique and must be treated as individuals. (2) All people are valuable, no matter how disoriented they are. [and] (3) There is a reason behind the behavior of disoriented old–old people" (p. 29).

Validation and DVT are similarly aligned in their conceptualization of the primary therapeutic benefit to the client. In DVT, according to Johnson (2000), "the process of play is used to loosen or remove (i.e., deconstruct) psychic structures that inhibit the client(s) from accessing primary experiences of Being" (p. 87). Feil (1993) similarly states another principle of validation: "painful feelings that are expressed, acknowledged, and validated by a trusted listener will diminish. Painful feelings that are ignored or suppressed will gain strength" (p. 29). As such, both approaches presuppose that the natural state of the psyche is one of health and wellness, and that this state is reached through the "via negativa," or the removal of blocks to pure being (Johnson, 2001). Thus in both validation and DVT the ultimate goal is not to change the demented individual, but rather to provide them a container through which painful feelings, unresolved conflicts and inhibiting psychic structures can be expressed. The Alzheimer's patient will never become less demented. However, Johnson (2005) suggests that through DVT, the "fear of the instability of being," which can lead to withdrawal, rigidity and confusion, will be reduced. Feil (1991) further proposes that if this process of validation is successful the demented individual will not withdraw inward to vegetation, but rather will be able to die validated and with a sense of peace.

Validation therapy has truly revolutionized dementia care. Its therapeutic benefits to the Alzheimer's individual are light years ahead of those offered by its predecessor, reality orientation. Developmental transformations shares many of the fundamental theoretical and philosophical premises of validation, and yet, it offers even greater means to address the physical, emotional, psychological and existential needs of this population.

Developmental transformations with Alzheimer's patients

Developmental transformations is particularly well-suited to the unique needs of the Alzheimer's population because (1) it utilizes play as an area of remaining competency for the demented individual, (2) it promotes the symbolic expression of unresolved conflict, psychic material and existential concerns, (3) it subscribes to the philosophical proposition that being itself is unstable, and (4) it is non-linear and allows for high levels of formlessness and ambiguity.

Play as an area of competency

In work with the demented elderly, DVT is concerned primarily with imagination and play as areas of remaining competency. One might be skeptical of the benefits of imaginative play for this population, fearing that it might create even greater confusion and disorientation. On the contrary, the demented often become *more* alert and active within the playspace, a phenomenon which is supported by the neurophysiology of the disease (R. Sarison, personal communication, 11 April 2007).

In Alzheimer's disease, memory loss progresses backwards in time. Thus recent memories are the first to be lost, whereas very early memories persist into the later stages of the illness. Numerous developmental psychologists have identified play as the earliest form of learning and the foundation for all later cognitive development. As such, even when the Alzheimer's patient has lost major cognitive skills such as memory, logic, reasoning and abstract thinking, he or she retains the ability to play. Thus, when engaged in the playspace Alzheimer's patients are actually utilizing portions of the brain which are still intact. As a result, they often become more lucid, alert and active. They relate more in the present moment, initiate interactions among one another and demonstrate greater bodily awareness. Operating within an area of competency also leads to greater self-esteem and self-efficacy, which in turn facilitates an increase in positive affect as well (R. Sarison, personal communication, 11 April 2007).

Symbolic expression of their inner worlds

Due to their cognitive deficits, Alzheimer's patients are no longer able to consciously process or verbalize their inner experience as a high-functioning adult might in traditional psychotherapy. However, they are able to express and explore pertinent psychic material symbolically through images and metaphors that arise within the playspace. This is similar, in some ways, to the manner in which a young child might explore intra-psychic conflicts through sand tray or play therapy. The following excerpt, derived from a DVT session with fourteen Alzheimer's patients, illustrates this point.

> Betty sits in the back of the dayroom – tall, elegant and meticulously groomed. We have just begun our weekly DVT group and in an effort to coax her into the circle my co-facilitator playfully sings out "C'mon up Betty. There's a chair right here with your name on it!" Her curiosity piqued, Betty stands up and tentatively enters our circle. Parking herself in the chair, she remarks sharply: "It doesn't have my name on it!" Sensing her distrust and suspiciousness, I respond in a playful manner, "You're right Betty. That chair doesn't have your name on it! [Pointing to my co-facilitator, with an exaggerated accusatory tone] She lied to you, didn't she?!" My co-facilitator immediately takes on the role of the pathetic, guilty perpetrator as I become the sadistic plaintiff. "We don't like liars around here, do we?" I howl. "NO!" come the enthusiastic replies from the group members. "Well then how should we punish her?" I ask. The energy in the group rises steadily as they offer various suggestions. "Throw her in prison!" one gentleman calls out. They all agree and cheer as I mime locking up my co-facilitator. She then turns to the group and asks what she'll have to do in prison. "Eat!" one participant calls out. "Well that doesn't sound so bad," she replies. "What else?" "Play!" another bellows. Agreeing that a prison where you eat and play sounds quite pleasant, I decide to join her. Together in prison we turn to the residents who are seated in a circle around us. "Well if we're in prison," she inquires, "then are you all the prison guards?" "They're the guards!" Betty asserts boldly, pointing across the circle at two of the lower-functioning

residents who have been dozing intermittently throughout the session.

The participants in this group are perhaps not consciously aware that they live in a locked facility where their time is strictly regimented between eating, sleeping and activities. This reality cannot be acknowledged directly as it would undoubtedly cause them great anxiety, confusion and emotional distress. However, Feil believes that on some level of consciousness the demented are aware. This seems to be the case as they are easily able to explore their experience through the thinly veiled but quite poetic metaphor of the prison where you eat and play. They give us a glimpse into their experience by enrolling us as the prisoners and utilizing us as projective objects.

Interestingly, when we inquire as to the prison guards, Betty adamantly points across the circle. For her, and likely for many of the other higher-functioning residents, their captivity is not imposed by the nurses or unit staff as one might think, but rather by the lower-functioning members of their own community who serve as a constant reminder of the inevitable deterioration and decline hovering just over the horizon. The prison might also be interpreted as a metaphor for their intra-psychic or existential experience. Not only are they prisoners on the locked unit, but also prisoners within their own inner worlds, held captive by the isolating effects of dementia. Within the playspace the unplayable becomes playable. Those topics which would normally create unbearable emotional distress become accessible. As this excerpt demonstrates, even the many aspects of Alzheimer's patients' experience which are beyond their conscious awareness can find expression through image and metaphor using developmental transformations.

The instability of being

Unlike most other psychological paradigms, the theoretical foundation of developmental transformations does not rely on notions such as growth, insight and stability which are immaterial within the world of the demented individual. At the core of developmental transformations is the philosophical proposition that being itself is unstable. According to Johnson (2005) "The universe is not at rest, we are not at rest, and whatever frame, form, awning, shelter, floor, ground, or shield we build or hang on to that gives us the temporary illusion that life is stable, will yield to transformation, change and eventually disappearance" (p. 9). This illusion of stability serves an important function—it provides a sense of continuity over time, a feeling of control over the outcome of our lives and a common ground on which to relate to one another. However, this illusion of stability is a luxury that the demented no longer enjoy. For the Alzheimer's patient, consciousness is fluid and time is nonlinear; the past, present and future flow together into a single, ever-shifting moment of being, and this is often a terrifying experience. The ultimate goal of developmental transformations is to reduce our fear of this condition, in part through experiencing moments of joy through humor and play. This is an especially important goal for the demented as they live in constant and inescapable awareness of the instability of their own being.

Non-linearity, formlessness and ambiguity

Unlike other forms of drama therapy, DVT does not rely on the use of role, story or plot. Rather it "emphasizes the continuous approach to the moment of presence, to forming rather than to form" (Johnson, 2005, p. 7). Other more structured methods of drama therapy generally involve some form of dramatic enactment with a specific location or setting, various roles, and a clear beginning, middle and end. In order to engage in this type of scene, participants must be able to remember the setting, the roles and the arc of the story. They must also be able to retain the fact that they are participating in an enactment as opposed to a real life encounter. For Alzheimer's patients this is not usually possible, especially as the disease progresses. This is not to say that they cannot pretend, but simply that their pretend play cannot be expected to remain within any fixed form.

In DVT memory is not a prerequisite. Setting shifts seamlessly from one's childhood bedroom to the surface of the moon and back to the here-and-now. Roles shift from moment to moment, from person to person and from individual to collective. Elements may be repeated or developed, but there is no plot. All elements of the play can and often do remain undefined. Through this ambiguity of space, time and role, Alzheimer's patients are able to engage fully in the play even despite their memory impairment. Furthermore, in some ways this ambiguity actually mirrors the internal world of the demented individual and gives them an opportunity to explore and express their feelings in relation to it. I will illustrate this point through a case example. The following is derived from a developmental transformations group conducted with thirteen Alzheimer's patients.

> Early in the group we decide to take a trip to Paris. Rose devises a magic sound and movement which we use to transport ourselves instantly to a beautiful garden overlooking the Eiffel Tower where we dine on delicious French wine and cheese, pick fragrant bouquets of flowers and even hold a conference with the President of the United States. Eventually Paris begins to fade away and we shake our hands to release the image. I ask where we should travel next. "Around the world!" shouts Jean.. "And how should we travel?" I ask. After much deliberation we decide to fly. Using another one of Rose's magic movements we sprout wings and begin to fly around the world. "Should we fly the whole way, or should we stop somewhere?" I ask. "Oh, we must stop somewhere!" one participant replies. "Well then where should we go first?" I inquire, but no one has a response. We cease our flapping as everyone contemplates. Stanley stands up, wanders to the back of the dayroom, and retrieves a large rubber ball with the earth painted on it. Holding the ball up for the group to see he mumbles "Well this is where we're. . . and I've been. . . and this is. . . oh. . ." "Let me see it" calls Jean. Stanley places the rubber globe in her lap. "She's got the whole world in her hands!" I joke. We break out singing "She's got the whole world in her hands; she's got the whole wide world in her hands. . ." Jean turns the globe over and over but is still at a loss. "I know why we can't think of a place to go!" I declare. "Maybe where we really want to go is to nowhere." The energy rises suddenly and there are shouts of "No!" and "Definitely not!" Even Myrna, who rarely comes to group, let alone participates, speaks up to share her disdain for my idea. "Why don't you want to go to nowhere?" I ask. Betty replies: "Because no one will be able to find us there." There is a pregnant silence in the room. It hangs for a moment and then is broken by Jean who suddenly shouts: "Timbuktu! Let's go to Timbuktu!"

The struggle to define the setting of the play was a reoccurring theme in our groups, and perhaps reflected the residents' ongoing disorientation to place. After many attempts to define our location I suggest that perhaps we should just accept the ambiguity and allow ourselves to remain in "nowhere". It may be that their familiarity with this condition, including averse feelings about it, lead to increased interest and flow around this issue, which manifested in their immediate and united opposition to my idea. Thus the image of traveling to nowhere served as a metaphor for their experience of disorientation and allowed them to express their feelings about it, namely anger and fear. Betty's comment that "No one will be

able to find us in nowhere" seemed to strike a cord with the other residents. On one hand it refers to a very literal fear that many of the residents have expressed that their family and friends will be physically unable to locate them. In addition, it can be interpreted as a deeper existential concern related to isolation—a fear that as their dementia progresses they will gradually withdraw to some interminable void where they will be psychically and spiritually unreachable. Thus the playspace permits a certain ambiguity which is not only attuned to their fluid state of consciousness, but can even serve as a metaphor for their experience of dementia.

Adaptations in using developmental transformations with Alzheimer's patients

Due to the unique needs and cognitive deficits of Alzheimer's patients, there are a number of adaptations that must be made in order for the method to be used effectively with this population. These adaptations relate to issues of (1) range of functioning, (2) mutuality, (3) deficits in memory, (4) the role of the therapist and (5) the use of physical touch.

Range of functioning

In discussing his work with the elderly, Johnson (1986) warns that "if the range in cognitive functioning is too great, the group will have difficulty establishing a sense of cohesion" (p. 18). Within a group of Alzheimer's patients, there can be enormous deviation in lucidity, attention span, cognitive processing, verbal coherence, interpersonal awareness and memory retention. Ideally in a DVT group with this population, members would be pre-selected to assure a similar level of cognitive functioning. However, this is not always possible and so I have developed several strategies to meet this challenge. First, I encourage each individual to participate at his or her own unique optimal level—that is, as fully as possible but without becoming anxious or overwhelmed. This means that some residents are called on more frequently to offer imagery for the session and to take on roles in structured play, while others participate only in unison sound and movement and still others simply act as witnesses. In addition, I seat all of the higher functioning residents together, as they will often act as catalysts for one another, thus increasing the overall energy level of the group. Furthermore, I try to always utilize the individual strengths of the participants. For instance, some love to dance, others know all the words to certain familiar songs and still others can tell stories about their lives or converse at length on particular topics of interest. Over time I have become familiar enough with them to anticipate who is likely to become energized around a particular image, movement, theme or role and I engage them accordingly so as to maintain the flow of images and the level of energy.

Mutuality

In DVT mutuality is a shared agreement among all participants that what takes place within the playspace is pretend, and that participants will be playing together interactively with a shared sense of imagery and theme. When left unengaged Alzheimer's patients tend to retreat into their own idiosyncratic realities. However, with assistance, they can join temporarily in a mutual reality, and during a group session it is the facilitator's primary task to create and maintain such a reality. In her work doing expressive therapy with severely confused patients, Sandel (1987) states that "since the therapist alone is able to maintain the notion of a group, s/he is the primary link among the participants, as well as the major tie to social reality" (p. 118).

Although the patients that I worked with were able to differentiate between real and pretend, their memory impairment prevented them from retaining this information, thus making it impossible for us to remain in a mutually agreed upon state of play for the duration of the session. Because mutuality cannot be taken for granted with this population, discrepancy takes on added importance. Actions and roles must be clearly discrepant and participants must be reminded of the playspace throughout the session. This can be done through explicit verbal reminders such as "Let's all take a bite of our *imaginary* apples", "If I was to *pretend* to be Betty's mother. . ." or "we're all going to *make believe* that. . ." Thus mutuality can occur during an Alzheimer's DVT group. However, it cannot simply be assumed, but rather it must be actively assessed and sustained throughout the session.

Deficits in memory

In Alzheimer's disease there appears to be a certain degree of implicit memory formation. Patients will demonstrate an increasing level of familiarity and trust in the therapist over time, and this trust leads to an increased willingness to engage in play over time. However, the lack of explicit memory prevents group norms from developing as they otherwise might. Thus, whereas the therapist in a non-demented group would be less directive over time, in a demented group, even one that has met for years, the therapist will still introduce and maintain the playspace in a more explicit manner. Furthermore, the majority of the action will be what Johnson calls surface and persona play, revolving around more obvious roles and superficial themes. Given an adequate level of trust in the therapist, there can be intermittent moments of what he calls intimate and deep play, focusing on more significant interpersonal, intra-psychic and existential themes. This is made possible, in part, by the loss of persona which naturally occurs as the disease progresses. However the play will not deepen in a gradual, linear fashion, as it would in a higher functioning group (Johnson, 2005).

The role of the therapist

The therapist in a DVT group has two roles: manager of the playspace and playobject. As manager the therapist offers various structures for the play. A structure may enhance the play leading to greater flow, or it may inhibit the play leading to impasse, at which point the therapist offers a new structure to reengage the group. As playobject the therapist accepts and embodies the projections of the client(s). In a high-functioning group the therapist would serve simultaneously as both manager and playobject. Johnson (1986) suggests that the elderly, in general, are "best served if there are two therapists who can play out different aspects of a relationship with group members and whose relationship with each other can become a useful focus for the group" (p. 18).

In my experience a DVT group with Alzheimer's patients functions most effectively if the primary therapist manages the playspace while a co-therapist serves as playobject. Due to their fluidity of consciousness, Alzheimer's patients require greater structure than other higher-functioning groups. If there is only one therapist and he or she, while acting as playobject, steps too far into role, the participants may become confused, disoriented or even agitated. However, if there are two therapists then the co-therapist can embody the images and projections of the group while the primary therapist facilitates the interaction between them. For example, let us say that during the course of play, the image of a monster emerges. The co-therapist would embody the monster while the

primary therapist elicits participants' responses to the monster, facilitates the interaction with the monster and, if necessary, reminds them that this is all pretend. In essence, the co-therapist serves as the three-dimensional canvas on which the group's imagery is projected and the primary therapist performs their lost observing-ego function, thus providing them with the necessary distance and safety to project and explore their intra-psychic content. My suggestion is that a therapist who is working alone should always hold the role of manager as primary. When serving as play-object, she or he should do so with added discrepancy so as to assure that participants continue to recognize the action as pretend.

Physical touch

According to the ethical standards of DVT touch is allowed within the playspace. However, "the action of the touch is guided by a shared image in the play, rather than by the kinesthetic feelings evoked by the physical contact" (Johnson, 2005, p. 27). Alternatively, with Alzheimer's patients who are often cut off from the world due to visual and auditory impairments touch becomes a necessary source of human contact. Feil (1993) describes touching as a fundamental element of validation and outlines several specific techniques which can help to foster an intimate and loving relationship between caregiver and patient (p. 48). Of course, without special training in somatic methods, touch should only take place in public areas of the body such as hands, shoulders or upper back. Furthermore, as the demented elderly are often less able to communicate their needs and preferences, the therapist must have a heightened awareness and sensitivity to the needs of the patient and must heed any signs of resistance to touch.

Limitations and areas for further exploration

One limitation of this method is the extensive training necessary to conduct DVT effectively. Whereas the basics of validation therapy can be taught to caregivers and family members through brief workshops and training sessions, it takes years of training, as well as a significant degree of comfort with improvisational theatre, to become a certified practitioner of developmental transformations. However, this added training does lead to greater knowledge, experience and skill in helping the demented individual to processes deeper emotional, psychological and existential material. In a society which increasingly idolizes youth, beauty and productivity, it is difficult to justify expending greater resources to the elderly, let alone the demented elderly. However, they are a rapidly growing population with great psychological need. Developmental transformations is an actual method of psychotherapy, and perhaps the only one that can meet the needs of these unique individuals.

Another limitation of this method is the difficulty in providing quantifiable data to support its effectiveness. As Alzheimer's patients cannot be considered accurate reporters of their own experience, effectiveness must be measured through observable changes, or in movement toward certain therapeutic objectives such as those listed earlier. Over the course of the DVT session I have witnessed an observable increase in positive affect and decrease in negative affect, increase in interpersonal interaction and decrease in withdrawal, as well as an increase in emotional expression and sense of community. The group does provide physical, cognitive and sensory stimulation and, as evidenced by my case examples, the content of the play often contains deeper interpersonal, intra-psychic and existential themes. However, I currently have no way of measuring change in these factors over the course of many sessions. According to Feil, effective treatment with this population should prolong withdrawal into vegetation. However, the rate at which the disease progresses varies greatly across individuals. As such, even in a controlled study, in which participants were matched on variables such as age, health and personality, one could never entirely account for this natural variability in rate of decline. As such, results would always be subject to scrutiny. Of course, such is the plight of every form of psychotherapy which seeks to validate its own effectiveness according to a scientific model. Human behavior will always involve infinitely more variables than we are able to control.

I believe that the most convincing evidence for the effectiveness of developmental transformations with this population is the subjective experience of its benefit as judged by those who are closest to the patients. Further research might begin with interviewing professional caregivers as well as family members of Alzheimer's patients on how they view this method as being beneficial to their client or loved one. However, it may be necessary to provide psycho-education in advance around the notion of play as an area of competency for this population in order to avoid potential perceptions of this method as infantilizing. It might also be informative to interview caregivers and nursing home staff as to how the use of DVT in the facility affects their level of job satisfaction. In my experience, not only do the positive effects of DVT on the patients lead to more positive interactions between patients and staff, but staff members who themselves participate in DVT groups also exhibit more positive affect and elevated mood. Perhaps the DVT group could even be used as a forum for patients and staff of the nursing home to play with their feelings toward one another, thus working toward healing the entire system.

I have attempted to communicate my own subjective experience of the benefit of this method for Alzheimer's patients. Further research begins with the proliferation of developmental transformations as an appropriate and valuable method for working with this population, and I hope to have contributed to that aim through this paper.

Summary

A large segment of our population is soon to enter their elder years, thus creating a new challenge for the field of mental health. In the past it was believed that the demented elderly must be reoriented to reality. Owing to the truly groundbreaking work of Naomi Feil, we now have ways of understanding and validating the internal experience of Alzheimer's patients, and through developmental transformations we can move even further. DVT focuses on play and imagination as areas of competency for the Alzheimer's patient, it attunes to their reality through its belief in the instability of being and its focus on the present moment, and it elicits the symbolic expression of psychological and existential issues in ways that no other form of psychotherapy can achieve with this population. Through DVT the demented elderly experience improved affect, an increase in interpersonal connection, a decrease in isolation and withdrawal, and an increased sense of community. They reconnect with important aspects of their identities, their sense of self is reaffirmed, and they access and share memories of their lives. Through the playspace, they are able to express unresolved pain and conflict from the past and to explore significant existential concerns through image and metaphor. They smile, laugh, play and delight in their reawakened capacity for human connection. The transformation that can occur is nothing short of miraculous, and the joy and wisdom of our elders need not be lost.

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