Power-Play: Exploring the Potential of Theatre of the Oppressed (TO) as Group Psychotherapy with Patients and Clinicians

Akhila Khanna

Presented in partial fulfillment of the MA in Drama Therapy at the Steinhardt School of Culture, Education, and Human Development at New York University.

2023

CONTENT

- Abstract………p. 3
- Acknowledgements………p. 4
- Introduction………p. 5
- Literature Review………p. 10
  - Partial Hospital Program (PHP)
  - Mental Illness, Clinical Care and Power
  - Group Therapy: An Approach to Framing Relational Power
  - Drama Therapy: An Approach to Feeling Personal Power
  - TO: An Approach to Reimagining Systems of Power
  - TO: An Approach to Group Therapy
- Methodology………p. 26
  - Setting, Participants, and Timelines
  - Data Collection
  - Data Analysis
  - Ethical Considerations
- Findings………p. 34
  - Emergent Protocol and Treatment Goals
  - Spectrogram Data
  - Case Vignettes
  - Yalom's Therapeutic Factors in TO
  - Drama Therapy Core Processes in TO
  - Starhawk's Model of Power in TO
  - Embodied Mapping
- Discussion………p. 59
  - Therapeutic Potential of TO in Group Therapy
  - Factors to Consider when Framing TO as Group Therapy
  - Limitations
  - Future Directions
  - Conclusion
- References………p. 75
- Appendices………p. 93
  - Appendix A – Subjective and Objective Observation Template
  - Appendix B – Spectrogram Table
  - Appendix C – Video of Embodied Mapping Exercise

ABSTRACT: Patients and clinicians both experience varying degrees of power and powerlessness in a clinical setting that can impact a patient's recovery. Theatre of the Oppressed (TO) is a theatre methodology developed by the Brazilian activist Augusto Boal that is historically rooted in the idea that enacting power dynamics can lead to transformative action and collective liberation (Boal, 1992). What is the potential of TO as a group therapy model with patients and clinicians who otherwise represent polar ends of power within a hospital setting? This thesis is an observational case study of a 10-week-long TO group with patients and clinicians at a Partial Hospitalization Program (PHP) in New York City. In this study, the 'potential' of TO is examined by observations of pre- and post-spectrograms (Kole, 1967), Yalom's (1995) therapeutic factors of group psychotherapy, drama therapy core processes (Jones 2007, 2016; Frydman et. al., 2022), Starhawk's (1990) model of power and an embodied mapping exercise (Rieger et al., 2022). On average, group members rated themselves as feeling more powerful on the spectrograms after the TO intervention than before. Consistent examples of group therapy and drama therapy core processes were observed in the sessions. Power dynamics between clinicians and patients changed from moment to moment in every group depending on the nature of the TO enactments. The group facilitator encountered a blurring of boundaries between her role as 'joker' and 'therapist' and between 'clinician' and 'patient.' The thesis concludes by discussing the potential of TO as group psychotherapy and therapeutic factors for practitioners to consider when situating TO in heterogeneous communities.

KEYWORDS: Theatre of the Oppressed; group psychotherapy; drama therapy; power dynamics; Partial Hospitalization Program

ACKNOWLEDGEMENTS

To Mama, Papa, and Ishaan, for securing the firm yet shaky grounds for my power.

To Dr. Yamini Krishnamurty, for teaching me to dance my power.

To Nani, for nurturing my poetic power.

To Sanyukta and the core team at Aagaaz, for reminding me to be humble and responsible in my power.

To all my TO teachers - Dr. Radha Ramaswamy, Jill Wadsworth, Julian Boal and Escola de Teatro Popular, Vandana Asha, and Rang Kaarwaan - for debating with me how to critically re-imagine our power.

To Nisha, for modeling an unapologetic and urgent embrace of power.

To Maria, for tending to my quiet, messy, and vulnerable power.

To Britton, for emboldening and expanding my power.

To the community at PHP - Chantal, Sean Paul, Laura, Dani, Matt, Carolyn, Shoshana, and every human who walked through that unit - for trusting my power.

To all the drama therapists and creatives whom I consulted and collaborated with on this study - Opher Shamir, Mecca Burns, Jessica Bleuer, Aabshaar Wakhloo, and Ashim Bery - for sharing with me your wise power.

To Romik, for loving me in all my power.

To the Drama Therapy 2023 Cohort, for strengthening our collective power.

INTRODUCTION

"Miss who you be to be talkin' to us about power? You want me to feel powerful when I don't have power? That's fake. Y'all fake."

One of the first drama therapy groups that I facilitated as an intern at a Partial Hospitalization Program (PHP) was entitled 'Power Play.' When a patient said this to me on entering the group, he made the parameters of our relationship quite clear. He existed in a system that disempowered him. I would not be able to understand the extent of that disempowerment. I was actively part of a system that contributed to his disempowerment. Yet he could exert power at this moment by stating his own disempowerment. These dynamics of power/disempowerment, within me, within the patient, and within the relational spaces we occupied together in the hospital, will frame my thesis.

Patients and clinicians both experience varying degrees of power and powerlessness in a clinical setting (Ocloo et al., 2020). On receiving the diagnostic label of a severe and persistent mental illness (SPMI) patients can often experience social and perceived stigmas, financial barriers, social isolation, and job losses that are associated with increased suicidality, self-directed shame, anger, and diminished self-efficacy (Hamann et al., 2017; Livingston and Boyd, 2010; Quinn et al., 2015). That patients voluntarily attend treatment programs like a PHP and engage in recovery is also evidence of their innate proactive capacity to assert agency and cope with those stressors (Deshmukh et al., 2021). Clinicians can also experience disempowerment when routinely interfaced with their patients' trauma(s) (Figley, 2002), an overburdened and under-resourced healthcare system (Pines & Maslach, 1978), and more recently pandemic-exacerbated exhaustion (Fink-Samnick, 2022). At the same time, their licensure, state-sponsored education, and clinical knowledge give them the power to dominate, oppress, and exclude, as

well as to treat, care, and institutionalize (Montero, 2004). In treatment settings patients and clinicians enter a kind of power-play with each other. The clinician in a position of institutional power treats a patient, yet each carries within their personhood an induced or internalized sense of power *and* powerlessness. What is the therapeutic potential of visualizing these contradictions of power with patients and clinicians in a group?

My thesis assumes an urban liberation psychology definition of ‘power’ and ‘health.’ Power is “dynamic, relational, and multidimensional, changing according to context, circumstance, and interest. Its expressions and forms can range from domination and resistance to collaboration and transformation” (Hunjan & Pettit, 2011, p. 5). Power emerges not only from an absence of constraints but also from an active selection of life choices in our environment (Bandura, 2006). Patients and clinicians are both intrinsically motivated by a desire for power over their life choices and limitations imposed on them by a mental health system that exists at the intersection of state control, capitalism, and a strictly objective medical model (Montero, 2004). An awareness of these social forces can then motivate them to transform these dynamics to liberate not only themselves but also each other (Freire, 1970). As a drama therapist-in-training, I feel my role then is to understand that my own and my patients’ lived experiences and illnesses emerge from within these (sometimes shared) oppressive contexts. A sign of health in a treatment setting is when these unconscious enactments and directions of power can become conscious and subject to true will and action toward mutual change (Haddock-Lazala, 2021).

Theatre of the Oppressed (TO) is a methodology developed by the Brazilian activist and dramaturg Augusto Boal. It is historically rooted in the above principle of liberation psychology, which assumes that an examination of one’s power dynamics can lead to collective action and liberation of self and others (Boal, 1992). In a TO exercise, a protagonist-actor uses the “aesthetic distance” provided by the theatre to rehearse real-life conflicts (Boal, 1990, p. 28).

This aesthetic distance exists whenever there is a separation between the space of the actor and that of the audience members, or when there is a dissociation between the two (Boal 1990, p. 28). According to Robert Landy (1996, p.13), drama therapy as a modality also facilitates this “distance” for a patient who is perhaps seeking either a closeness to or alienation from their feelings, thoughts, and physical self-image. This aesthetic distance allows an actor in a TO performance, much like a patient in drama therapy, to be optimally engaged both affectively and cognitively so that they can imagine and transform their everyday realities into a more desired reality. The audiences who are watching a TO performance are not mute spectators but action observers or ‘spect-actors.’ Within this aesthetic distance, they too actively transform themselves into the protagonist or parts of the protagonist to rehearse alternative actions in response to the protagonists’ conflict. Meaning-making in the imaginary realm of aesthetics can stimulate intrapsychic change for a patient in drama therapy (Landy, 1996). Similarly, collective brainstorming around a conflict in the imaginary realm of TO can stimulate action toward the disruption of power dynamics, which is liberating to both the actor and the spect-actors (Boal, 1992).

For years, TO’s participatory and dialogic format has been used widely in communities by drama therapists, social workers, and activists to address therapeutic goals - with patients with a social anxiety disorder (SAD) (Paula & de Oliveira, 2014), with female victims of intimate partner violence (Mondolfi-Miguel & Pino-Juste, 2021), with LGBT2SIQ+ youth (Bleuer, 2020), in family therapy (Proctor et al., 2008), with at-risk immigrants (Ramdath, 2016; Sajnani, 2010) and even with healthcare professionals (Bewer et al., 2021; Mayor, 2020; Middlewick et al., 2012); however, there is limited literature on TO involving both patients and clinicians in a group therapy setting (Proctor et al., 2008). According to Yalom and Leszcz (2020), group therapy is a form of social therapy in which members who have been through a

similar experience replicate their everyday interpersonal behaviors with each other. The social microcosm of the group facilitates a rehearsal of new behaviors within the group, which members then replicate in their everyday life. Group therapy models like drama therapy involve a triadic relationship between the therapist, the group members, and the artistic process so that members experience connections and transformations not just with other people, but also with the art that they and other members are creating (Rusch & Imus, 2017). Group therapy and drama therapy interventions have been used widely in clinical settings all over the world to reduce patient wait time, reduce inpatient hospitalizations and promote overall patient recovery (Haen & Webb, 2020; Orkibi et al., 2014; Weiner, 1992). The therapeutic factors that are specific and unique to group therapy have also been shown to increase the efficacy and accessibility of treatment by facilitating peer-to-peer support for individuals who may be experiencing similar symptoms of illness (Lyons et al., 2021).

In order to examine the potential of TO as a group therapy model my thesis then poses these subsidiary questions - what happens when a TO group involves not just patients but also clinicians as equal participants in the therapeutic process, given that they are both co-existing within the healthcare ecosystem? TO like drama therapy centers a creative process and aesthetic distance in its methodology. What are the potential therapeutic functions of this aesthetic distance when TO is situated as group psychotherapy? How do therapeutic functions of TO elevate, shift or/and transform power dynamics between the patient, clinician, and me?

In an attempt for liberation, therapists are often at risk of replicating the systems of their own past oppressors and oppressing their patients for the sake of their own freedom (Montero, 2004). I am an upper-caste, able-bodied, English-speaking female, born and brought up in India, interning within the American hospital system. My verbal and non-verbal body language is highly influenced by my caste and class which are in turn rooted in India’s complicated colonial

history. I am what Bhatia (2008) terms a "child of liberalized India" (p. 92). I have spent my youth living in a post-colonial and post-liberalized India dialogically engaging with Western ideas because of my exposure to English medium education, social, and transnational mobility. At the same time, I am steeped in Indian traditions, cultural norms, and family systems that govern my citizenship, sense of self, and everyday choices. When I attended my first TO training at age 16, I experienced for the first time my hybrid identities come to head with each other. As a spect-actor I wanted to exert my power to stand up against the oppression in a play, but I was also scared to intervene because *log kya kahenge?* (a rhetorical question that is repeated to me by elders in my family, which translates to "What will others think of you?"). Now ten years later, how do my intersectional identities and corresponding historical tensions inform my own power struggles in an American hospital setting? Particularly when I am facilitating a TO group with patients and clinicians.

As mentioned earlier, in a group therapy model, relationships from the social environment emerge within the group microcosm to influence and transform the behaviors of members. Unfortunately, the role of the social environment both in the creation and alleviation of mental health is still not given sufficient attention in psychotherapy (Paska, 2020). My thesis then is an attempt to address this gap by inviting clinicians who are an essential part of a patient's social environment in the hospital into a group exploration of TO, to observe its therapeutic potential.

LITERATURE REVIEW

The following literature review introduces the context of a Partial Hospitalization Program (PHP) in the U.S, examples of how power (or the lack thereof) with/in patients and clinicians in this setting can impact a patient's recovery, and the current group therapy and drama therapy approaches to addressing these power struggles. I will then offer a brief history of Theatre of the Oppressed (TO), its therapeutic benefits with different populations, and how the techniques have identified and transformed power dynamics in a group. I will conclude the literature review by describing the current possibilities and tensions that lie in the application of TO as group therapy in a PHP setting with patients and clinicians.

Partial Hospitalization Programs (PHP)

PHPs in the U.S. are time-limited, locally-based, relatively cost-effective, voluntary day programs that are a community bridge between inpatient hospitals and outpatient services (Hersen et al., 1979). Their treatment intention is to reduce the length of hospital stay for a patient by fostering a de-stigmatizing, community-centered, and least-restrictive environment of care (NY State Government, 2020). These include ensuring that a patient's basic daily living needs are met, providing medication for the stabilization of acute symptoms, and assisting the patient in the acquisition and sharpening of psychosocial skills while the patient returns to their communities (Hersen et al., 1979; Khawaja & Westermeyer, 2010). Psychosocial interventions involve individual therapy, regular assessments, and groups on psychoeducation (i.e: medication management, after-care planning), vocational training (i.e: IT learning, resume building, and interview skills), skills training (i.e: in DBT/CBT) creative arts therapies (i.e: music, dance, visual arts, and drama) and recreational activities (i.e cooking, eating, walking and exercise) (Lenz et al., 2014). In the PHP where I interned, for an average of six weeks, from 9:00 am - 3.00 pm, Monday through Friday, adult patients met with their psychiatrists, received weekly

individual therapy, and attended 45-60 minutes groups based on goals they identified with their treatment team (a therapist, a psychiatrist, case manager and/or social worker).

Programmatically a PHP setting intends to limit constraints and create active choice points for patients and clinicians (Lenz et al., 2014). Patients attend voluntarily during the day, participate in their own treatment, and then return to their communities. Clinicians can design their own group sessions, interact with patients one-on-one, in groups, and in the unstructured therapeutic milieu and share clinical responsibilities with a multidisciplinary team. Yet both clinicians and patients are governed directly by the policies, politics, targets, and measures (i.e: regarding finances, health insurance, compliance, and safety regulations) of the larger public hospital or/and mental health clinic where the PHP is located (Hoge et al., 1992). A PHP's flexible and communal milieu structure housed within a larger healthcare ecosystem can then be conducive to supporting a therapeutic inquiry of social and relational power within and amongst patients and clinicians.

Mental Illness, Clinical Care, and Power

Power can exist both outside us in the form of social power, which is the ability to influence others (Weber, 1914) or/and inside us in the form of our personal power, which is the ability to do and get what we want (Galinsky et al., 2008). These dynamics of power can have a profound impact on patients' and clinicians' relationships with themselves, with each other, and subsequently on a patient's recovery in a hospital unit (Huynh & Dicke-Bohmann, 2020; Kelley et al., 2014).

Patients who are admitted to a PHP are diagnosed with some form of a severe and persistent mental illness (SPMI) including schizophrenia, bipolar disorder, depression, or/and some personality disorders (NIHM, 1987). They often present with disorganized thought and speech, impulsive behaviors, engaging with hallucinations and delusions that may not be part of

a shared consensus reality (APA, 2013). Perceptions of social stigma associated with such symptoms have been shown to undermine self-esteem (Link et al., 2001) and increase social withdrawal and isolation (Perlick et al., 2001). In November 2022, the mayor of New York City pushed for authorities to remove people who have treated or untreated SPMIs from New York's streets and subways, furthering perceptions of people with mental illness as being a danger to society (Nir, 2022). Social stigma can induce internalized stigma which for individuals with SPMIs is associated with increased suicidality, self-directed shame, and diminished self-efficacy (Hamann et al., 2017; Livingston and Boyd, 2010; Quinn et al., 2015). Patients who attend PHP programs are either employed part-time, have asked for a medical leave of absence, or are currently unemployed. Many are entering PHPs after being discharged from a highly monitored inpatient unit increasing periods of prolonged hospitalization, medication dependency, family separation, housing issues, and financial losses (Khawaja & Westermeyer, 2010). These factors can be enhanced for patients who belong to ethnic minority identities as they can encounter greater structural barriers to recovery than the dominant majority (Schouler-Ocak, et al., 2021). For these reasons (amongst many others), clinical research shows that empowerment is an essential treatment goal for individuals with SPMI(s) (Corrigan, 2002; Sowers, 2012).

Patients with SPMIs report rarely expressing these feelings of powerlessness to clinicians due to fear of re-stigmatization or further rejection (Brüggemann et al., 2012; Mulcahy et al., 1998; Hamilton et al., 2016). They report often feeling excluded from decisions, receiving subtle or overt threats of coercive treatment, being made to wait excessively long for their sessions, being given insufficient information about one's condition or treatment options, being treated in a paternalistic, discriminatory, or demeaning manner or being told they would never get well (Hamilton et al., 2016; Thornicroft et al., 2010). In a study by Laugharne et al. (2012), patients perceived the need for a shifting balance of power with their clinician, according to the severity

of their illness and their own experience of care. At the beginning of their illness, they lacked information about their illness and were overly reliant on the expertise of clinicians; however, with time as they entered outpatient and PHPs, their own resources increased and they expected more power to shift towards themselves. They particularly valued ‘the personal touch’ of their clinician that went beyond their expertise, which could otherwise feel disabling and infantilizing (Laugharne et al., 2012).

Research with clinicians on the other hand demonstrated that the abuse of power is not isolated to a few insensitive providers but is more systemic in nature (Abbey et al., 2012; Knaak et al; 2017). Many clinicians reported an inadequate awareness of certain disorders and clinical skills because of gaps in their training or/and a lack of time and/or finances to invest further in their own learning (Knaak et al; 2017). Moreover, their own cultural stigmas around mental health, their repeated exposure to vicarious trauma on the units, the inefficiency of partner services (i.e: outpatient care, transport services), and the over-burdened and under-resourced healthcare system contributed to feelings of burnout, compassion-fatigue, and hopelessness (Knaak et al; 2017; Pirelli & Formon, 2020). Studies in hospitals in the U.S and Canada also demonstrated that clinicians reported facing bias, harassment, anger, and discrimination from patients or/and their families because of their gender, religion, race, age, or/and national origin (Crutcher et al., 2022; March et al., 2018; Watson, 2017). These factors (amongst others) can contribute to the clinicians’ depletion of empathy toward their patients (Figley, 2002), poor clinical decision-making, and helplessness (Sinclair et al., 2001), further disempowering the patient.

Within these interdependent relationships, both patients and clinicians also possess sources of personal power. Depending on the acuity of their diagnoses and personal factors (i.e: a patients’ support systems, life goals, hobbies, socioeconomic privileges, etc.) people with SPMIs

can have strong decision-making capacities (Saks et al., 2002, Vollmann et al., 2003) and access to resources in their communities (Saleebey, 2006). Many, in the case of those with psychosis, have over the years created alternate realities and ego defenses (i.e delusions and hallucinations) that provide them with feelings of grandiosity, purpose, self-identity, and belonging (Kaufmann & Paul, 2014; Isham et al., 2021). Such beliefs may have helped them make sense of a difficult situation in the past but may or may not serve them now (Volkan, 1994). In the absence of those stressors in a supportive PHP setting, therapeutic approaches that acknowledge the self-protective nature of these realities and the patient's intimate knowledge of their health and capital can then be a great reminder of their power (Abraham et al., 2007). For clinicians, their clinical knowledge, autonomy, control of resources, authority to make decisions, respect of co-workers, and certain dominant identity markers of gender, class, ethnicity, ability, age, years of experience, etc. can all contribute to their perceptions of personal power on the unit (Ash et al., 2006; Kuokkanen & Leino-Kilpi, 2000). Their perceptions of personal power can in turn influence their treatment of patients (Boyd, 1996).

Clinicians and patients thus exist on a continuum of power relationally always. While power can be greatly enabling, an imbalance at any one end of the continuum caused by a myriad of systemic factors in a hospital setting can be disabling to therapeutic recovery resulting in feelings of dehumanization both for patients and clinicians. Rather than direct their distress only toward themselves or to each other, what if clinicians and patients could together acknowledge sources in their environments that contribute to their feelings of power/disempowerment? How does identifying the systemic causes of power mutually help clients and patients to shift and transform them (if at all)? What is then the therapeutic potential of that shift if clinicians and patients are co-existing in a group?

Group Therapy: An Approach to Framing Relational Power

The interpersonal nature of group therapy has historically promoted psychosocial support, reduced isolation, and stigma, and developed effective communication and coping skills with group members (Wendt & Gone, 2017; Wenzel et al., 2012). When group therapy is complimented with individual therapies, research has shown improved treatment engagement and perceived peer support (de Moura et al., 2017). Since groups function as a social microcosm, members can rehearse new forms of relating to each other within the group, developing a sense of agency and a greater tolerance for conflict. For example, they may challenge their group leaders and/or each other by expressing feelings of honesty, dissatisfaction, frustration, or anger (Yalom & Leszcz, 2020). An effective group therapist can offer the space for these power tensions to play out as well as offer moments of repair (Burlingame et al., 2018). In a PHP setting, examples of effective group therapy interventions that have facilitated such exchanges of power include models of co-production and simulation.

Internationally, the World Health Organisation (2015) promotes the development of health service models that are based on co-production – "an approach in which citizens can play an active role in producing services that are of consequence to them" (Ostrom, 1996, p. 1073). On adopting this model, a range of acute, primary care, and mental health services have shown incremental quality improvements and empowerment of patients and healthcare staff (Donetto et. al., 2014). PHPs, including in the hospital where I interned, follow this co-production model by including shared-decision making strategies (Hill & Laugharne, 2006) in treatment team meetings and facilitating peer support groups. In treatment team meetings clinicians include patients and their loved ones in making decisions about their care so that the patients can choose care that meets their needs and reflects what is important to them. A systematic review by Légaré et al. (2014) concluded that healthcare professionals and patients arriving at treatment decisions together in this manner worked better than if they arrived at treatment goals separately. In peer support groups led

by a peer support counselor (a person who shares similar diagnoses to the group), the mutuality of experience facilitates patients – as peers – to help, empathize, debate, validate, inform, and provide hope and direction for each other's recovery (Puschner et al., 2019). Peer-to-peer counseling has not only been shown to improve hope, quality of life, self-esteem, and social inclusion for patients but it has also been shown to improve power relations between the counselor and patients over time (Farr, 2017).

As patients return to their home environments daily after PHPs, group therapy interventions that rely on role-play and simulation techniques have also been shown to support them in rehearsing the application of desired behaviors with others in the group, and then transferring acquired social skills to their communities (Washburn & Conrad, 1979). TO is framed around the collaboration between actors and spect-actors, similar to the co-production group strategies. Moreover, like group therapy techniques that simulate socialization in a clinical space, TO also relies on creating fictional enactments of oppression that allow the actors and spect-actors to rehearse desired behaviors with each other in roles. What is then the potential of framing TO as a model of group therapy that can facilitate exploration and exchange of relational power?

Drama Therapy: An Approach to Discovering Personal Power

Drama therapy groups in clinical settings have successfully facilitated a rehearsal opportunity for desired behavior and met the treatment goal of empowerment (Resiman, 2016), self-control (Casson, 2004), and overall symptom reduction (Gatta et al., 2010) with SPMI populations. Patients (re)enact past/present concerns and (re)imagine the situation reoccurring in the therapy room in front of a trained drama therapist, allowing them to uncover thoughts, feelings, and/or roles that may not be accessed solely through talk therapy (Emunah, 1983). For example, in Casson's (2004) drama therapy work with individuals with psychosis, the drama allowed the individuals to look at and integrate unacceptable parts of themselves, such that they felt less

threatened and more in control, with choices rather than ultimatums. In her work with individuals with schizophrenia, Emunah (1983) expanded on this idea of power by noting how dramatic play facilitated patients to “control in fantasy impulses which are difficult to control in reality, of assimilation and mastering reality” (p. 78). Drama therapy interventions that engaged patients in spontaneous and free play in group settings allowed them to identify a sense of power that they had not felt before. The integration of these hidden parts of themselves stimulated mutually satisfying relations with others in a group (Johnson, 1980, pp. 60–61).

For clinicians – drama therapy wellness workshops (Offerman et al., 2022) and embodied supervision (Trottier & Hilt, 2017) have also been shown to offer protective factors in reducing clinician burnout and supporting feelings of self-care, autonomy, and well-being.

Drama therapists have employed models like developmental transformations or DvT (Johnson, 2014) and therapeutic theatre (Woods & Mowers, 2015) to not just realize but also relativize power structures by having clinicians and patients engage in a group process together. In DvT the clinician is as equally involved in the play as the patient by noticing them, having a feeling about what they are doing, animating that feeling, and choosing a form of expression in response to the patient (Johnson, 2014; Sajnani, 2012). In therapeutic theatre, the character/patient experiences personal agency as they transform their real-life stories through a rehearsal process. This process (often several weeks long) is a form of group psychotherapy facilitated by a skilled drama therapist and then performed as a play for a public audience (Snow et al., 2003). During these rehearsals, while not compelled to agree with the patient/actor’s aesthetic choices, the clinician as director and/or co-actor cannot impose their points of view on them. Instead, they function as active “co-leaders” (Woods & Mowers, 2015, p.221) or even “mid-wives” (Pendzik, 2021, p. 342) who feel the weight of their own power and mirror, nurture, question, challenge, witness, and help the patient/performer to work through and integrate their sources of power.

Allied theatre practices including playback theatre (Fox, 1994) and psychodrama (Moreno and Moreno, 1969) have been applied by drama therapists over the years, as a form of group therapy to also facilitate empowerment. In co-leading a psychodrama group with patients at a PHP, Konopik and Cheung (2013) observed patients who were not in the acute stages of their psychosis interacting with their clinicians consistently. At this stage, a redirection of their innate creative capacities (that helped them initially create split-off realities) into a psychodramatic scene provided them with more control of their emotions and relationships with others in the unit. In a study by Moran and Alon (2011), patients in a hospital unit who attended playback theatre workshops over a 10-month period experienced a significant increase in emotional well-being and social connectedness, as well as a reduction in psychiatric symptoms. More recently, Kowalsky et al., (2022) wrote a comprehensive guide to the use of playback theatre as a form of psychotherapy in the context of group therapy. The authors considered the therapeutic potential of patients narrating and performing their personal stories in a playback theatre format with each other and their clinicians and their relationship to their clinician as the conductor of the performance (Kowalsky et al., 2022). In my thesis, I am similarly extracting the therapeutic potential of an applied theatre practice like TO by situating it within a group therapy context. Subsequently, I am observing how drama therapy processes that can empower clinicians and patients aid in a similar therapeutic inquiry when working with them in a TO group together.

Theatre of the Oppressed (TO): An Approach to Re-imagining Systems of Power

TO is an arts-based and group-oriented methodology that encourages participants to identify and enact contradictions of power within, between, and around them so that they can actively challenge oppressive systems that are locked by those very dynamics. Through enactments, TO facilitates social and therapeutic changes between populations otherwise separated by divisions of 'the actor' and 'spect-actor' (Sajnani et al., 2020; Howe et al., 2021). These

enactments are mediated by a "joker" whose job is to invite the spect-actors onto the stage and then to question, deepen and complicate the power dynamics emerging in the interactions between the actors and spect-actors (Barbosa et al., 2021, pg. 168). This mediation can create "aesthetic distance" (Boal 1990, p. 28) between the conflicts of power in real life and those being performed and transformed in the dramatic reality of the stage. This distance allows the actor and spect-actor to first represent contradictory systems of power through concrete images and scenes. Within that aesthetic frame, they then act collectively to challenge those very systems, which can otherwise be socially and psychologically distressing to address directly and in isolation. In the TO process, actors and spect-actors become empowered not only to imagine change but to actually practice that change, reflect collectively on possible interventions, and thereby generate social action (Sajnani et al., 2021).

TO's varied branches have historically concerned a reimagining of systemic power between two culturally diametric populations – the "oppressor" and the "oppressed" (Boal, 1992, p. 23). In response to an authoritarian military coup, rampant censorship, and artistic repression in the 1950s-1970s in Brazil, activist, theorist, and theatre director Augusto Boal founded TO with peasants, workers, and artists who performed in front of masses all over the country (Boal, 1992). While it may have been challenging to confront the military coup directly, Boal's TO enactments and games enabled these 'oppressed' communities to theatrically, sometimes even satirically resist the arbitrariness and violence of the military regime – the 'oppressors' - by caricaturing them (Matsunaga, 2021). For example, in one of the oldest forms of TO called Newspaper Theatre, newspaper articles were dramatized to reveal how the supposed objectivity of journalism served the dominant class and hid the truths of the working class (Speranza, 2021). In Image Theatre, participants' non-verbal expressions, feelings, political concerns, or personal moments of tension were sculpted into static physical images to concretize otherwise abstract, unconscious, or

stigmatized topics (Santiago-Jirau & Thompson, 2021). These images were then dynamized or activated into performances of Forum Theatre scenes in which audiences enrolled as spect-actors were invited to halt the action, replace characters, and rehearse alternative ways to struggle against the oppressions depicted by the actors (Barbosa et al., 2021). Invisible Theatre took enactments of Forum Theatre onto the street where activists would disguise the fact that their scene is a performance, thus leading spect-actors to view and naturally participate in a scene as a real, unstaged event (Bôas, 2021). Much later, Legislative Theatre took these enactments of oppression directly into the political arena in front of advocates and policymakers in hopes of transforming new laws or changing existing laws (Soeiro, 2021).

This methodology - though theatrical in its form – has thus always lent itself to non-actor participants who desire some form of liberation from systems that have otherwise entrapped them and who may not have the language or power to directly address those systems (Howe et al., 2021). This makes TO a potential framework when engaging with non-actor clinicians and patients. While both parties are separated by their social hierarchies and sometimes even physical locations within the hospital ecosystem, they are both intrinsically motivated by a deep desire to question their positions within those very systems (Montero, 2004). Patients want a balance of power between themselves and clinicians that moves with time and is dynamic according to circumstances (Laugharne et al., 2012). Clinicians too aspire to become witnesses, partners, the ones walking besides, the mirrors, and the vessels of faith for the therapeutic process through which their patients can discover their full potential and move toward social and therapeutic change (Watkins & Shulman, 2008). These desires, however, are restricted, bounded, and sometimes even trapped by a system that limits clinicians to the role of the "doer" and patients to the "done-to" (Benjamin, 2004, p.5). How can these contradictions of power that exist personally, relationally, and

systematically in the hospital emerge into the consciousness of patients and clinicians within a TO group therapy process to then be reimagined (if need be)?

Theatre of the Oppressed: An Approach to Group Therapy

During a period of European and North American exile from Brazil in the 1980s, participants of TO began asking what happens when there are no tangible or visible forces of power to resist. At this time, the transplantation of Boal's work to the West brought him into contact with people who found it less easy than peasant and worker groups to synthesize their experiences of the world into binaries of 'oppressor' and 'oppressed.' Instead, they voiced oppressions of 'fear' 'depression', and 'emptiness' (Sajnani, 2009; Schutzman & Cohen Cruz, 1994). Influenced by these thematic changes and Boal's wife who later became a psychoanalyst, Boal created one of the youngest forms of TO known as Rainbow of Desire which included theatrical techniques to tackle internalized oppression (Jackson, 2021; Schutzman & Cohen Cruz, 1994). One of these techniques included a detailed and multi-stage process called Cop-in-the-Head in which a protagonist-actor works with a group to explore why he/she follows a particular course of action knowing that the action is unhelpful to her/him and knowing that no one is forcing her/him to take that action. There are no 'cops' on the outside dictating their actions, the only cops present are those in their heads.

This was the first time TO acknowledged that while finding solutions through enactments can lead to social and political change, looking at the problem in a dramatic form can also be therapeutic (Jackson, 1992). While some Marxist theorists have argued that Boal's movement into the therapeutic arena was him relapsing into bourgeois individualism, contemporary TO practitioners like Schutzman and Cohen-Cruz (1994, p. 11) argued that TO has always functioned as "political therapy" with historically no distinction between political and psychological agendas. Even the psychological cops in our heads who appear to be invisible and have power over us have all emerged from somewhere, in response to the dynamics of power in our larger social

environment (Jackson, 1992). These include the societal and moral values dictated by parents, teachers, peers, politicians, and media that both limit an individual's choices and foster passivity (Schutzman & Cohen Cruz, 1994). Through TO, Boal helped to identify these cops in our heads as 'real' antagonist forces despite their literal absence and then transformed them with games and sociodramatic enactments.

TO techniques ranging from Newspaper Theatre to Cop-in-the-Head acknowledged that a feeling of catharsis can be achieved in action by encouraging individuals to dynamize, clarify and release their repressed desires without being tamed by societal constructions which may have otherwise imprisoned them (Jackson, 2021). When participants' fears are purged, their actions can be redirected to subverting social order on stage, which can then kindle the need for further action in real life (Boal, 1990). According to the World Health Organization "the root causes of health inequities are to be found in the social, economic, and political mechanisms" (Solar & Irwin, 2007, p. 67). The aim of healthcare, then like TO, is to minimize and eradicate daily manifestations of inequity to minimize psychological distress. Rather than look at a patient's diagnosis as a personal limitation, TO can also be a depathologizing strength-based therapeutic intervention that promotes awareness of these systemic inequities that a patient/participant can identify and transcend. Within a healthcare system built on co-production, a TO participant like a patient is not a passive recipient but the director of his/her own therapeutic process. Like in group therapy, a TO exercise requires the presence of multiple participating 'others' to act as mirrors or witnesses to enable the patient/participant to have new and multiple readings of an oppressive event. When individuals who identify as belonging to 'oppressed' communities express and transform their desires for power in front of those who have historically oppressed them, the emerging catharsis can be greatly therapeutic as they feel "seen" in a way they have not before (Boal, 1990, p. 39). TO with its multiple iterations of dynamizing the body can also, much like drama therapy, use the aesthetic

space of verbal and non-verbal dramatic enactments to attune to the varying needs of participants in a group. This can also facilitate catharsis across varied populations experiencing psychological distress rather than be a formulaic prescription (Jackson, 2021).

TOs innate therapeutic potential in groups has been widely recognized and utilized by social workers, therapists, activists, and educators as a tool to reduce stress (Yuksek, 2018), increase self-confidence (Moreno, 2018; Saeed, 2015; Sullivan et al., 2008; Yuksek, 2018), develop feelings of self-efficacy (Sullivan et al., 2008) and empowerment (Karabekir, 2004). Evidence-based research on TO has also been used widely as a supplementary or complementary form to facilitate therapeutic work - with patients with a social anxiety disorder (SAD) (Paula & de Oliveira, 2014)), with LGBT2SIQ+ youth (Bleuer, 2020), in family therapy (Proctor et al, 2008), with at-risk immigrants (Ramdath, 2016; Sajnani, 2010) and even as a tool for public health advocacy, education, and training (Bewer et al., 2021; Mayor, 2020; Middlewick et al., 2012).

While these studies demonstrate TOs therapeutic potential with groups of individuals, healthcare professionals, or students separately there is limited evidence of a TO intervention involving both patients and clinicians as equal participants in a therapy process (Proctor et al, 2008). Boal (1992) in fact clarified that while his work was 'therapeutic' it was not 'therapy.' My thesis aims to explore this tension. Given that TO has historically tackled power dynamics between otherwise polarized members of society, how can it be used as a form of group therapy with clinicians and patients in a hospital setting?

Perhaps there is merit to being critical about framing TO as a form of exclusionary group therapy. Through her work with LGBT2SIQ+ and other targeted communities, drama therapist and TO practitioner Jessica Bleuer (2020) warns of the following significant challenges::

> "The multiple power dynamics that exist in the presence of both the oppressed and the oppressor may very well exacerbate minority stress, and thereby enhance social

> isolation, the fear of rejection and/or actual rejection, perpetuating the very violence TO formats seek to address. Exposing participants to the factors that make up their minority stress will not always be worth the revolution. Rather, it could be more restorative to connect with the community on shared injustices, without needing to explain, defend, and justify what one knows and has lived to be true." (p. 79)

Here, Bleuer warns of the anti-therapeutic potential of the excessive vulnerability displayed when doing TO with heterogeneous populations. TO interventions like Forum Theatre have been shown to work best in groups with a high degree of homogeneity, creating opportunities for spect-actors to culturally identify with the protagonist-actor and have the courage to face and transform the oppression enacted (Fisher, 1994; Moreno, 2018). In their application of TO, Lee (2015) identified how linguistic and cultural barriers can contribute to silence by spect-actors when no one intervenes to transform the oppression. For the purposes of facilitating larger equity work between different populations, TO can then run the risk of compromising on an individual's well-being by having them re-enact traumatic situations in front of spect-actors who have inflicted upon them that very harm (Bleuer, 2020).

Even though the TO group I would be facilitating would be integrated with multiple other therapies being offered to patients within a flexible therapeutic PHP environment I was aware that I still may run the risks articulated by Bleuer above. I may potentially inflict harm by working with patients with varied SPMI diagnoses (and corresponding psychosocial histories of traumas) and their clinicians who may reinforce those very traumas (both in the hospital and within a TO enactment). As a weekly intern in the program, I also may not be privy to the preexisting relationships between clinicians and patients on the unit. Rather than provide any conclusive evidence, my thesis then hopes to explore the therapeutic potential of bringing these populations - with all their varied levels of power and me (an intern) - together in a group therapy setting. How

can space for both the emotional nature of our personal power and the emerging systemic inequities of our relational power be created, supported, and/or transformed? How can a TO structure and my own facilitation style as a drama therapy intern expand within the clinical setting of a PHP to create more safety to invite dissenting voices to participate *with* and not against each other?

METHODOLOGY

To explore the potential of TO as group therapy, my thesis assumes a critical theory framework that breaks down the separation between the researcher (me) and the focus of the research (potential of TO as group psychotherapy with patients and clinicians) (Brookfield, 2005). This application of critical theory is further informed by liberation psychologists who emphasize that clinical researchers must develop intentional relations of mutuality that recognize and interrogate power inequities within research relationships with their patients and clinical contexts (Fernández, 2020). In TO praxis, a similar research framework is observed in action when the facilitator or "joker" of a TO intervention understands principles of democracy and equal participation to then trust in the spect-actor's abilities to solve problems depicted on stage (Fritz, 2012, p. 138).

My thesis thus is an anonymous observational case study of a TO group where I am observing the emerging behavioral dynamics between and within the clinicians, patients, and myself (the researcher and facilitator). If I was going to expect the group members to engage in enactments of power in a TO group, then I - as an observer-participant and joker in the process – had to observe my contradictory and confusing relationship to their power (and my own) as part of my research. An observational case study method would not only help me observe the potential of TO as group therapy but also would help me to develop an in-depth understanding of TO within a clinical setting. Observing myself, other clinicians, and the patients as equal participants in the naturally occurring context of a TO group could further reveal much more honest information than any other self-reporting data collection method (Mays & Pope, 1995). The current lack of evidence on TO as a group therapy model also influenced my decision to offer a primary analysis based on my direct observation of a process within a bounded system and time frame before proceeding with a deeper analysis (Creswell, 2002).

Settings, Participants, and Timeline

The observations of my study were recorded at a single PHP site at a New York City municipal public hospital over ten TO group sessions titled ‘Power Play.’ The sessions took place once a week for ten weeks from October - December 2022. 'Power Play’ was 45-60 minutes long and was attended weekly by at least five to seven patients who were all adults diagnosed with an SPMI (including schizophrenia, schizoaffective, bipolar, major depression or/and borderline personality) and at least two other staff members other than me (these included interns or/and senior therapists/supervisors/clinicians on the unit). Since participants were in the PHP day program for a duration of six weeks, each group had new members (with a few repeating members depending on discharge dates). The group was voluntary and part of the daily programming at the site. All the patients in the TO group were thus concurrently receiving individual therapy, case management support, and medication, and attending other groups throughout the day on the unit.

Data Collection: *Feeling What I Touch*, *Listening to What I Hear, Looking at What I See*

I collected data in three ways - subjective and objective accounts, spectrograms, and journal reflections.

After every session, I recorded subjective and objective observations of myself and all the group members, which is a notation approach often used in clinical work to examine the interplay of values operating during a particular interaction in time between the clinicians and patients (Urbanowski & Dwyer, 1988). This format includes first writing a verbatim dialogue of the entire session next to which the clinicians note their feelings and emerging themes connected to psychotherapy theory. The clinical supervisor offers comments next to each segment of the process recording (Urbanowski & Dwyer, 1988). I adapted this format for a clinician who is practicing TO. My notation format included the verbatim dialogue of the session, next to which I wrote my subjective thoughts on what I was seeing, feeling, and hearing in each session and what I perceived

the group to be seeing, feeling, and hearing. According to Boal (1992), a key ingredient to the interaction between actors on a stage and spect-actors in the audience was engaging in games that challenged both parties to truly feel what they are touching, to listen to what they are hearing, to see what they are looking at and, in the process, dynamize their bodies into an active dialogue with each other. This sensorial framing of games that guided my TO groups also helped me as a researcher-participant to frame my observations. An example of this adapted template is in Appendix A.

At the beginning and end of every group, I used spectrograms as a diagnostic pre and post-assessment to also help me record spatial movements. A spectrogram is a tool usually used in a group therapy format before a psychodrama enactment in which a group (or the facilitators) defines two ends of a pole that inform the enactment/discussion (Kole, 1967). Since I was observing the potential of TO as a group therapy model, the spectrogram allowed me to warm up the group to a therapeutic processing of power. I introduced the two ends of a pole as 'Powerful' and the other end as 'Powerless.' Each participant could then assign a value/meaning/story or number to their experiences of power along this continuum. Since every group had different members and diagnoses, they could each assess, visualize, and project their own feelings of power onto parts of that continuum, which helped guide the direction of the subsequent TO enactment. This concept of using a spectrogram to facilitate a diagnostic assessment aligns with TOs understanding that individual bodies and arrangements of bodies reveal much more about systems of power than verbal expression (Howe et al., 2021). At the beginning and end of every session, I sketched everyone's position of power (including mine) on the spectrograms to compare them with my written subjective and objective observations.

Finally, at the end of each group, I processed my own feelings, confusions, agreements, and points of contention with my supervisor as free writing excerpts in my private journal.

Data Analysis: ***Dynamizing Several Senses***

I analyzed my data in three ways incorporating my several senses. First, I organized the data from the spectrograms into line graphs to visually locate any relational power dynamics between clinicians, patients, and myself before and after the group. Second, I thematically coded observable behavior patterns from my objective and subjective accounts using apriori codes of Yalom's (1995) therapeutic factors for group psychotherapy, core processes in drama therapy (Jones 2007, 2016; Frydman et. al., 2022) and Starhawk's (1990) model of power. Third, I analyzed my emerging reflections from my journal through an embodied mapping process (Rieger et al., 2022) to physically move through my own shifts of power in each session.

Yalom suggested that "therapeutic change is an enormously complex process that occurs through an intricate interplay of human experiences" which he referred to as "therapeutic factors" (2005, p. 1). These comprehensive factors have been seminal to group therapists worldwide based on years of exhaustive research (Yalom et al., 1970), i.e with patient groups in de-addiction treatment (Lovett & Lovett, 1991), for high-risk adolescents and adults with an SPMI diagnosis (Hauber et. al., 2019; Macnair Semands et al., 2010) and in creative arts therapy groups (Pelletier, 2014)

Meanwhile, drama therapist Jones (1991) articulated a series of core process variables that offered a foundational layout of a drama therapy group session. After reviewing various iterations of literature around the core process of drama therapy by Jones (1991, 1996, 2007, 2008 and 2016), drama therapists Frydman et al., (2022) conducted a Delphi study that operationalized the seven most common core drama therapy processes that enable therapeutic change. Like Yalom's factors, drama therapy core processes have also been used to understand and evaluate the therapeutic merit of group processes (Elowe et al., 2022). Making connections between these tested core therapeutic factors and TO could then provide further validity to TO as a form of group therapy. Moreover,

perhaps new definitions of therapeutic factors could emerge when centering TO processes as group therapy. This could support other practitioners in applying TO in their clinical practice. Below is the list of factors that I used as apriori codes in this study:

Yalom's Factors	**Definitions**
Instillation of Hope	A member recognizes other members' improvement and develops optimism for his or her own improvement.
Universality	A member perceives that other members share similar feelings or problems.
Imparting Information	Advice given by therapist or fellow members.
Altruism	Member gains a positive view of himself or herself by extending help to others in the group.
Corrective Recapitulation of the Primary Family Group	Member experiences the opportunity to reenact some critical familial incidents with members of the group in a corrective manner.
Development of Socializing Techniques	Group provides members with an environment that allows the member to interact in a more socially adaptive manner.
Imitative Behaviors	Member learns through the observation of others' learning experiences.
Interpersonal Learning	Member gains personal insight about their behavior through other members' sharing and can act on that insight outside the group.
Group Cohesiveness	Feeling of togetherness provided and experienced by the group
Catharsis	Member releases feelings about past or here-and-now experiences; this release leads to the member feeling better.
Existential Factors	Member ultimately accepts that he or she has to take responsibility for his or her own life.

Kivlighan, D. M., Jr., & Holmes, S. E. (2004). The Importance of Therapeutic Factors: A Typology of Therapeutic Factors Studies. In J. L. DeLucia-Waack, D. A. Gerrity, C. R. Kalodner, & M. T. Riva (Eds.), *Handbook of group counseling and psychotherapy* (pp. 23–36). Sage Publication

Drama Therapy Core Processes	**Definitions**
Dramatic projection	The process of outwardly expressing and representing aspects of oneself, others, social forces, feelings, and experiences onto dramatic material (e.g., puppets, props, masks, text, role, story) and engaging with that material.
Dramatic play	Engagement in a co-created improvised relationship with reality, utilizing imagination and spontaneity. Typically, there is a sense of experimentation and engagement in experiential processes that are expressive and collaborative.
Dramatic embodiment	A physical, vocal, or emotional inhabiting of the body; attending to sensations; touch; the spectrum of physicalized expression of emotions, thoughts, reactions, impulses, and inner experiences.
Aesthetic Distance	A process of titrating emotion and cognition through engagement with dramatic media
Active witnessing	The process by which participants notice aspects of themselves, others in a group, or the drama therapist. At the same time, participants are seen by the drama therapist, other group members, or an invited audience.
Multi-dimensional relationship	The inter-relationship between the participant(s), drama therapist(s), and dramatic reality.
Dramatic reality	Participating in a transition from external reality to a liminal state, bringing the imaginal realm into outward expression; an in-session departure from ordinary life.

Frydman, J. S., Cook, A., Armstrong, C. R., Rowe, C., & Kern, C. (2022). The drama therapy core processes: A Delphi study establishing a North American perspective. The Arts in Psychotherapy, 80, 101939. 10.1016/j.aip.2022.101939

While the therapeutic factors in group and drama therapy can examine the potential of TO from a clinical perspective, I was also interested in using an analysis frame for power that was inherent to TOs core philosophies in restorative social justice. Starhawk's (1990) definition and types of power (described below) have been used by TO practitioners like Spry (1994) when working in heterogeneous communities to examine the social structure and enactments of power

in a TO group. To examine the potential of TO as group therapy, I wanted to specifically observe how the therapeutic functions of TO can elevate, shift or/and transform power dynamics between the patient, clinician, and me. What did instances of domination, collaboration, resistance, or/and transformation look like within me, the clinicians, and the patients?

Four Types of Power	**Definitions**
Power-Over	Instances of power built on force, coercion, domination, and control and motivated largely through fear
Power-With	Instances of respect, mutual support, shared power, solidarity, influence, empowerment, and collaborative decision making
Power- To	Instances of the generative potential of power, to build new possibilities or actions that can be created without using relationships of domination
Power-Within	Instances of when a person can recognize individual differences, their own self-worth while respecting others

Starhawk. (1990). *Truth or dare: Encounters with power, authority, and mystery*. HarperSanFrancisco

Finally, I used embodied mapping – a form of performative inquiry – to explore beyond the analysis of codes and physically 'become with' the verbal and visual data of my process recordings, journals, and spectrograms (Rieger et al., 2022). For the past 20 years, my feelings of power have emerged from my rigorous training in Bharatnatyam - a classical South Indian temple dance known for its highly coordinated and graceful rhythmic gestures; however, the dance has also historically been associated with preserving colonial and oppressive caste hierarchies (Srinivasan, 1985). Boal (1985, p.127) fundamentally believed that relations of power discipline our bodies and that it is necessary for each one of us to feel the "muscular alienation" imposed on our body by our work to then analyze how society can work inside and on the body. Bharatnatyam as an embodied form contains in its practice these contradictions of social and relational power,

which I have in turn inherited in my ancestral lineage. I was thus interested to use the musculature of dance to explore my relationship with power as an emerging clinician.

With the help of another dancer and choreographer from Delhi, I responded to prompts from my journal entries by improvising Bharatanatyam movements along the same spectrogram of power that I used with the group members. The purpose of mapping my somatic responses was to identify and externalize my shifting positions of power in relation to both patients and clients. How can that inform the various patterns of unconscious beliefs that operate through my physicality? How am I moving others and in turn how are they moving me? How do my expressions of power differ when I am within a closed hospital unit in the U.S., a place of health for my patients, versus an open-air dance floor in New Delhi, a place of health for me?

In my thesis, I thus analyzed my data according to how the change factors of group therapy, drama therapy, restorative justice, and performative inquiry contributed to the potential of TO as group therapy. Each of these multimodal forms of analyzing data informed my findings.

Ethical Considerations

To protect the privacy of all participants, all data was anonymized. The visualizations of movement on the spectrogram only revealed whether the participant was a clinician or a patient and at what value they rated themselves without any other identifying details. The research took place within a milieu treatment environment of PHP where the object of study was the emerging TO process and group dynamics from the researcher's perspective. Per NYU IRB, this study did not involve collecting information about participants but was limited to my anonymized observations towards deepening insights about how TO may function within a group therapy format in a PHP.

FINDINGS

My thesis aimed to explore the potential of TO as group therapy with patients and clinicians in the context of a PHP. After collecting my data through subjective and objective observations, spectrograms, and journal entries, I coded the 'potential' of this data through the visual line and bar graphs, Yalom's (1995) therapeutic factors of group psychotherapy, drama therapy core processes (Jones 2007, 2016; Frydman et. al., 2022), Starhawk's (1990) model of power and embodied mapping (Rieger et al., 2022).

In this chapter, I will first describe the emerging protocol and corresponding treatment objectives and goals that evolved through the process. Then, through bar and line graphs I will offer visualizations of pre- and post-spectrograms to demonstrate how the patients, the clinicians, and I on average rated our subjective feelings of power before and after the TO interventions. I will animate these graphs through case vignettes and a table of behaviors highlighting Yalom's therapeutic factors (1995), drama therapy core processes (Jones 2007, 2016; Frydman et. al., 2022), and Starhawk's (1990) types of power in action. I will conclude this chapter with observations from my journal which I have creatively distilled into a video of an embodied mapping exercise.

Emergent Protocol and Treatment Goals

The 45-60-minute-long group started at 1:00 pm every Friday. Every group was different with participants of varied diagnoses, presenting symptoms, and professional titles on the unit. Very early into the groups, I realized that in order to make the most of the allotted time and to focus and expand the dynamic narratives of power in the room I needed to have some structure to my sessions. I framed this protocol using Paulo Freire's (1970) Pedagogy of the Oppressed model. Freire was one of the biggest influences on Boal's Theatre of the Oppressed method.

According to Freire, the only way to emerge out of a state of disempowerment is to develop a critical praxis of dialectical thought involving “reflection, action and reflection” (p.66). When one reflects on the concrete situation of their power struggle, they will automatically be called to action. An action can only be sustainable and truly liberatory if it again becomes the object of critical reflection (Freire, 1970). This frame mirrored the general structure of drama therapy groups which begin with a warm-up that develops into an active exploration of areas that are problematic for clients, followed by a closure and debrief of the session (Jones, 2007). Here is the emerging protocol for the TO group with patients and clinicians:

Frame	**Exercises**	**Instructions**
Warm-Up (Reflection)	● Introductions/Physical stretch ● Spectrogram of Power ● Subgroup Sharings	After an opening stretch and a brief introduction to myself and TO, group members are invited to assign a numerical value to how powerful they feel right now. They can do this by physically standing on an imaginary scale extending from one end of the room to the other, or they can choose an object (from a selection of random objects) to symbolize their feelings of power and place that on the spectrogram (see Figure 1). Else, they can simply raise their fingers to show a number from 0 to 10 or other times mark their value on a white board (see Figure 2). Participants then share out loud why they chose to assign themselves that numeric value or share in small groups with others who are physically near them.
Action	● Dynamization: Image Theatre, Forum Theatre, Newspaper Theatre, Rainbow of Desire (Cop-in the head)	Based on themes that emerge in the stories, the group or part of the group dynamizes one or more stories into an enactment while the rest are spect-actors offering interventions.
Closure (Reflection)	● Processing ● Spectrogram of Power ● Physical stretch/grounding breath	The group concludes with reflections or/and questions from the actors and the spect-actors with any connections they can identify to their lives right now. Using the

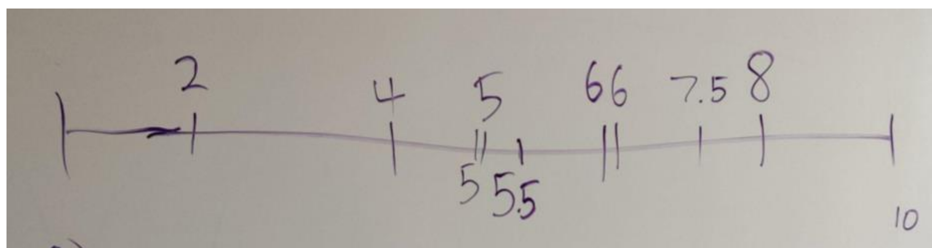
		same spectrogram as the one from the beginning of the session, members depict how powerful they feel in their bodies now.

Figure 1

Objects placed on a spectrogram of power going from ‘0’ (powerlessness, left) to ‘10’ (powerful, right). This image was recreated from my memory after the end of the session.

Figure 2

Group members rate their feelings of power on a spectrogram on a white board before the TO enactment.



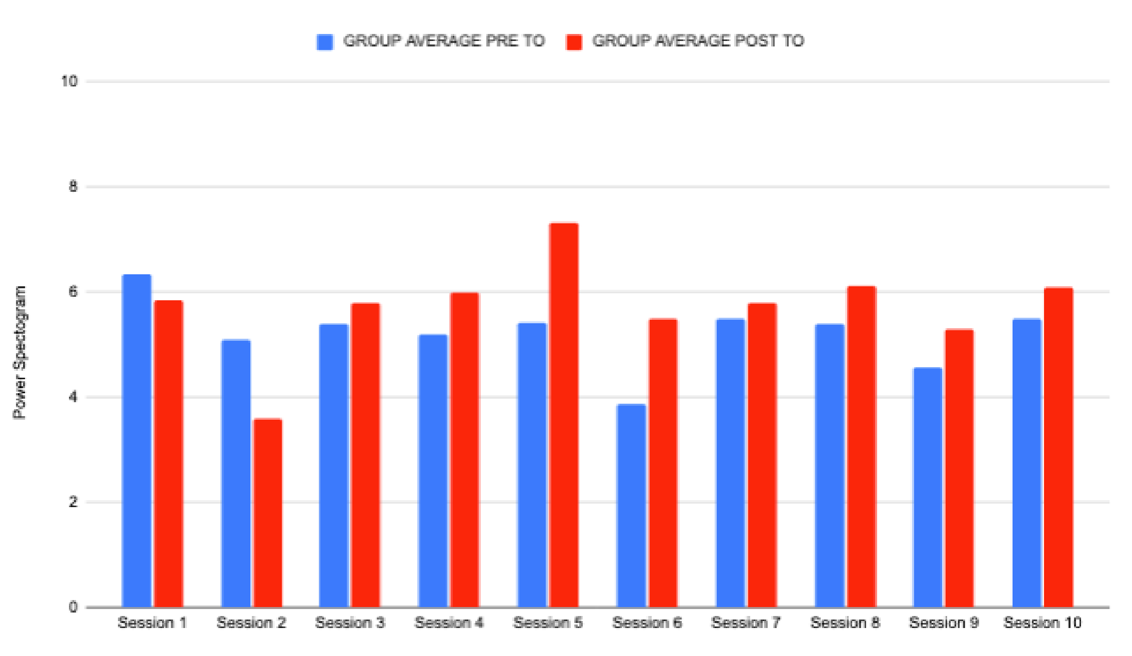
In Augutso Boal’s (1995) *Rainbow of Desire,* he lays out three purposes for the “aesthetic space” in TO (p. 20-23). The first is to encourage plurality - where one person’s story can integrate many others. The second is a dichotomy - where there is tension between opposing forces, and the third is telemicroscopy - where those forces can be controlled and changed because they are being enacted and enlarged in front of everyone in the present moment. In every session, I observed these purposes translate into the following therapeutic goals - to enhance relational capacity, and to increase conflict tolerance and feelings of individual and collective agency amongst the group members. As the patients and clinicians immersed themselves into the TO enactments, the corresponding objectives were to have at least one member identify or/and enact at least one moment when they were struggling with feelings of power and to collectively with other members identify or/and enact at least one action that could potentially transform that current struggle.

Data from the Pre and Post-Spectrograms

After collecting data on the subjective feelings of power for patients, clinicians, and myself before and after the TO sessions (see Appendix B), I organized the key findings from the pre and post-spectrograms into the following graphs

Figure 3

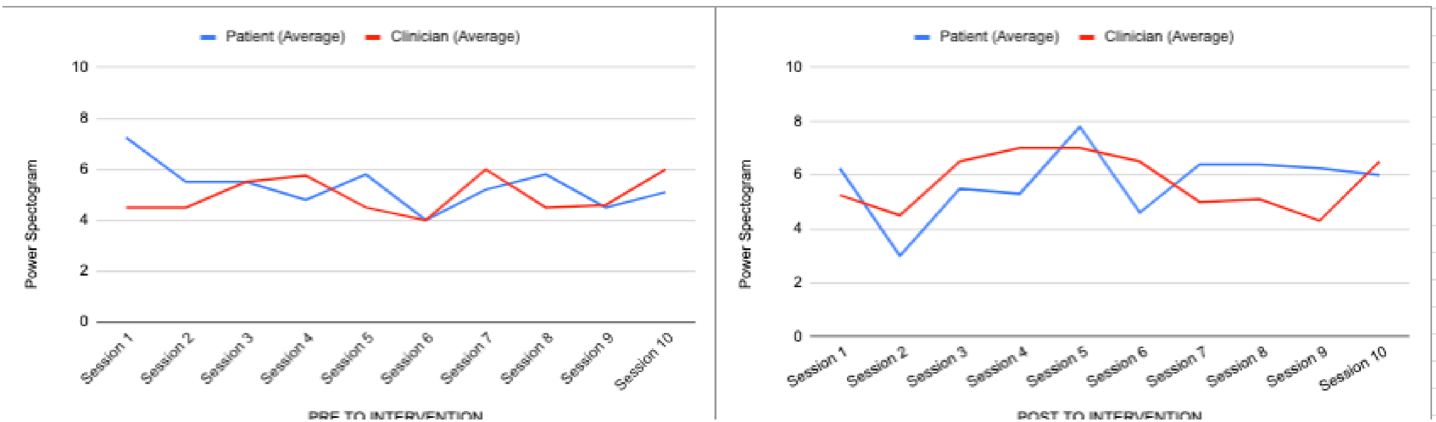
Pre and Post Average Subjective Feelings of Power for the Group



In all but two sessions (session #1 and session#2), group members on an average rated themselves on a higher number on the power spectrogram after the TO intervention than before (see Figure 3). Some individual members rated themselves as higher on the spectrogram while others rated themselves as lower after the TO interventions (see table in Appendix B)

Figure 4

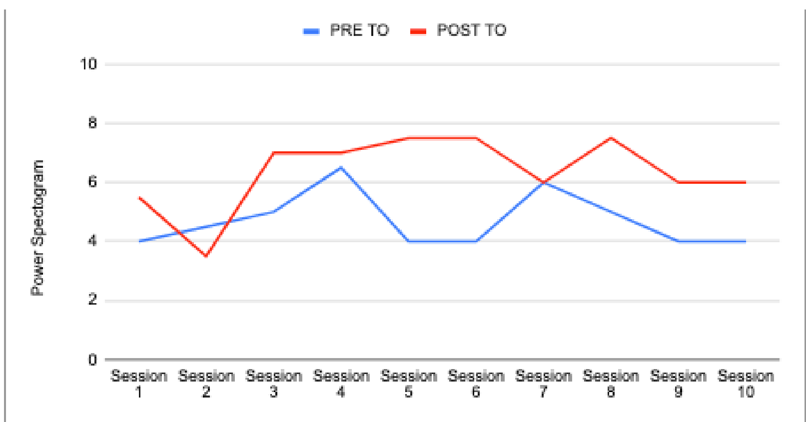
Pre and Post-Average Subjective Feelings of Power for Patients and Clinicians



On an average, patients and clinicians rated themselves differently on the spectrogram before and after the TO intervention (see Figure 4).

Figure 5

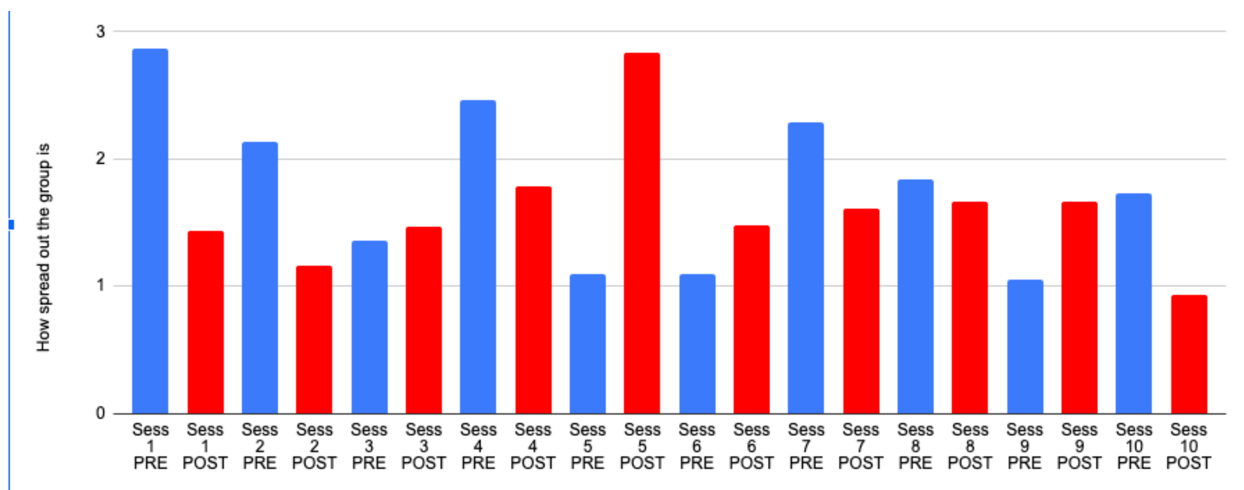
Pre and Post-Subjective Feelings of Power for Me



My subjective feelings of power were different before and after the TO intervention (see Figure 5).

Figure 6

Measure of Group Cohesiveness across Sessions



In six out of the 10 sessions, patients and clinicians moved closer to each other on the power spectrogram after the TO intervention than before (see Figure 6). In the remaining four sessions (session#3, session#5, session #6, and session #9) group members stood further apart on the spectrogram after the TO intervention than before.

Central Findings from Case Vignettes

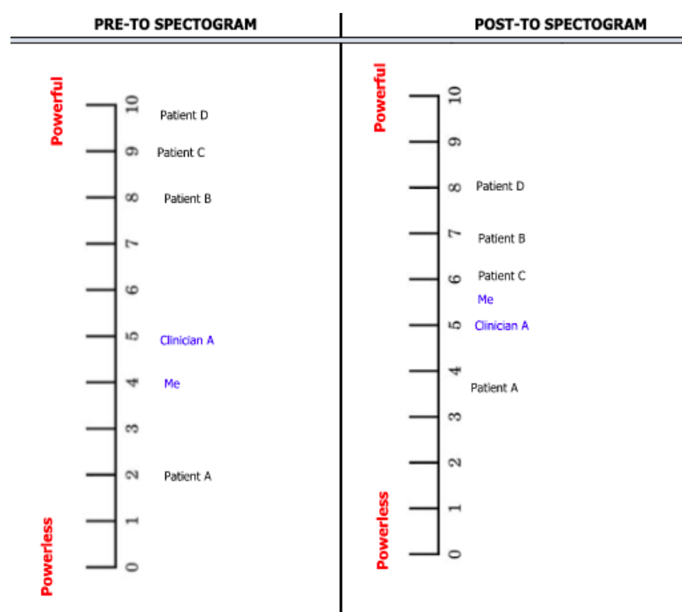
Below are case vignettes that animate additional findings from the 10 TO sessions.

The desire and conflict of the protagonist-actor(s) became stronger in the enactment

Depending on where group members positioned their subjective feelings of power on the spectrograms, different feelings of power emerged. When individual participants would begin the session by placing themselves on either of the extreme ends of the spectrogram at 0-3 or 8-10, feelings of worthlessness or/and omnipotence respectively were often shared. Those who rated themselves in the middle 4-7 often felt "completely okay" or "very confused." In certain sessions, these feelings revealed personal stories that had a central conflict and a clear desire to overcome a power struggle; however, in most others, the conflict and the desire became clear as the TO enactment unfolded. With the support of spect-actors who projected their struggles and desires onto a TO enactment, the conflicts and demands of the protagonist-actor(s) became stronger.

Case Example: Atlas and Cleopatra

In session#1 the spectrogram demonstrated a split between one participant A who marked themselves towards a feeling of powerlessness on a 2 and three participants B, C, and D who marked themselves towards feeling powerful on an 8, 9 and 10 respectively. Group members turned to those next to them and shared reasons as to why they choose to stand at that number today. Using Boal's "Image of the Word" exercise (Boal, 1992, p. 176-179) and "interior monologues" from the Rainbow of Desire (Boal, 1995, p. 79) each participant standing on the spectrogram then created a sculpt of the emerging theme in their narratives and a one sentence interior monologue inspired from that image. A said "I feel so tired" and D said, "I am getting discharged - I feel on top of the world!" I then invited A and D at the two ends of the power spectrogram to remain in their frozen sculptures becoming our actors while the rest of the participants became spect-actors. Inspired by the postures and internal monologues of the two actors, the spect-actors assigned a fictional conflict about Atlas and Cleopatra to their relationship. Atlas (standing at a '2') was holding the weight of the world on his shoulders and needed help while Cleopatra (standing at a '10'), the queen of Egypt was too busy ruling the kingdom. The two actors in-role acted out this conflict that was simultaneously being written for them by the spect-actors. As the joker, I used Boal's "simultaneous dramaturgy" format (Boal, 1989, p. 51) to ask spect-actors different ways to resolve this conflict. Each time the spect-actors



suggested an intervention like “Cleopatra can give up her Queendom!” or “Atlas can ask other Gods to carry some of the world” the two actors could choose whether their character wanted to perform the suggestion. After multiple audience suggestions and simultaneous enactments, the spect-actors began entering the scene as either different Gods or members of the masses trying to bring down Cleopatra and in-turn support Atlas. As spect-actors entered the scene, A became more articulate, specific, and confident in his desire for support. In the post-TO spectrogram, each participant ended up moving a few steps closer to each other. In the debrief, D shared fears about losing her freedom and ending up in the hospital again, while A spoke about feeling overburdened by the metaphorical weight of his illness and desiring more support in his recovery outside the hospital.

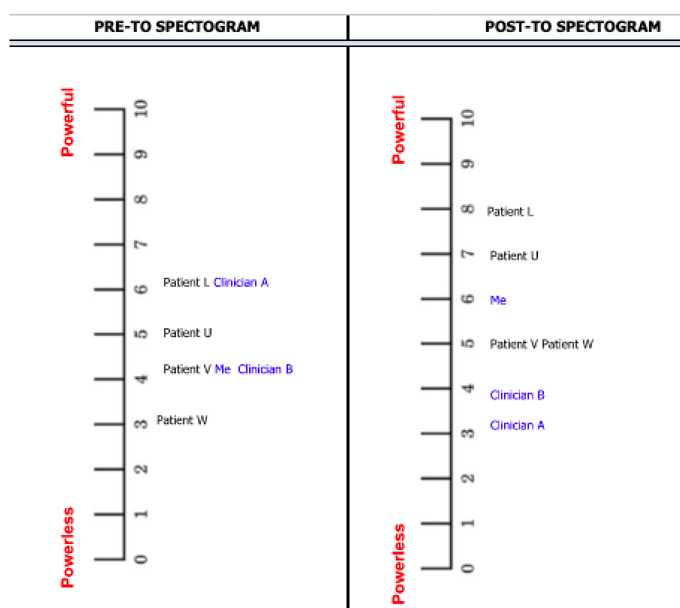
Patients enrolled clinicians as their antagonists

In sessions when a patient’s story had a clear antagonist, they often enrolled their clinician as the antagonist. “I know you can handle it because you are not like this in real life,” said one patient when casting their clinician in the role of an antagonist, to which the clinician responded, “I am happy to help you.” The clinicians always committed to the roles and the oppositional stances they were assigned by the patient.

Case Example: Mental Health Revolution and Mayor Adams

In session #9, W stood at a 3 because she was feeling hopeless after reading a newspaper article discussing Mayor Adams’ recent directive on forced hospitalization of people living with mental illness. Using Boal’s “Newspaper Theatre techniques" (Speranza, 2021, p.152) I asked one member to read aloud the headline of the article that W was referring to, which stated “On City Streets, Fear and Hope as Mayor Pushes to Remove Mentally Ill: Mayor Eric Adams intends to remove people with severe, untreated mental illness from the streets. That will mean involuntary

hospitalization of people deemed unable to care for themselves" (Nir, 2022). I then asked W to sculpt a few other members into an image that she felt accompanied this headline. She placed two members at the back of the room with their hands behind their backs as if they were being handcuffed and then directed clinician A to stand on a chair with his hands above him like a puppet master. From their positions, each group member voiced an internal monologue about how they were feeling. On witnessing the image, a spect-actor L was then invited to co-create with W the headline they would like to read instead. Together they came up with "Politicians caught red-handed: The mental health revolution is here."



L and W had the opportunity to transform each actor on stage into the sculpt of their corresponding desired headline. In the new image, clinician A was the person handcuffed while the other two participants stood behind him on two chairs laughing. W and L then had the opportunity to confront the politician directly with anything they would like to tell him. In the end, W placed herself on a 5 on the power spectrogram while the two clinicians in the group positioned themselves on the lower end of the spectrogram. Themes around unexpressed anger, being controlled and manipulated by politicians and media, and feeling imprisoned in the hospital system emerged in the debrief.

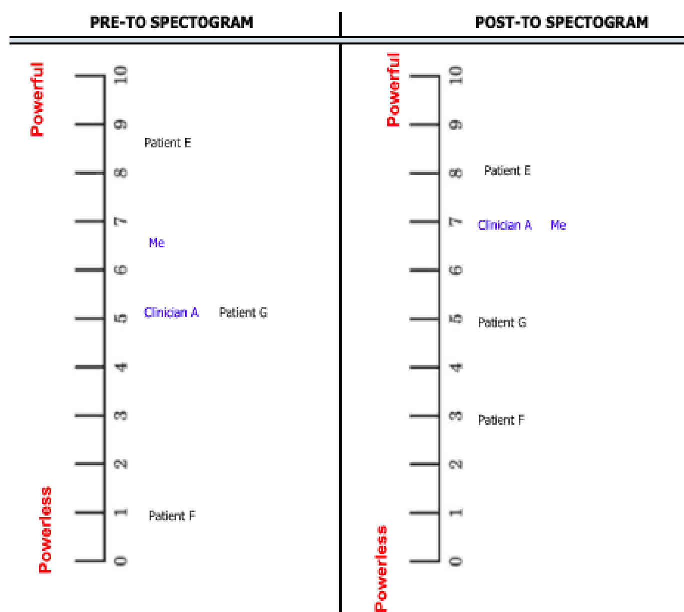
Instead of replacing the protagonist-actor, allied characters were introduced in interventions

When I invited spect-actors to replace the protagonist in a scene there was often some hesitation Instead, the spect-actors were more willing to include themselves as allied characters in

a scene even if those characters were not initially a part of the protagonist's story. These characters introduced by the spect-actors engaged in the fictional reality of the protagonist's story rather than replacing the protagonist directly.

Case Example: The Clam and the Egg

In session#4 F who placed himself on a 1 on the spectrogram shared the following story with everyone - "I live in a partitioned one-bedroom. I am trying to get my landlord to give me a P.O. box so I can receive my SSI checks, but since my name isn't on the lease, he is refusing to let me use his address to receive my mail. It's stressing me out and I feel like I have no power." I then invited everyone to identify a projective object (from a bag of broken toys) that connected to their current feelings of power. F chose a clam. I then asked F to look around at other objects that group members had chosen and to cast one of their objects in the role of his landlord. F chose G's object - a plastic egg - "Yup that's my landlord - he is an egghead." At this point, I brought out a black piano bench to the center of the room and invited F to place his clam anywhere on the bench. I then invited him to direct G to place her egg anywhere in relation to the clam. F placed his clam on one extreme edge of the bench, and the egg in the middle. "Who else is in the scene?" I asked. F responded by placing the object of clinician A - a starfish - on the bench beside him. "That's my sister. I wish I could live with my sister and send her my SSI checks, but she does not let me stay with her. I think she



is ashamed of me." From this point onwards, I invited F's clam to have a conversation with the other objects in the scene. F took his clam, pointed it towards the egg, and said "I cannot live my life without my shell. Can you give me one?" G responded back with - "Well you cannot have mine. My shell is broken." The conversation continued for a few more rounds with clinician A also responding as the starfish (sister) and denying the clam his shell. I then invited group member E as a spect-actor to stop the scene at any point and replace the clam with their object to resolve the clam's dilemma. Instead of replacing the clam, E introduced their object - a toy snake - as an additional supporting character in the scene - "I am F's friend from the hospital," said E. The scene proceeded with E's toy snake arguing with the starfish and the egg to provide F with his shell and concluded with E and F trying to fit themselves inside the egg. I then asked members to locate themselves, with their objects on the same spectrogram of power as the one in the beginning. F placed his clam at a 3 and E placed himself at a slightly lower power than before. During the debrief, themes of challenges around receiving SSIs, needing privacy, safety, and stability while also feeling isolated from family emerged.

Interventions departed from reality

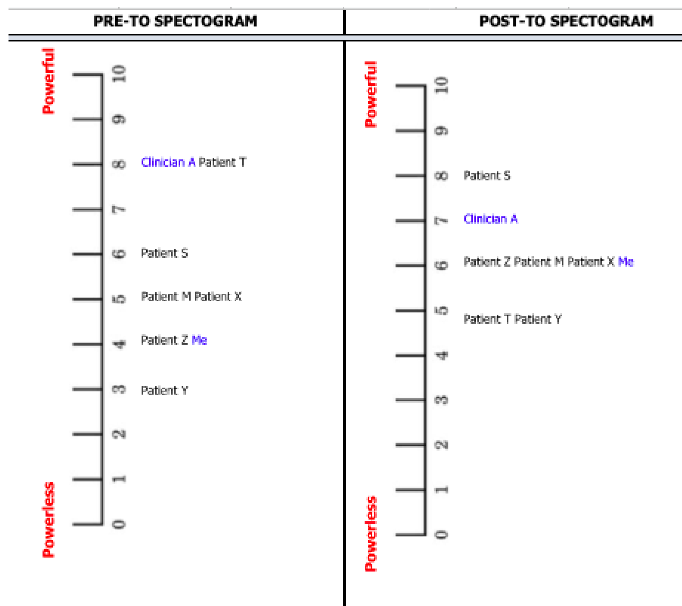
Quite a few of the TO enactments concluded with interventions that challenged the rules of reality resulting in laughter and humor at the conclusion of the group.

Case Example: Giraffe and Doctor Crocodile

In Session #10, the group had six patients and only one other clinical intern along with me. M who was standing at a 5 shared a story about how she had been having difficult conversations with her psychiatrist where she felt like she had some power but not a lot. She revealed how her psychiatrist had reduced her dosage of clozapine, which helped M sleep better at night. As a result, M had begun to smoke marijuana because it helped her feel less anxious before bed.

When M brought this up to her psychiatrist, she felt stigmatized and shamed for mentioning her marijuana intake. M articulated that she wanted to see this scene played out. She cast herself as the patient and another member T (another patient) in the group as her psychiatrist. When I asked M to ascribe certain characteristics to her psychiatrist, M said that she reminded her of a crocodile who was very evil and could snap anytime like a crocodile, so we named her Dr. Crocodile. M then said, "I am like a giraffe - warm, cozy, and a bit clueless." In the enactment, T dismissed M by exaggerating her gestures, tone of voice, and body language in a crocodile-like manner while M responded by posturing herself tall like a giraffe. At different points in the conversation, I paused the scene and checked in with how the actors were feeling in their bodies. Both expressed emotions of "frustration" "tension" and "anger". I then invited audience members as spect-actors to replace either the protagonist Giraffe or Dr. Crocodile to continue the conversation. Since spect-actors were reluctant I used the psychodramatic technique of "doubling" (Garcia & Buchanan, 2009, p. 415). With this method, they could stand behind any of the characters and voice an unsaid thought, feeling, or desire, which the protagonist could either accept, reject or change. Doubling evoked some spect-actors to stand behind the Giraffe attempting interventions like "You are you are not listening to me" and "I feel so frustrated and helpless." M repeated these lines, craning her neck like a giraffe. Others stood behind T croaking in a crocodile-like voice "I am so sorry you are struggling but I am the doctor, I have the degrees." "I am telling you - that marijuana will kill you." By this point the whole group was in splits. Eventually, an audience member S stepped up to offer intervention for the Giraffe but instead of standing behind M, they spoke directly to Dr. Crocodile saying, "I want to speak to your supervisor." Inspired by Boal's (1992) Forum dramaturgy technique where he motivated actors to demonstrate a "continuity of action" (p. 233), we then played out a scene between Dr.

Crocodile, Giraffe, and the supervisor. This time, S replaced M in the role of the Giraffe, and spect-actors were invited to stop the scene at any point and attempt interventions (in the role or as doubles). The scene concluded with all the spect-actors trying to distract Dr. Crocodile by singing nursery rhymes loudly into her ear so that the Giraffe and the supervisor could have a conversation without the crocodile's interruptive croaking. In the end, M stood at a 6 on the power spectrogram. In the debrief, we discussed issues around not feeling heard, the stigma of marijuana consumption, and how clinical knowledge (or the lack thereof) can impact a person's mental health.



Yalom's Therapeutic Factors in TO

Drama therapists Frydman et al. (2022) systematically conceptualized the core processes of drama therapy by articulating what they observed in participants while each process was taking place and what each process correspondingly did. When dynamizing an image, Boal similarly mentioned the importance of first encouraging the spect-actors to notice what they objectively see before they interpret. "If an image is interpreted in one way, it ceases other possibilities of being dynamized and illustrated. We first must ask - what do you see?" (Boal, 1992, p. 175). I used the formulation by Frydman et al. (2022) and Boal (1992) to help me table observable behaviors according to the therapeutic factors and forms of power I saw emerging in the groups. Then I expanded on what I saw those factors were doing to the TO process.

Yalom's Factors	**What did I see?**	**What did I see it do?**
Instillation of Hope: *A member recognizes other members' improvement and develops optimism for his or her own improvement.*	When one spect-actor offered an intervention either through a projective object, simultaneous dramaturgy, psychodramatic doubling, or through a physical replacement of the protagonist - other spect-actors always proceeded with follow-up interventions to resolve the dilemma.	Each intervention provided a little improvement to the struggle. When members recognized this improvement, they were motivated to develop optimism and constantly desire to act upon a better outcome for the struggling protagonist.
Universality: *A member perceives that other members share similar feelings or problems.*	Spect-actors would suggest intervention either in support of the protagonist or as the protagonist in a TO enactment. In turn, the protagonist-actor would act upon the suggested interventions (like in session #1 and session#10).	The spect-actors could perhaps recognize and relate to the struggle of the protagonist in the TO enactment. The protagonist-actors at some level also related to the interventions. Having received connection, support, and validation through the suggested interventions, the protagonist-actor would then strengthen their own desires.
Imparting Information: *Advice given by the therapist or fellow members.*	On witnessing an enactment of the protagonists' struggle, spect-actors offered some form of advice in their interventions (i.e seeking social support like in session #1 or professional support like in session #10).	Each advice-giving intervention was either partially or fully accepted or even rejected and challenged by the protagonist. After the enactments, the member who played the protagonist often acknowledged that the spect-actors had offered them new ideas that they had not thought of before.
Altruism: *Member gains a positive view of himself or herself through extending help to others in a group.*	In most of the sessions, spect-actors who provided interventions to the protagonist-actor assigned themselves a higher numeric value on the spectrogram at the end than they had at the beginning of the session.	These spect-actors perhaps gained a positive view of themselves and experienced moments of high self-esteem when extending help to another group member, even if the story performed was not their own.
Corrective Recapitulation of the Primary	In most of the enactments, critical familial relationships (i.e in session #4 between F and his sister) emerged as	Casting a clinician as an authority figure and antagonist in a TO enactment offered the

Family Group: *A member experiences the opportunity to reenact some critical familial incident with members of the group in a corrective manner*	territories of conflict and power struggles. Group members who were clinicians were often cast in the role of parents/authority figures/antagonists in these dynamics.	protagonist (and the spect-actors) the opportunity to attempt reparative interventions that they may not have attempted in their real family dynamics.
Development of Socializing Techniques: *Group provides members with an environment that allows the member to interact in a more socially adaptive manner.*	Some of the TO enactments around power (i.e. in sessions #4 and #10) were conversations about the protagonist and their current social systems - i.e. their family members, their doctors, their friends, and employers, etc. Each of these conversations was rehearsed in different ways by the intervening spect-actors.	Witnessing multiple reiterations of the same difficult relationship encouraged members to rehearse varied adaptive ways of resolving social conflicts without feeling judged. After certain enactments, members admitted to feeling more prepared to face these social interactions in their real life.
Imitative Behaviors: *Member learns through the observation of others' learning experiences.*	In the initial sessions (session #1-session#3) the same participants were attending the group consecutively. A group member who was the spect-actor in the first session volunteered to be the protagonist and enact their story in the second session. Similarly, a group member who was a spect-actor in the first two sessions and offered to be the protagonist-actor in the third session.	Group members who were spect-actors were observing and learning from the experience of the protagonist- actor thus perhaps desiring a similar intervention for their own stories. Many of them may not have been open to enacting their stories initially, but perhaps after observing therapeutic benefits for the protagonist-actor they also felt willing in the succeeding groups to be the protagonist and share their struggles.

Interpersonal Learning: *A member gains personal insight about their behavior through other members' sharing and is able to act on that insight outside the group.*	The original desire of the protagonist-actor at the beginning of an enactment would strengthen with every subsequent spect-actor intervention (as prevalent in session #1 and session#10). Moreover, at least one other clinician (other than me) was a consistent member of every group, despite their participation being voluntary and an addition to their regular work responsibilities on the unit.	By witnessing multiple interventions in their own struggle, perhaps the protagonist-actor gained clarity about what they truly desired. Moreover, that at least one clinician attended every group demonstrated that they too were gaining some form of learning about their patients or/and themselves through the group. I can't really determine to what extent group members necessarily acted on their insights outside the group
Group Cohesiveness: *Feeling of togetherness provided and experienced by the group*	In most of the sessions, group members physically moved closer to each other on the spectrogram after the TO intervention as compared to before.	The enactments and intervention perhaps stimulated insight not just at an intrapersonal level but also at an interpersonal and collective level, physically uniting the group and reducing the gaps in subjective feelings of power between members after the enactment.
Catharsis: *Member releases feelings about past or here-and-now experiences; this release leads to member feeling better.*	In most of the sessions, group members who volunteered their stories for a TO enactment rated themselves as feeling more powerful after the session than they did before. Many of them verbally expressed feeling grateful to those spect-actors who stepped in to transform their conflict.	Perhaps a protagonist-actor experienced a feeling of release by rehearsing a past conflict in the present moments in front of a group of fellow patients and clinicians. Perhaps witnessing their own conflict transform repeatedly with multiple interventions provided a feeling of power that they had not experienced when they entered the group.
Existential Factors: *Member recognize the unfairness of reality and*	In certain sessions, group members rated themselves as feeling less powerful after the session than before (like in session #9 and session #4). During the debrief, these members would share that the	Members who rated themselves as feeling less powerful than before perhaps recognized their realities are sometimes unfair and unjust (like the clinicians in

ultimately accepts that he or she has to take responsibility for his or her own life.	attempted interventions in the enactment were unrealistic and made them feel hopeless. Themes around the impossibility of mental health care systems, family dynamics, housing, and employment would emerge.	session #9). No matter how many interventions were attempted in the TO enactments, these group members did acknowledge that they would ultimately return to coexist within systems where they may feel alone and stigmatized. This often led to moments of prolonged silence towards the end of some sessions.

Drama Therapy Processes in TO

Drama Therapy Core Processes	**What did I see?**	**What did I see it do?**
Dramatic projection: *The process of outwardly expressing and representing aspects of oneself, others, social forces, feelings, and experiences onto dramatic material (e.g., puppets, props, masks, text, role, story) and engaging with that material*	Each spectrogram allowed the participants to physically express their feelings of power onto an imaginary scale. Each TO enactment further facilitated a projection of feelings (D's fear of losing her freedom in session #1) or/and social forces (the portrayal of clinician A as an oppressive politician in session #9 and the egg as a landlord in session#4) or/and aspects of oneself (M's cluelessness in herself was externalized into the giraffe in session #10). With every intervention, spect-actors then had the opportunity to project their solutions to the story of the protagonist.	Projections provided some aesthetic distance from or towards the initial story or feelings of power that emerged from the spectrograms. This facilitated interventions and suggestions by the spect-actors that aided in providing agency to the protagonist. For example, the objects in session#4 reduced the scale of the initial conflict into miniature toys that were then manipulated by both the protagonist and the spect-actors during the interventions to offer the protagonist more agency. The projections also facilitated thematic connections between the TO enactment and real-life conflict which emerged during the debrief (i.e.: in themes of having a lack of social support, of the stigmatization of hospitalization, of struggling with housing, etc.)

Dramatic play: *Engagement in a co-created improvised relationship with reality, utilizing imagination and spontaneity. Typically, there is a sense of experimentation, and an engagement in experiential processes that are expressive and collaborative*	Once the story and characterizations were provided by the protagonist, within a TO enactment, both clinicians and patients as actors would improvise the conversations (like in session#4 and session# 10). The actors then would improvise the interventions of the spect-actors at that moment (like in session #1). Each time a spect-actor offered an intervention, they too engaged in an experimentation process, collaboratively brainstorming the solutions with other spect-actors to the presented problem.	Dramatic play allowed the clinicians and the patients to explore aspects of reality (such as time, place, events, consequences, attitudes, actions, and held ideas). For example, in session #10 the dramatic play evolved into exploring a consequent scene between the supervisor, patient, and psychiatrist. The play further created an environment for cognitive, emotional, developmental, and interpersonal flexibility to generate new possibilities (through interventions) and empowerment without real-life consequences.
Dramatic embodiment: *A physical, vocal, or emotional inhabiting of the body; attending to sensations; touch; the spectrum of physicalized expression of emotions, thoughts, reactions, impulses, and inner experiences.*	In a TO enactment, actors and spect-actors either embodied a role physically or vocally expressed their thoughts/views of a character. They heightened or altered the use of their body (like in session #1, session#9 or session#10) for the task of expression of the conflict and/or awareness of their behavior during an intervention.	Embodiment supported an intentional sense of presence and immediacy, and a connectedness between mind, body, emotion, and/or a heightened awareness of the power dynamics between each of the characters. When actors/spect-actors took on a bodily identity, there was the development of insight or perspective; release; and/or new behaviors that moved the scene forward. The actors further explored the personal, social, and/or political forces that influenced one's experience of their body (i.e: in session#9 and session #10)
Aesthetic Distance: *A process of titrating emotion and cognition through engagement with dramatic media*	Rather than emotionally flooding or intellectualizing their conflicts, the TO enactments through the use of fictional characters (session#1), objects (session#4), a newspaper headline (session #9) and animals (session#10) allowed actors and	Aesthetic distance helped patients and clinicians to fully feel, express, and tolerate difficult conflicting emotions of power and/or expand their perspectives around feelings of power while also self-regulating. This was

	spect-actors to move along a continuum of emotional and cognitive expression.	evident as most participants shifted along the power spectrogram before and after the sessions (Fig 4).
Active witnessing: *The process by which participants notice aspects of themselves, others in a group, or the drama therapist. At the same time, participants are seen by the drama therapist, other group members, or an invited audience.*	During the TO enactment, the spect-actors demonstrated active witnessing by watching, listening, and then providing interventions that both demonstrated empathy, and/or provided concrete actions that supported the protagonist towards their desired goal (as shown in sessions #1, #4, #9 and #10).	Witnessing created an active exchange of power between patient and clinicians, particularly when clinicians were spect-actors and witnessing patients enact their stories of powerlessness (as evidenced in session #9 and session #10) when clinicians rated themselves at a lower rating of power than before the TO enactment. Witnessing also facilitated the spect-actor patients to act upon their relatability to the enactment thus offering supportive feedback to the protagonist (session #10). For the protagonist-actor being witnessed, active witnessing promoted the experience of being supported, acknowledged, validated, and helped develop perspectives or new feelings of power as evidenced by their shift on the power spectrogram after every enactment.
Multi-dimensional relationship: *The inter-relationship between participant(s), drama therapist(s), and dramatic reality.*	The patients engaged with the clinicians, and vice versa within the dramatic reality of the TO enactment. When I as the joker entered an enactment, patients, and clinicians both engaged with me in role. Spoken and unspoken connections between what took place in the TO enactment and in real-life concerns were observed in the debrief at the end of the sessions.	As evidenced by the shift in the pre and post-power spectrograms (as seen in Figure 4) clinicians and patients were mutually and dynamically influenced by what took place within and outside of the dramatic reality of the TO enactment.

Dramatic reality: *Participating in a transition from external reality to a liminal state, bringing the imaginal realm into outward expression; an in-session departure from ordinary life.*	As the joker of a TO session, I would invite any participant on the power spectrogram to enact their story of a power struggle. At this point, there was a transition into a dramatic reality as the protagonist-actor had the opportunity to cast spect-actors as different characters in the story and provide attributes to those characters from their perception (as evidenced in session#4 and session #10). Thus a story from the protagonist's real life was made concrete, an inner experience made visible, tangible, and/or audible in the TO enactment.	The transition into a TO enactment through objects (in session #4), a newspaper headline (in session #9), or/and fictional characters (session#1 and session #9) created a flexible space to express and explore the inner and external conflicts, to review past experiences and rehearse future possibilities for real life within an imaginative reality.

Starhawk's Model of Power in TO

Types of Power	**What did I see?**	**What did I see it do?**
Power-Over: *Instances of power built on force, coercion, domination and control and motivates largely through fear*	Though clinicians always participated in the spectrograms, subgroup sharing, interventions, and discussions, they never once in the 10 sessions volunteered their story as a protagonist for an enactment. They usually always stayed within the 4-7 range on the spectrograms before and after the TO enactment.	This reinforced a boundary between clinician and patient. Though the group was intended to be both for clinicians and patients, clinicians still may have felt that their role was to be in service to their patients. Perhaps there may have been a fear of self-disclosure, of being the subject of support by others (specifically their patients) and of taking up space in a hospital setting that was intended for patients. This decision of clinicians to not share their stories perhaps also reflecting the larger healthcare system that has power over the clinicians, controlling how much of themselves they can share with patients in a group therapy setting.
Power-With: *Instances of respect, mutual support, shared*	When participants turned to others who were near them to share why they assigned	These highly engaged subgroup discussions perhaps became an opportunity for group members to perceive others as also sharing similar moments of power and powerlessness. In

power, solidarity, influence, empowerment, and collaborative decision making	themselves a certain value on the spectrogram, both patients and clinicians in every session offered an explanation. I too stood on the spectrogram and shared my story with other participants who were around me.	these instances, while patients shared about the realities of their lives, clinicians too opened up about their multiple personal, professional, and academic responsibilities and the feelings those evoked. Perhaps the equality and mutuality of these moments encouraged at least one patient in every session to step forward to offer their story for enactment.
Power- To: *Instances of the generative potential of power, to build new possibilities or actions that can be created without using relationships of domination*	When patients would cast clinicians as either allies or antagonists in their enactments, clinicians played the role of the character they were assigned (i.e: session #4 and #9). This sparked a range of interventions from the spect-actors that would challenge and transform the power dynamics in the scene.	When clinicians were enrolled as part of a patient's story, they were able to dissolve parts of their clinician persona and instead lean into the nuances of their characters (a friend, family member, doctor, politician, etc) as per the description and story provided by the patient. Witnessing clinicians as actors possibly stimulated both the protagonist-actor as well as the spect-actors to reimagine varied possibilities to resolve the dilemma. In many cases, both patient and clinician spect-actors would provide innovative clinical and interpersonal interventions to encourage the protagonist to challenge the oppression in the scene. That a patient as a protagonist-actor could enroll a clinician as a member in their life possibly inhibited clinicians from using their institutional power of domination to advise the patient and instead commit to a reimagination of power dynamics, influencing the spect-actors to do the same.
Power-Within: *Instances of when a person can recognize individual differences, their own self-worth*	In moments when a clinician spect-actor would offer their interventions as a 'double' to a protagonist patient, the patient did not simply repeat the intervention word for	Instead of complying with the voice of a clinician, a patient enrolled as the protagonist-actor in their story demonstrated the power within themselves to recognize their own agency. The patient was perhaps able to differentiate between their needs and the clinician's desires for them. Neither patient nor clinician felt disrespected in these moments as more interventions by clinicians and patients alike soon followed, each one attempting to

while respecting others.	word but enacted the suggestion in their own way.	support the protagonist in some form or the other.

Embodied Mapping

Using the data from my movement on the spectrogram of power (see Figure 5) and prompts from my journal entries, I engaged in an embodied mapping exercise that is presented in a video sample in Appendix C and in the images below (see Figure 7).

Figure 7

Exploring my Feelings of Power and Powerlessness through Bharatnatyam.

Through my embodied exploration I found that I experienced feelings of powerlessness when I observed the spect-actors hesitant to intervene in a TO enactment. Had the enactment triggered them? Did they understand what was going on? In these moments I would attempt to intervene as a spect-actor to model the process for others and then simultaneously shift to jokering the enactment by asking clarifying questions, all the while providing a therapeutic scaffold. When a spect-actor would present an intervention, but I would notice them visibly experiencing emotional

dysregulation (i.e. circumstantial or tangential speech, thought-blocking, hallucinations/delusions) I struggled to proceed with the intervention as a joker without offering some containment/clarification as a therapist. When patients reported feelings of hopelessness even after multiple interventions, I too was left with an induced sense of powerlessness in myself. Was I providing them with false hope if they could not act upon these interventions in their reality? Were these TO enactments enough to empower them to challenge their realities outside the group? (see Figure 7).

I rated myself as feeling more powerful after an enactment when the protagonist of that enactment also placed themselves at the higher end of the spectrogram. In these moments, I felt as if I had successfully ‘helped’ the group member. I experienced feelings of power when a protagonist would volunteer their story or/and when the spect-actors would commit to the fictional reality of the enactment and offer interventions without much prompting. This made me feel that TO as an intervention was ‘working.’ I also experienced power when patients would act as clinicians or/and vice versa and when there was laughter in the room as it felt like group members were fully engaging with each other in these moments. While as a researcher my aim was to investigate the potential of TO as a group therapy, my own biases to ‘prove’ its potential informed my subjective feelings of power in the room.

While dancing, I also observed that all my movements along the pre and post spectrograms of power were limited to the 4-7 range, much like the other clinicians (see Figure 5). Possibly I was cautious of how I was consistently being perceived by the other patients and clinicians in the room. Though I was trying to challenge my own relations of power, I stopped myself from rating my feelings of power at either extreme end of the spectrogram because of my fear of *“log kya kahenge”* (translating to “what will people say” in Hindi). I did not want to appear more powerful

than the clinicians or less powerful than the patients. Since I was confused about the boundaries between the provocative joker of a TO enactment and the clinical role of a group therapist, I got caught in the fear of how I am being perceived by others in these roles. Furthermore, my intersectionalities and biases as an Indian, clinical intern without an SPMI diagnosis on a hospital unit where I did not culturally resemble any of the patients nor clinicians in the groups also informed my hesitancy to reveal my full self while facilitating these TO sessions. I figured that if I stayed within the 4-7 ‘moderate’ range, the focus of the group would be less on my specific identities and roles and more on the group; however, through the embodied mapping exercise, I observed the tensions that existed within me and around me because of my seemingly ‘safe’ choices on the power spectrogram. I was caught between the visible institutional expectations of the hospital system and the more invisible expectations of my identity politics and belief systems. These complex visible and invisible power dynamics were informing a gap between my perceptions of power in the room and each group member’s internal experience of that power. While I may have perceived a patient’s tangential speech as their confusion around the TO process, what if they were in fact feeling powerful and safe enough at that moment to express themselves without any restrictions?

As I danced through my journal reflections in a public park in Delhi with people occasionally staring at me, I felt my internal states of confusion and tension transform into flexibility between roles and relationships. I physically allowed myself to shift and teeter along the entire range of the power spectrogram which in turn helped me to destabilize my own belief systems around power and loosen my boundaries between joker and therapist, actor, and spect-actor, Indian and American, sick and healthy, dancer and pedestrian, patient and clinician.

DISCUSSION

In my thesis, I investigated the potential of TO as a group therapy model with a heterogenous population of patients and clinicians. I used spectrograms, core processes in drama therapy and group therapy, Starhawk's model of power, and embodied mapping to examine this potential. From the spectrograms, I observed that on an average group members reported feeling more powerful after the TO intervention than before (see Figure 3). Certain individual members positioned themselves as feeling less powerful after the session than before the session. On average, patients, clinicians, and I reported shifting states of power before and after the session (see in Figure 4 and Figure 5). While after some TO sessions, group members moved closer to each other on the spectrogram, in other sessions they moved farther apart from each other (see Figure 6).

Additionally, I observed that the conflicts and desires of the protagonist would unfold and strengthen through the TO enactments. Protagonist-actors would cast a clinician in the role of the antagonist, and spect-actors usually introduced new allies into the scene to support the protagonist, and concluding interventions to the enactments often challenged notions of reality. I observed consistent examples of Yalom's therapeutic factors (instillations of hope, universality, altruism, corrective recapitulation of familial relationships, development of socializing techniques, group cohesiveness, existential factors, interpersonal learning, imparting information, imitative behavior, and catharsis) and the drama therapy core processes (dramatic projection, dramatic play, dramatic embodiment, aesthetic distance, active witnessing, multi-dimensional relationship, and dramatic reality) in action during the sessions. I also observed power dynamics shifting moment to moment between clinicians and patients across sessions. Finally, by physically dancing through my own

contradictory feelings, biases, and beliefs of power I encountered a destabilization of roles between ‘therapist’ and ‘joker’ and ‘patient’ and ‘clinician.’

In this chapter, based on these key findings, I will discuss the therapeutic potential of TO with patients and clinicians and some factors for practitioners to consider when situating TO as a group therapy model with heterogenous communities. I will conclude this section by offering a few limitations and possible future directions for this study.

Therapeutic Potential of TO in Group Therapy

The patients in the group presented with a range of symptoms depending on their diagnoses including mood swings, suicidal ideations, disorganized thought and speech, impulsive behavior, hallucinations, or/and delusions that may not be part of a shared consensus reality (APA, 2013). With these symptoms, individuals can move between experiencing a primitive object-relations split to an object-relations complexity in their thinking, each serving important developmental functions (Klein, 1946). In the TO sessions, I observed that an equilibrium between these forms of thinking, feeling, and acting offered a range of therapeutic potentials to both patients and clinicians. These included facilitating moments of catharsis, emotional safety, and individual agency to increase conflict tolerance, community support, and critical reimagination.

Split-Thinking: Catharsis, Emotional Safety, and Individual Agency

According to psychoanalyst Melanie Klein (1946), those who experience an object-relation split are unable to have an integrated or differentiated sense of self and others. Their fragmented egos have over the years created alternative realities or defenses perhaps in response to a past stressor, childhood insecure attachment, or traumatic event (Volkan, 1994; Kaufmann & Paul, 2014). As a result, parts of themselves are easily split into concrete values of ‘good’ or ‘bad’ which

individuals can fixate on and internalize in themselves or project onto others. The emerging anxieties also result in individuals splitting themselves from others, or perceiving their own states of self as separate from those around them (Klein, 1946).

In the TO sessions, splitting was evidenced in how certain patients would stand on the extreme ends of the power spectrogram at 0-3 or 8-10 before the enactment and from these positions share feelings/stories of either omnipotency or worthlessness (like in session #1). Evidence of splitting was also demonstrated in how certain protagonist-actors would describe the antagonists in their stories as one-dimensional characters, like when M described her psychiatrist in session #10 as an evil crocodile. Moreover, when patient T stepped into the role of the psychiatrist she exaggerated her dialogues and movements even more. Sometimes the interventions also furthered this splitting by departing from the norms of reality. For example in session#4 when the snake and the clam forced themselves to fit into the shell of the egg or when in session#10 the spect-actors entered the scene singing nursery rhymes loudly in Dr. Crocodile's ear. I observed the group feeling threatened by the characters of the landlord and the psychiatrist respectively. These interactions induced a single-minded hate and fear that further led to the caricaturing of these characters by the patients in role. In these moments, neither the protagonist nor the spect-actors perhaps viewed the antagonist as individuals they could work with, but rather as people who existed as separate from themselves.

According to Klein (as cited in Steiner, 1991), this kind of splitting can allow for the emergence and expression of otherwise repressed ego states. This split can be self-protective for an individual who may be threatened by destructive forces from within and/or around them. They may need to impulsively and assertively split these forces from their realities to survive (Klein, 1946). To this point, Boal (1992) expands on how TO enactments often give rise to many extreme

or exaggerated forms of expression to arouse laughter from the spect-actors. This humor is a form of catharsis that recognizes the tricks of the oppressors, the ingenuity of spect-actors' ruses, and the defeat of oppression (Boal, 1992). A departure from realism into absurdism is a way for a TO group to rescue itself, to feel emotionally safe within the impossibility of their initially presented conflict, which Klein described as self-protective and impulsive. This form of splitting or "caricaturing" (Boal, 1992, p.59) in the TO enactment perhaps protected the protagonist from experiencing further disempowerment, which may already be dominating their current lived reality. In fact, the split thinking could then be an expression of how the patients and clinicians asserted agency to revert power dynamics that may otherwise be challenging to enforce in their lived reality. This was particularly evident when patients exaggerated their acting of a clinician or of characters who held high degrees of systemic power (landlord, psychiatrist, queens, etc.)

Complex Thinking: Conflict Tolerance, Community Building, and Critical Reimagining

According to Klein (1946), in object-relation integration, people engage in complex thinking patterns where whole objects can be recognized and ambivalent impulses are directed towards a primary object. Such thinking facilitates the integration of both 'good' and 'bad' values at the same time towards a single object which can then result in feelings of loss, confusion, and ambivalence. The consequences of this position lead not only to an acceptance of co-existing split states within the person but also between the person and others around them (Klein, 1946).

In certain TO sessions, complex thinking was prevalent towards the end when participants who rated themselves at extreme ends of the power spectrogram on 0-3 or 8-10 at the beginning, moved closer to the middle of the power spectrogram after the session within the 4-7 range (like in session #1 and session #10). During this shift, some patients and clinicians rated themselves as less powerful than before the session, perhaps experiencing a sense of loss or confusion after

engaging in a TO enactment. Moreover, certain interventions integrated allied characters into the scene rather than creating further splitting and departure from reality. In session#4 E introduced his object as “F’s friend from the hospital” and in session#10 S stood up from the audience and asked Dr crocodile if he could speak to her supervisor. Both these attempts acknowledged the shared complex realities of patients and clinicians within the hospital setting. These allied supporting characters were not prevalent in the initial enactment of the conflict but existed in between the ‘good protagonist’ and ‘bad antagonist’ to assist in tolerating their conflict. They emerged as members of the same community as the protagonist and the antagonist, rather than as split departures from a consensus reality. Complex thinking was also evident when patients as protagonists would cast the clinicians as the antagonist in their story (like in session #9) while declaring “I know you can handle it because you are not like this in real life.” The clinicians in turn committed to playing these otherwise one-dimensional antagonists, perhaps accepting and tolerating the split between their own individual identities and who they may represent institutionally and professionally to their patients.

According to Klein (1946), complex thinking increases our capacity to integrate and tolerate otherwise extreme experiences. When a person’s fixed and concrete thought patterns about themselves and others loosens and repairs then their primary concern shifts from surviving for themselves to thriving and feeling concerned for and with others (Klein, 1946). What emerges then is an increased capacity to relate and find connections not only between split self-states but also with others who are different from the self (Klein, 1946). TO is inherently a form that elevates the dialectics between the actor and the spect-actor and between the oppressor and the oppressed (Howe et al., 2021). Recently Julian Boal, the son of Augusto Boal created an anti-model for a Forum scene that centers the submissive-subversive tendencies between the protagonist and their

allies without including the antagonist in the scene (Khanna, 2018). The protagonist is let down by the very people who he/she would turn to for support. “When we include complex allies, the oppression, and the subsequent interventions expand from remaining interpersonal to institutional” (personal communication, June 12, 2018). While Augusto Boal’s TO model historically began with a homogenous population desiring to overthrow a singular oppressive regime, Julian Boal’s revised model blurs this oppositional concept of oppressor and oppressed to integrate contradictory dynamics of heterogeneous communities. When patients and clinicians appeared more cohesive on the power spectrogram after the session, I observed the integration between and amongst their submissive-subversive tendencies and an increase in their capacity to relate to each other. On witnessing each other’s complexities certain patients and clinicians also rated themselves as feeling less powerful than before, which perhaps demonstrated their capacities to recognize and tolerate difficult feelings within themselves. The inclusion of allies functioned as ego supports not only for the singular protagonist but also for the larger systems that the protagonist-actor represented through their desires (i.e.: the supervisor in session#10). These interventions thus existed within an integrated sense of the reality of the scene but also attempted to liberate the protagonists from these very realities.

Patients and clinicians both shifted along this continuum of complex and split thinking at different points in the sessions. Each of these positions offered group members varying therapeutic potentials including experiences of catharsis, emotional safety, and individual agency, increasing tolerance for conflict, and identifying community support. Along this spectrum, patients and clinicians also experienced different ways of relating and empathizing with each other by either reversing roles of power or enacting exaggerated versions of their own social positions of power.

As a result, an emerging therapeutic consequence was a critical and creative reimagination of reality from how it *is*, to how it *can* be.

Factors to Consider when Framing TO as Group Therapy

For clinicians and practitioners who are considering using TO as a model for group therapy with heterogeneous populations, below are a few recommended questions based on my observations and learnings.

Pre-existing Power Structures: What are the pre-existing structural power dynamics in the setting? What is your role in that hierarchy?

To a large extent, the milieu treatment environment at PHP was conducive to the therapeutic processes emerging in the TO sessions. Clinicians engaged fully and committed to the roles they were assigned - either as the antagonist or the ally character in a story. The patients were also comfortable sharing struggles of power in front of their clinicians in the sessions and casting their clinicians as antagonists. Perhaps a degree of safety and trust was already present in the patient-clinician dynamics in the PHP environment. Moreover, since the program offered a menu of group options throughout the day, patients had the opportunity to demonstrate some power by simply showing up to the TO session and leaving whenever they wanted to. The group took place every week in the same room and followed a very similar structure (as demonstrated in the emergent protocol). This perhaps also contributed to a sense of familiarity, consistency, and containment for both patients and clinicians in an otherwise unpredictable and chaotic hospital unit. I also had the confidence to encourage participants to offer and transform stories of personal conflict because I knew that I could check in with individual participants after the sessions and through the week within the milieu incase incase they appeared particularly dysregulated.

There were always more patients than clinicians in a group. Clinicians were usually quite busy managing their own patient caseload during the day and struggled to show up to the sessions. Clinicians who did show up engaged as characters in a story but never volunteered their story for an enactment. Perhaps they always perceived themselves as being in service to their patients even when they were given permission to share space as equals in the group. This made me wonder about the impact of institutional labels and boundaries of the hospital on the interactions between patients and clinicians in a group therapy setting. By demonstrating power *with* their patients as characters in their story, were they maybe continuing to reinforce power *over* their patients (as they did not volunteer their own story)? Or were clinicians perhaps protecting their own boundaries of self-disclosure in order to facilitate the therapeutic process for their patients? Situating a group therapy model within a hospital setting with deeply embedded systemic power hierarchies definitely impacted these dynamics between patients and clinicians.

Having an awareness of my intersectional identities also contributed to these dynamics. That I was a student-intern who was not employed by the hospital nurtured a risk appetite in me to facilitate questions around power dynamics that I had already been noticing on the unit. I was also on the unit twice a week and did not share the social position of either the patient or the full-time clinician. Moreover, as an Indian international student on the unit with majority of white clinicians and black patients, I existed between racial and professional polarities and roles. In TO, the joker is similarly an 'in-betweener' who mediates the transitional space between actors and spect-actors. While facilitating the TO sessions, my sociocultural and professional identity on the unit was lending itself to the transference and countertransference that I was experiencing between me, the patients, and the clinicians.

Aesthetic Distance and Safety: What is the history and nature of trauma in the group? How can you employ aesthetic distance to hold these narratives of trauma?

While facilitating the groups I relied heavily on the drama therapy and TO shared process of aesthetic distance to maintain the therapeutic intent of the group. When a client feels overwhelmed or too close to their feelings and/or body, they are said to be "under-distanced" and when too far away, they are said to be "over-distanced." As mentioned earlier, a place of balance to heal at an emotional and physical level is "aesthetic distance" (Landy, 1996, pg. 13).

In TO, group members are re-enacting a real-life conflict from their past in the present. The body of the protagonist-actor becomes a dramatic container for their own narrative, which they reinforce or transform through interventions in the scene. The protagonist-actor can thus experience little distance between their feelings and thoughts as they embody a real-life challenge that other bodies are also directed to step into. In many of my TO sessions (i.e. session#10) the patients were enacting a power struggle that had taken place in the same setting as the group and in front of clinicians who potentially represented their real-life oppressors in the hospital. I knew that if I did not titrate the distance between reality and fiction in the group, I might run the risk of repeating a traumatic situation for the patients and evoking real feelings of harm and helplessness. All the patients in the group had an extensive history of psychosocial trauma. As a result of any kind of trauma, individuals have a ruptured relationship with their own physical sensations. An approach that affords them greater distance from their affective states is then recommended (Landy, 1993). Similarly, when patients with psychosis encounter a past trigger or stressor, they can experience states of re-traumatization which can result in presentations of emotional flooding, impulsive behaviors, dysregulating delusions or hallucinations that are not part of a shared consensus reality (Volkan, 2014). Aesthetic distance can then support patients with psychosis and

histories of trauma to organize boundaries between their otherwise fragmented realities and ego states (Emunah, 1983).

While facilitating the TO group I used aesthetic distance to gauge a group member's need for expression and/or repression. I observed an overabundance of emotions particularly when I invited group members to volunteer their story for an enactment or/and when the conflict in an enactment was increasing in intensity or/and when spect-actors were invited to intervene in the enactment. In these moments, certain patients presented with circumstantial or tangential speech or/and thought blocking offering suggestions or stories that were not part of a shared consensus reality. In other instances (like in session#10), group members appeared frozen while witnessing an enactment, not wanting to physically replace any of the characters in the scene or leaving the group entirely. These moments informed my use of drama therapy processes of dramatic projection (through spectrograms and objects) and dramatic embodiment (through caricaturing of animals and fictional characters) to create the boundaries of a dramatic reality within which a TO enactment could play out. These boundaries allowed me to notice how group members were responding to the dramatic play and to accordingly assess how much aesthetic distance would be needed for the group to tolerate the emotional resonances of the play to their real-life struggles. In some sessions, like in session #4 and session#10 TO enactments began with the aesthetic distance offered by the objects and animal-like characters respectively; however, the boundaries between fiction and reality eventually blurred when spect-actors and actors began addressing each other as their real-life roles. In other sessions, like in session #1, the entire enactment remained within the dramatic reality created by the fictional characters of Atlas and Cleopatra. Similarly, the psychodramatic technique of doubling and Boal's simultaneous dramaturgy scaffolded a spect-actors' embodied

entrance in a TO enactment and offered the protagonist-actor more agency over how their narrative was being re-written by the spect-actors.

I also integrated trauma-informed principles of safety and stabilization as articulated by psychiatrist Judith Herman (1994) when I noticed emotional flooding. For example, in session #10 when M and T were engaging in a heated discussion as the patient and psychiatrist, I observed them both beginning to act out impulsive and aggressively towards each other. I paused the enactment mid-way and invited everyone in the group to check-in with their bodies. In other sessions when I observed the protagonist-actors becoming overwhelmed in their enactment I asked them to name five objects they noticed in their surroundings. These grounding techniques returned individuals who perhaps may have been experiencing some dissociation from their self-states back into their bodies and into the present moment. When particular TO enactments concluded with a feeling of overwhelming despair or helplessness, I offered a breathing exercise that returned group members to asserting agency over their bodies.

Boal (1992) claimed that TO should not be used to incite people to do what they are not ready to do. Clinically, the drama therapy process of aesthetic distance and trauma-informed principles of safety slowed down the mechanics of the TO process and helped me assess the group's readiness for liberatory action. It was only when the group felt safe enough in the dramatic play could they then take a social action that challenged the bounds of that fictional reality. Often these two processes were happening parallely through the sessions. Oscillating along the pendulum of distance was governed by my clinician judgement in the moment.

Sustainability: How are you caring for yourself to sustain the facilitation of the group?

Historically, a group of actors would perform TO productions across various communities to incite political and social action. When framing TO as group therapy, the focus shifts from the

creation of a conclusive play to sustaining the process of TO over a longer period. I believe even as group therapy, the intention of TO is still to incite political action within the social microcosm of the group so that those actions can then be replicated by group members outside the group. When working with a heterogenous group where members have varied degrees of social power, conflicts are bound to occur within the TO enactment and the group dynamics. The group therapist then has an added responsibility to not only instigate participatory action but to also provide therapeutic containment within those moments of conflict. When working with clinicians and patients, I realized I needed to be more flexible so that I could move along this continuum of rupture and repair with them. The ratio of patients to clinicians changed every day and often I did not know who would attend the groups on any given day. Since the dynamics of power in the group were always shifting, I was also stretching my own tolerance for the unknown so I could be fully present to improvise, instigate, and/or contain the TO process as necessary.

Journaling and dancing as a therapeutic practice allowed me to verbally and non-verbally process some of the exhaustion and confusion that emerged in juggling these multiple roles. In fact, this study has made me greatly value embodied mapping as perhaps a supervision tool in a TO group therapy process. By embodying various moments in a TO session, the group therapist can enquire into different power dynamics in their therapeutic relationship towards clients, parallel processes, and unconscious communication. Consistent supervision also supported me in differentiating when feelings of powerlessness or omnipotence were mine or/and when they were induced by the group. In order to sustain the TO process I also realized that I could not be the only clinician who was facilitating the group. After the end of 10 TO sessions, I asked another social work intern (who had been a participant in the group all this while) to facilitate a session of their version of Power-Play while I supported them as a co-facilitator. Then eventually a few patients

also requested to joker TO enactments during the sessions. Now even though the research is over, the group continues to exist in the unit with a few facilitators splitting responsibility for holding the group. In January when I was in India visiting my family, a dance movement therapy intern on the unit facilitated the power spectrogram as a 10-step movement sequence before directing a TO enactment. This was a format I had never even imagined before, yet it still held the intention of dynamizing conflicts and transformations of power.

Distributing leadership in this scaffolded manner and allowing the TO process to evolve along the way not only presented an opportunity for me to rest but also encouraged the group members to extend their agency beyond the dramatic reality of a TO enactment into their realities on the unit. For the process of TO to sustain itself as group therapy, I see the value in it extending beyond the group to infuse into the surrounding system and attitudes of care.

Limitations

The credibility of data is weak as the number of participants in each group was too small, the ratio of patients to clinicians was always changing, and the engagement of the study was limited to only six months. The conditions, timelines, and participants of this particular TO group within a specific PHP setting created a unique circumstance that cannot be replicated. This study was limited to my biased observations of the group influenced by my lived experiences, histories, and identities as a drama therapy intern on the unit. I relied on my memory for the construction of my observations after each TO session which also influenced the reliability of the data. Several sources of information were used to collect data, including spectrograms, subjective and objective accounts, and journal reflections. Group therapy, drama therapy, and restorative justice theories were used to analyze this data; however, each of these data sets was only collected and analyzed by me. My subjective observations of this data thus cannot be expected to regenerate the exact

findings for a trustworthy and credible application of the research. I was limited to my observations of behaviors of the participants in a naturally occurring group setting and I could not include them in member checking the data, which again limits the credibility of the study.

Future Directions

Given the increasing racial, socio-political, economic, and ecological tensions across the world in the last decade, any community today is impacted by some form of a deep psychological wound. TO as a methodology has historically always responded to and shape-shifted according to the needs of its times. As drama therapists, I feel we have a unique opportunity now to extend support to TO practitioners who are embedded in community care and working with diverse populations. Drama therapists Hastings (2021) and Bleuer (2020) are already building a trauma-informed TO pedagogy for victims of sexual and gender-based violence and children and educators in school systems respectively. I am excited about expanding on their work and supporting my colleagues in India who are facilitating TO in their communities. How can drama therapy and group therapy processes be disseminated amongst TO practitioners who may not have a clinical degree? How can therapeutic frameworks be more consciously embedded into a TO process to serve the needs of people who hold variegated degrees of power? How can there be more collaboration between TO practitioners and therapists when programming, facilitating, and researching socially engaged practices of care?

Conclusion

In her article titled *The Implicated Witness,* Sajnani (2012) expands on the possibilities of healing and social change when the intimate relationships between actors and audiences are made visible and open to audience interaction. In her paper, she offers an example of her personal communication with Augusto Boal, where Boal offered the following story:

"When a visitor arrives on Earth they might observe that drivers stop at red lights and proceed when the traffic light turns green. However, they would not be able to see the people who installed the traffic lights nor those who decided at what frequency they would operate. Without these details, this visitor might conclude that human behavior is regulated by the changing color of traffic lights rather than understand this behavior as a result of a complex system of power and control" (Boal as cited in Sajnani, 2012, p. 9).

When I first started as a drama therapy intern at PHP, I often felt like the visitor in Boal's story. I was witnessing patients enter the hospital upon an attempt to harm others or/and themselves and then exit after their time-bound treatment program, to only return again post another attempt at harm. Similarly, I was witnessing clinicians feeling exhausted by their caseload, falling sick, taking extended days off from work, and then returning to the hospital again to an overburdened caseload. On observing these repeating patterns, I became curious about what conditions within and beyond the hospital were regulating this vicious cycle. Also partially, it was my own fear of reinforcing this pattern as an emerging clinician that led me to the reflection-action-reflection praxis of TO - a structure that has historically converted my feelings of fear to courage. Within an intimate group setting in a hospital, TO in its very form called the stability of the 'patient,' 'intern' and 'clinician' roles into question by having us witness and replace each other in roles of power. The TO structure in itself intended to resist the repetition of certain narratives in the hospital - that the clinician treats the mentally ill patient and a mentally ill patient is treated by the clinician; however, as Sajnani (2012) articulated that in order to transcend these narratives we must first acknowledge them. A group therapy model within the TO dramaturgical frame can overtly honor the heterogeneity of the group, allow differences to become more tolerable, and center capacities to overcome interdependent power struggles through collaboration rather than in isolation. TO as

group therapy can then allow us to dance together along the spectrogram of power, adding new dimensions of agency and allyship to our roles as clinicians, patients, and interns. In this way, maybe our co-imagined liberatory ecosystem of care created within the social microcosm of a TO group can become easier to replicate in the outside world.

REFERENCES

Abbey, S., Charbonneau, M., Tranulis, C., Moss, P., et al. (2012). Stigma and discrimination. *Canadian Journal of Psychiatry, 56*(10), 1–9.

Abraham, A., Windmann, S., McKenna, P. & Güntürkün, O. (2007). Creative thinking in schizophrenia: the role of executive dysfunction and symptom severity. *Cogn. Neuropsychiatry 12*, 235–258

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

Ash, J. S., Sittig, D. F., Campbell, E., Guappone, K., & Dykstra, R. H. (2006). An unintended consequence of CPOE implementation: shifts in power, control, and autonomy. *AMIA ... Annual Symposium proceedings. AMIA Symposium*, *2006*, 11–15

Bandura, A. (2006). Toward a psychology of human agency. *Perspect Psychol Sci,* 1, 164–80.

Barbosa, I., Camarda, V., & Dwyer, P. (2021). Forum theatre: A dramaturgy of collective questioning - An interview with Inês Barbosa, Vanesa Camarda, and Paul Dwyer. In K. Howe, J. Boal, & J. Soeiro (Eds.), *Routledge companion to theatre of the oppressed* (pp. 168-180). Routledge.

Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness, *Psychoanalytic Quarterly, 73*(1), pp. 5-46.

Bewer, V. V., Woodgate, R. L., Martin, D., & Deer, F. (2021). Exploring theatre of the oppressed and forum theatre as pedagogies in nursing education. *Nurse Education Today*, *103*, 104940. https://doi.org/10.1016/j.nedt.2021.104940

Bhatia, S. (2008). *Decolonizing Psychology.* Sage Publications.

Boal, A. (1985). *Theatre of the oppressed*, trans. C. A. & M. L. McBride.

Urizen Books.

Boal, A. (1990) *Méthode Boal de théâtre et de thérapie: l'arc-en-ciel du désir.* Ramsay.

Boal, A. (1992). *Games for actors and non-actors*. Routledge.

Boal, A. (1995). *Rainbow of desire.* Routledge.

Boyd K. K. (1996). Power imbalances and therapy. *Focus (San Francisco, Calif.)*, *11*(9), 1–4.

Bleuer, J. (2020). Theatre for revolution or theatre for healing? In K. Afary & A. M. Fritz (Eds.), *Communication research on expressive arts and narrative as forms of healing.* (p. 57-83). Rowman & Littlefield.

Brookfield, S. D. (2005). *The power of critical theory for adult learning and teaching.* McGraw-Hill Education.

Brüggemann, A. J., Wijma, B., & Swahnberg, K. (2012). Patients' silence following healthcare staff's ethical transgressions. *Nursing Ethics, 19*, 750–763. https://doi.org/10.1177/0969733011423294.

Burlingame, G. M., McClendon, D. T., & Yang, C. (2018). Cohesion in group therapy: A meta-analysis. *Psychotherapy*, *55*(4), 384–398. https://doi.org/http://dx.doi.org/10.1037/pst0000173

Corrigan P. W. (2002). Empowerment and serious mental illness: Treatment partnerships and community opportunities. *The Psychiatric quarterly*, *73*(3), 217–228. https://doi.org/10.1023/a:1016040805432

Creswell, J.W. (2002). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research.* Merrill Prentice Hall.

Crutcher, R. A., Szafran, O., Woloschuk, W., Chatur, F., & Hansen, C. (2011). Family medicine

graduates' perceptions of intimidation, harassment, and discrimination during residency training. *BMC Medical Education, 11*, 88. https://doi.org/10.1186/1472-6920-11-88

de Moura, A., Pinto, R., Ferros, L., Jongenelen, I., & Negreiros, J. (2017). Efficacy indicators of four methods in outpatient addiction treatment. *Archives of Clinical Psychiatry, 44*(5), 117–121.

Deshmukh, P., Kulkarni, G., & Ganocy, S. J. (2021). Adults with severe psychiatric symptoms in a community partial hospitalization program: Characteristics and predictors of clinical response. *Community Mental Health Journal*, *57*(4), 667–674. https://doi.org/10.1007/s10597-020-00725-1

Donetto, S., Tsianakas, V., & Robert, G. (2014). *Using experience-based co-design (EBCD) to improve the quality of healthcare: Mapping where we are now and establishing future directions*. King's College London.

Elowe, R., Schorr, S., Faith, E., Alters, B., & Wood, L. L. (2022). Connections between therapeutic circus arts and drama therapy: A qualitative content analysis of core processes. *Drama Therapy Review, 8*(2), 249-272. https://doi.org/10.1386/dtr_00109_1

Emunah, R. (1983). Drama therapy with adult psychiatric patients. *The Arts in Psychotherapy. 10*, 77-84.

Farr, M. (2017). Power dynamics and collaborative mechanisms in co-production and co-design processes. *Critical Social Policy, 38*(4), 623-644.

Feldenhendler, D. (1994). Augusto Boal and Jacob L. Moreno: Theatre and therapy. In M. Schutzman & J. Cohen-Cruz (Eds.), *Playing Boal: Theatre, therapy and activism* (p. 87-109). Routledge.

Fernández, J. S. (2020). Liberation psychology of and for transformative justice: Centering

acompañamiento in participatory action research. In L. Comas-Díaz & E. Torres Rivera (Eds.), *Liberation psychology: Theory, method, practice, and social justice* (pp. 91–110). American Psychological Association. https://doi.org/10.1037/0000198-006

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58,* 1433–1441. http://dx .doi.org/10.1002/jclp.10090

Fink-Samnick, E. (2022). Collective occupational trauma, health care quality, and trauma-informed leadership: Intersections and implica- tions. *Professional Case Management*, *27*(3), pp. 107–23, https://10.1097/ NCM.0000000000000559.

Fisher, B. (1994). Feminist acts: Women, pedagogy, and Theatre of the Oppressed. In M. Schutzman & J. Cohen-Cruz (Eds.), *Playing Boal: Theatre, therapy and activism* (pp. 185–197). Routledge.

Fox, J. (1994). *Acts of service: Spontaneity, commitment, tradition in the nonscripted theatre*. New Paltz.

Freire, P. (1970). *Pedagogy of the oppressed.* The Continuum International Publishing Group Inc.

Fritz, B. (2012). *InExActArt—the autopoietic theatre of Augusto Boal: A handbook of theatre of the oppressed practice.* Routledge.

Galinsky A.D., Magee J.C., Gruenfeld D.H., Whitson J., Liljenquist K.A. (2008). Social power reduces the strength of the situation: Implications for creativity, conformity, and dissonance. *Journal of Personality and Social Psychology*, 95, 1450–1466.

Garcia, H. A., & Buchanan, N. T. (2009). Psychodrama. In D. R. Johnson & R. Emunah (Eds.), *Current approaches in drama therapy* (pp. 127-140). Charles C Thomas Publisher.

Gatta, M., Lara, D. Z., Lara, D. C., Andrea, S., Paolo, T. C., Giovanni, C., et al. (2010).

Analytical psychodrama with adolescents suffering from psycho behavioral disorder: Short-term effects on psychiatric symptoms. *Arts in Psychotherapy, 31*, 240.

Haddock-Lazala, C. M. (2021). Urban liberation: Postcolonial intersectional feminism and developing a socially conscious therapeutic practice. In L. Comas-Díaz & E. Torres Rivera (Eds.), *Liberation psychology: Theory, method, practice, and social justice* (pp. 45-56). Routledge. https://doi.org/10.4324/9781315180072

Haen, C., & Webb, N. B. (Eds.). (2020). *Creative arts-based group therapy with adolescents*. American Psychological Association.

Hamann, J., Bühner, M., & Rüsch, N. (2017). Self-tigma and consumer participation in shared decision making in mental health services. *Psychiatric services, 68*(8), 783–788.

Hamilton, S., Pinfold, V., Cotney, J., Couperthwaite, L., & Matthews, J. (2016). Qualitative analysis of mental health service users' reported experiences of discrimination. *Acta Psychiatrica Scandinavica, 134(*446), 14–22. https://doi.org/10.1111/acps.12611

Hauber, K., Boon, A. E., & Vermeiren, R. (2019). Therapeutic factors that promote recovery in high-risk adolescents intensive group psychotherapeutic MBT programme. *Child and adolescent psychiatry and mental health*, *13*, 2. https://doi.org/10.1186/s13034-019-0263-6

Hastings, E. (2021). Shadow liberation. http://shadowliberation.blogspot.com/p/about.html

Herman, J. L. (1994). *Trauma and recovery*. Basic Books

Hersen, M., Bellack, A. S., & Luber, R. F. (Eds.). (1979). *Partial hospitalization:A current perspective*. Springer.

Hill S. A., & Laugharne, R. (2006). Decision-making and information-seeking preference among psychiatric patients. *Journal of Mental Health*, *15*, 75–84.

Hoge, M. A., Davidson, L., Hill, W. L., Turner, V. E., & Ameli, R. (1992). The promise of partial

hospitalization: A reassessment. *Hospital & Community Psychiatry*, *43*(4), 345–354. https://doi.org/10.1176/ps.43.4.345

Howe, K., Boal, J., & Soeiro, J. (2021). Theatre of the Oppressed and its time(s). In K. Howe, J. Boal, & J. Soeiro (Eds.), *Routledge companion to theatre of the oppressed* (pp. 1-12). Routledge.

Hunjan, R., & Pettit, J. (2011). *Power—A practical guide for facilitating social change*. Dunfermline.

Huynh, H. P., & Dicke-Bohmann, A. K. (2020). Humble doctors, healthy patients? Exploring the relationships between clinician humility and patient satisfaction, trust, and health status. *Patient Education and Counseling, 103*(1), 173-179. https://doi.org/10.1016/j.pec.2019.08.017

Isham, L., Griffith, L., Boylan, A. et al. (2021) Understanding, treating, and renaming grandiose delusions: A qualitative study. *Psychology and Psychotherapy: Theory, Research and Practice, 94* (1), 119-140.

Jackson, A. (1992). Translator's introduction. In A. Boal, *Rainbow of desire: The Boal method of theatre and therapy* (pp. xi-xiii). Routledge.

Jackson, A. (2021). The rainbow of desire: Boal and doubt. In K. Howe, J. Boal, & J. Soeiro (Eds.), *Routledge companion to theatre of the oppressed* (pp. 180-186). Routledge.

Johnson, D.R. (1980). Effects of a theatre experience on hospitalized psychiatric patients. *The Arts in Psychotherapy, 7*, 265-272.

Johnson, D. R. (2014). Trauma-centered developmental transformations. In N. Sajnani & D. R.

Johnson (Eds.), *Trauma-informed drama therapy: Transforming clinics, classrooms, and communities* (pp. 122-151). Springfield.

Jones, P. (1991). Dramatherapy: Five core processes. *Dramatherapy, 14*(1), 8–15. https://doi.org/10.1080/02630672.1991.9689804

Jones, P. (2007). *Drama as therapy volume 1: Theory, practice and research.* Routledge.

Jones, P. (2008). Research into the core processes of drama therapy: Vignettes and conversations. *Arts in Psychotherapy, 35,* (pp. 271–279).

Jones, P. (2016). How do drama therapists understand client change? A review of the ‘core processes’ at work. In S. Jennings, & C. Holmwood (Eds.), *The International handbook of dramatherapy* (pp. 77–91). Routledge.

Karabekir, J. (2004). *Performance as a strategy for women’s liberation: The practices of Theatre of the Oppressed in okmeydan social centre.* [Master’s thesis]. Boğaziçi University.

Kaufman, S. B., & Paul, E. S. (2014). Creativity and schizophrenia spectrum disorders across the arts and sciences. *Frontiers in Psychology*, *5*, 1145. https://doi.org/10.3389/fpsyg.2014.01145

Kelley, J.M., Kraft-Todd, G., Schapira, L., Kossowsky, J., & Riess, H. (2014) The influence of the patient-clinician relationship on healthcare outcomes: A systematic review and meta-analysis of randomized controlled trials. *PLOS ONE, 9*(4), e94207. https://doi.org/10.1371/journal.pone.0094207

Khanna, A. (July 12, 2018). Boal-ing with Julian Boal: Introduction to forum theatre. *Bolworkshop*.https://bolworkshop.wordpress.com/2018/07/08/boal-ing-with-julian-boal-rehearsing-for-social-change/

Khawaja, I. S., & Westermeyer, J. J. (2010). Providing crisis-oriented and recovery-based

treatment in Partial Hospitalization Programs. *Psychiatry*, *7*(2), 28–3.

Kivlighan, D. M., Jr., & Holmes, S. E. (2004). The importance of therapeutic factors: A typology of therapeutic factors studies. In J. L. DeLucia-Waack, D. A. Gerrity, C. R. Kalodner, & M. T. Riva (Eds.), *Handbook of group counseling and psychotherapy* (pp. 23–36). Sage Publication.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psycho-analysis*, 27, p. 99--110.

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum, 30*(2), 111–116. https://doi.org/10.1177/0840470416679413

Kole, D. M. (1967). The spectrogram in psychodrama. *Group Psychotherapy, 20*(1-2), 23-30.

Konopik, D. A., & Cheung, M. (2013). Psychodrama as a social work modality. *Social Work*, *58*(1), 9–20. http://www.jstor.org/stable/23719587

Kowalsky, R., Raz, N., & Keisari, S. (2022). *Hall of mirrors on stage: An introduction to psychotherapeutic playback theater.* Routledge.

Kuokkanen, L., & Leino-Kilpi, H. (2000). Power and empowerment in nursing: three theoretical approaches. *Journal of Advanced Nursing*, *31*(1), 235–241. https://doi.org/10.1046/j.1365-2648.2000.01241.x

Landy, R.J. (1993) *Persona and performance*. Guilford Press.

Landy, R. (1996). The use of distancing in drama therapy. In R. Landy (Ed.), *Essays in drama therapy: The double life* (pp. 13-28). Jessica Kingsley Publishers.

Laugharne, R., Priebe, S., McCabe, R., Garland, N., & Clifford, D. (2012). Trust, choice and

power in mental health care: Experiences of patients with psychosis. *International Journal of Social Psychiatry, 58*(5), 496-504. https://doi.org/10.1177/00207640114086

Lee, Y. (2015). Theatre for the less oppressed than I: Reconsidering Augusto Boal's concept of spect-actor. *Theatre Research International, 40*(2), 156–169. https://doi.org/10.1017/S0307883315000036

Légaré, F., Stacey, D., Turcotte, S., Cossi, M.J., Kryworuchko, J., Graham, I.D., Lyddiatt, A., Politi, M.C., Thomson, R., Elwyn, G., & DonnerBanzhoff, N. (2014). Interventions for improving the adoption of shared decision making by healthcare professionals. CD006732. Cochrane Database of Systematic Reviews. DOI: 10.1002/14651858.CD006732.pub3.

Lenz, A. S., Conte, G. D., Lancaster, C., Bailey, L., & Vanderpool, E. (2014). Evaluation of a Partial Hospitalization Program for Adolescents. *Counseling Outcome Research and Evaluation*, *5*(1), 3–16. https://doi.org/10.1177/2150137813518063

Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric services (Washington, D.C.)*, *52*(12), 1621–1626.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Social science & medicine (1982)*, *71*(12), 2150–2161.

Lovett, L., & Lovett, J. (1991). Group therapeutic factors on an alcohol in-patient unit. *The British Journal of Psychiatry, 159*(3), 365-370. doi:10.1192/bjp.159.3.365

Lyons, N., Cooper, C. & Lloyd-Evans, B. (2021). A systematic review and meta-analysis of

group peer support interventions for people experiencing mental health conditions. *BMC Psychiatry,* 21, 315. https://doi.org/10.1186/s12888-021-03321-z

MacNair-Semands, R. R., Ogrodniczuk, J. S., & Joyce, A. S. (2010). Structure and initial validation of a short form of the therapeutic factors inventory. *International Journal of Group Psychotherapy, 60*(2), 245-281.

March, C., Walker, L. W., Toto, R. L., Choi, S., Reis, E. C., & Dewar, S. (2018). Experiential communications curriculum to improve resident preparedness when responding to discriminatory comments in the workplace. *Journal of Graduate Medical Education, 10*(3), 306–310. https://doi.org/10.4300/JGME-D-17-00913.1

Matsunaga, P. (2021). Arena theatre, Brazil, Boal: Between farces and allegories. In K. Howe, J. Boal, & J. Soeiro (Eds.), *Routledge companion to theatre of the oppressed* (pp. 22-33). Routledge.

Mays, N., & Pope, C. (1995). Observational methods in health care settings. *British Medical Journal*, *311*(6998), 182–184. doi:10.2307/29728110

Mayor, C. (2020). Embodied tableaux: A drama method for social work arts-based research, *Qualitative Social Work*, 1-21.

Middlewick, Y., Kettle, J., & Wilson, J. (2012). Curtains up! Using forum theatre to rehearse the art of communication in healthcare education. *Nurse Education in Practice, 12*(3), 139-142. https://doi.org/10.1016/j.nepr.2011.10.003

Mondolfi Miguel, M. L., & Pino-Juste, M. (2021). Therapeutic achievements of a program based on drama Therapy, the theater of the oppressed, and psychodrama with women cictims of intimate partner violence. *Violence Against Women*, *27*(9), 1273–1296. https://doi.org/10.1177/1077801220920381

Montero, M. (2004). *Introducción a la psicología comunitaria: Desarrollo, conceptos y procesos.* [Introduction to community psychology: Development, concepts and processes]. Editorial Paidós.

Moran, G., & Alon, U. (2011). Playback theatre and recovery in mental health: Preliminary evidence. *Arts in Psychotherapy, 38,* 318–324. https://doi.org/10.1016/j.aip.2011.09.002

Moreno, L. O. (2018). Fighting LGBTQ oppression through theater: A mixed methods study of

the impacts of theatre of the oppressed with queer-spectrum and trans-spectrum individuals. [Doctoral dissertation]. ProQuest Dissertations Publishing (10816071).

Moreno, J. L., & Moreno, Z. T. (1969). *Psychodrama: Theory and Method (Vol. 1)*. Beacon House.

Mulcahy, L., & Tritter, J. Q. (1998). Pathways, pyramids and icebergs? Mapping the links between dissatisfaction and complaints. *Sociology of Health and Illness, 20*, 825–847. https://doi.org/10.1111/1467-9566.00131.

National Institute of Mental Health. (1987). *Towards a model for a comprehensive community-base mental health system.* https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh

New York State Government (2020). *Partial hospitalization program KCHC*. Retrieved on October 11, 2022. https://www.nyconnects.ny.gov/services/partial-hospitalization-program-kchc-omh-pr-870306387003

Nir, S. M. (2022, November 30). On city streets, fear and hope as Mayor pushes to remove mentally ill. *The New York Times.* https://www.nytimes.com/2022/11/30/nyregion/new-york-mental-illness-homeless-reaction.html#:~:text=the%20main%20story-

,On%20City%20Streets%2C%20Fear%20and%20Hope%20as%20Mayor%20Pushes%20to,unable%20to%20care%20for%20themselves.

Ocloo, J., Goodrich, J., Tanaka, H. et al. (2020). The importance of power, context and agency in improving patient experience through a patient and family centred care approach. *Health Res Policy Sys, 18*(1), 1-10. https://doi.org/10.1186/s12961-019-0487-1

Offerman, E, Rothman, A.., & Trottier, D. G. (2022). H.E.R.O. Unmasking: A mixed methods pilot study to explore the impact of a tele-drama therapy protocol on frontline healthcare workers during COVID-19. *Drama Therapy Review, 8*(2), 213-233. https://doi.org/10.1386/dtr_00107_1

Orkibi H., Bar N., and Eliakim I. (2014). The effect of drama-based group therapy on aspects of mental illness stigma. *The Arts in Psychotherapy, 41*(5), 458–466. doi: 10.1016/j.aip.2014.08.006.

Ostrom, E. (1996). Crossing the great divide: coproduction, synergy, and development. *World Dev*, *24*,1073–87. 10.1016/0305-750X(96)00023-X

Paula, T. P., & de Oliveira, I. R. (2014). Using theater of the oppressed in group treatment for social anxiety disorder. *Revista Brasileira de Terapias Cognitivas, 10*(1), 44-51. doi:10.5935/1808-5687.20140005

Paska, P. (2020, December 3). Social adversity, mental distress, and the theatre of the oppressed. *Mad in America.* https://www.madinamerica.com/2020/12/social-adversity-mental-distress-theatre-oppressed/

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link,

B. G. (2001). Stigma as a barrier to recovery: Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric services*, *52*(12), 1627–1632.

Pendzik, S. (2021). Autobiographical therapeutic performance in drama therapy. In D. R. Johnson & R. Emunah (Eds.), *Current approaches in drama therapy* (3rd ed., pp. 338-361). Charles C. Thomas.

Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. *Hospital & Community Psychiatry*, 29, 233–237. http:// dx.doi.org/10.1176/ps.29.4.233

Pirelli, G., & Formon, D. (2020). Vicarious trauma and burnout amongst clinicians. *Journal of Loss and Trauma, 25*(2), 145-156. https://doi.org/10.1080/15325024.2019.1638807

Proctor, K., Perlesz, A., Moloney, B., McIlwaine, F., & O'Neill, I. (2008). Exploring theatre of the oppressed in family therapy clinical work and supervision. *Counselling and Psychotherapy Research, 8(*1), 43-52. DOI: 10.1080/14733140801889139

Puschner, B., Repper, J., Mahlke, C., Nixdorf, R., Basangwa, D., Nakku, J., Ryan, G., Baillie, D.,

Shamba, D., Ramesh, M., Moran, G., Lachmann, M., Kalha, J., Pathare, S., Müller-Stierlin, A., & Slade, M. (2019). Using peer support in developing empowering mental health services (UPSIDES): Background, rationale and methodology. *Annals of global health*, *85*(1), 53. https://doi.org/10.5334/aogh.2435

Quinn, D. M., Williams, M. K., & Weisz, B. M. (2015). From discrimination to internalized mental illness stigma: The mediating roles of anticipated discrimination and anticipated stigma. *Psychiatric rehabilitation journal*, *38*(2), 103–108.

Quinn, D. M., Williams, M. K., & Weisz, B. M. (2015). From discrimination to internalized

mental illness stigma: the mediating roles of anticipated discrimination and anticipated stigma. *Psychiatric Rehabilitation Journal, 38*(2), 103–108.

Ramdath, K. (2016). *The use of forum theatre as therapy with at-risk immigrant and refugee youth* [Unpublished master's thesis]. University of Calgary. doi:10.11575/PRISM/28410

Reisman, M. D. (2016). Drama therapy to empower patients with schizophrenia: Is justice possible? *The Arts in Psychotherapy, 50,* 91-100. https://doi.org/10.1016/j.aip.2016.06.001

Rieger, J., Devlieger, P., Van Assche, K., & Strickfaden, M. (2022). Doing embodied mapping/s: Becoming-with in qualitative inquiry. *International Journal of Qualitative Methods*, *21*. https://doi.org/10.1177/16094069221137490

Rusch, D. C., & Imus, S. (2017). The same kid in yet another hood—Deep game design as creative arts therapy? In D. C. Rusch, *Making deep games: Designing games with meaning and purpose.* (pp. 167–192). CRC Press.

Sajnani, N. (2009). Theatre of the oppressed: Drama therapy as cultural dialogue. In D. R. Johnson & R. Emunah (Eds.), *Current approaches in drama therapy* (pp. 461-482). Charles C. Thomas Publishers.

Sajnani, N. (2010). Mind the gap: Facilitating transformative witnessing amongst audiences. In Jones, P. (Ed.), *Drama as therapy: Clinical work and research into practice* (pp. 189-207). Routledge.

Sajnani, N. (2012). The implicated witness: Towards a relational aesthetic in dramatherapy, *Dramatherapy*, 34, 6-21.

Sajnani, N. (2016). Relational aesthetics in the performance of personal story. In S. Pendzik, R. Emunah, & D. Johnson (Eds.), *The self in performance,* (pp. 85-95). Palgrave Macmillan.

Sajnani, N., Mayor, C., & Boal, J. (2020). Theatre of the oppressed. In D. R. Johnson & R. Emunah (Eds.), *Current approaches in drama therapy* (3rd edition, pp. 561-581). Charles C. Thomas Publishers.

Saks, E. R., Dunn, L. B., Marshall, B. J., Nayak, G. V., Golshan, S., & Jeste, D. V. (2002). The California Scale of Appreciation: A new instrument to measure the appreciation component of capacity to consent to research. *The American Journal of Geriatric Psychiatry: Official journal of the American Association for Geriatric Psychiatry*, *10*(2), 166–174.

Saleebey, D. (2006). *The strengths perspective in social work practice* (4th ed.). Pearson.

Santiago-Jirau, A., & Thompson, S. L. (2021). Image Theatre: A liberatory practice for "making thought visible." In K. Howe, J. Boal, & J. Soeiro (Eds.), *Routledge companion to theatre of the oppressed* (pp. 156-162). Routledge.

Schouler-Ocak, M., Bhugra, D., Kastrup, M., Dom, G., Heinz, A., Küey, L., & Gorwood, P. (2021). Racism and mental health and the role of mental health professionals. *European Psychiatry, 64*(1), E42. doi:10.1192/j.eurpsy.2021.2216

Schutzman M. & Cohen-Cruz J. (1994). *Playing Boal:Theatre therapy activism*. Routledge.

Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International Journal of Nursing Studies, 69,* 9–24. http://dx.doi.org/10.1016/j.ijnurstu.2017.01.003

Soeiro, J. (2021). Legislative Theatre: Can theatre reinvent politics? In K. Howe, J. Boal, & J. Soeiro (Eds.), *Routledge companion to theatre of the oppressed* (pp. 187-195). Routledge.

Solar, O., & Irwin, A. (2007). *A conceptual framework for action on the social determinants of health*. Commission on Social Determinants of Health. http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

Sowers, W. E. (2012). Recovery and person-centered care: Empowerment, collaboration and integration. In H. McQuistion, W. E. Sowers, J. M. Ranz, & et al. (Eds.), *Handbook of community psychiatry* (pp. 79-88). Springer.

Speranza, S. (2021). Newspaper Theatre: The oldest branch of TO in the post-print present. In K. Howe, J. Boal, & J. Soeiro (Eds.), *Routledge companion to theatre of the oppressed* (pp. 150-156). Routledge.

Spry, L. (1994). Structures of power. In J. Cohen-Cruz & M. Schutzman (Eds.), *Playing Boal: Theatre, therapy, activism* (pp. 113-131). Routledge.

Srinivasan, A. (1985). Reform and revival: The devadasi and her fance. *Economic and Political Weekly, 20*(44), 1869-1876.

Starhawk. (1990). *Truth or dare: Encounters with power, authority, and mystery*. HarperSanFrancisco.

Steiner, J. (1991). The equilibrium between the paranoid-schizoid and the depressive positions. In R. Anderson (Ed.), *Clinical lectures on Klein and Bion* (1st ed., pp. 46- 58). Taylor and Francis.

Sullivan, J., Petronella, S., Brooks, E., Murillo, M., Primeau, L., & Ward, J. (2008). Theatre of the Oppressed and environmental justice communities: A transformational therapy for the body politic. *Journal of Health Psychology, 13*(2), 166–179. https://doi.org/10.1177/1359105307086710

Thornicroft, G., Rose, D., & Mehta, N. (2010). Discrimination against people with mental

illness: What can psychiatrists do? *Advances in Psychiatric Treatment, 16*(1), 53–59.

Trottier, D. G., & Hilt, L. (2017). I dont feel naked: The use of embodied supervision to examine the impact of patient clothing on clinical countertransference on an inpatient psychiatry unit. *Drama Therapy Review,* 3(2), 261-83.

Urbanowski, M., & Dwyer, M. (1988). *Learning through field instruction: A guide for teachers and students*. Family Service America.

Villas Bôas, R. (2021). Invisible Theatre: From origins to current uses. In K. Howe, J. Boal, & J. Soeiro (Eds.), *Routledge companion to theatre of the oppressed* (pp. 162-168). Routledge.

Volkan, V. D. (1994). Identification with the therapist's functions and ego-building in the treatment of schizophrenia. *The British journal of psychiatry. Supplement*, (23), 77–83.

Vollmann, J., Bauer, A., Danker-Hopfe, H., & Helmchen, H. (2003). Competence of mentally ill patients: A comparative empirical study. *Psychological Medicine, 33*(8), 1463–1471.

Washburn, S., & Conrad, M. (1979). Organization in the therapeutic milieu. In M. Hersen, M., A.

S. Bellack & R. F. Luber (Eds.), *Partial hospitalization:A current perspective* (pp. 47-70. Springer.

Watkins, M., & Shulman, H. (2008). *Toward psychologies of liberation*. Palgrave Macmillan.

Watson, S. (2017, October 18). *Credentials don't shield doctors, nurses from bias*. WebMD. https://www.webmd.com/a-to-z-guides/news/20171018/survey-patient-bias-toward-doctors-nurses

Weber, M. (1914). Power. In P. Baehr & G. Wells (Eds.), *The encyclopedia of political thought : Vol. 3* (pp. 1097-1102). Blackwell.

Weiner M. F. (1992). Group therapy reduces medical and psychiatric hospitalization. *International journal of group psychotherapy*, *42*(2), 267–275. https://doi.org/10.1080/00207284.1992.11490689

Wendt, D. C., & Gone, J. P. (2017). Group therapy for substance use disorders: A survey of clinician practices. *Journal of Groups in Addiction and Recovery, 12*(4), 243–259.

Wenzel, A., Liese, B. S., Beck, A. T., & Friedman-Wheeler, D. G. (2012). *Group cognitive therapy for addictions*. Guilford.

World Health Organization. (2015). *WHO global strategy on people-centred and integrated health services*. Geneva: World Health Organisation.

Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). Basic Books.

Yalom, I. D., & Leszcz, M. (Collaborator). (2005). *The theory and practice of group psychotherapy* (5th ed.). Basic Books/Hachette Book Group.

Yalom, I. & Leszcz, M. (2020). *The theory and practice of group psychotherapy* (6th ed.). Basic Books.

Yalom, I., Tinklenberg, J., & Gilula, M. (1970). Curative factors in group psychotherapy. In I. D. Yalom, *The theory and practice of group psychotherapy* (2nd ed.). Basic Books.

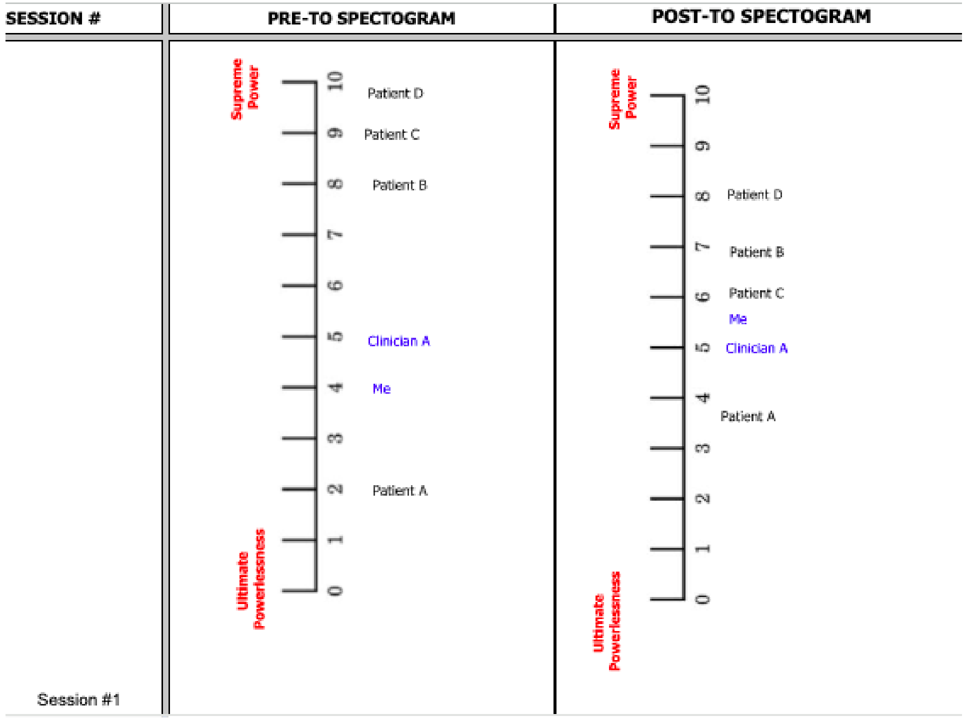
Yuksek, C. (2018). Dealing with stress using social theatre techniques with young Syrian students adapting to a new educational system in Turkey: A case study. *Intervention*, *16*(2), 175–180.

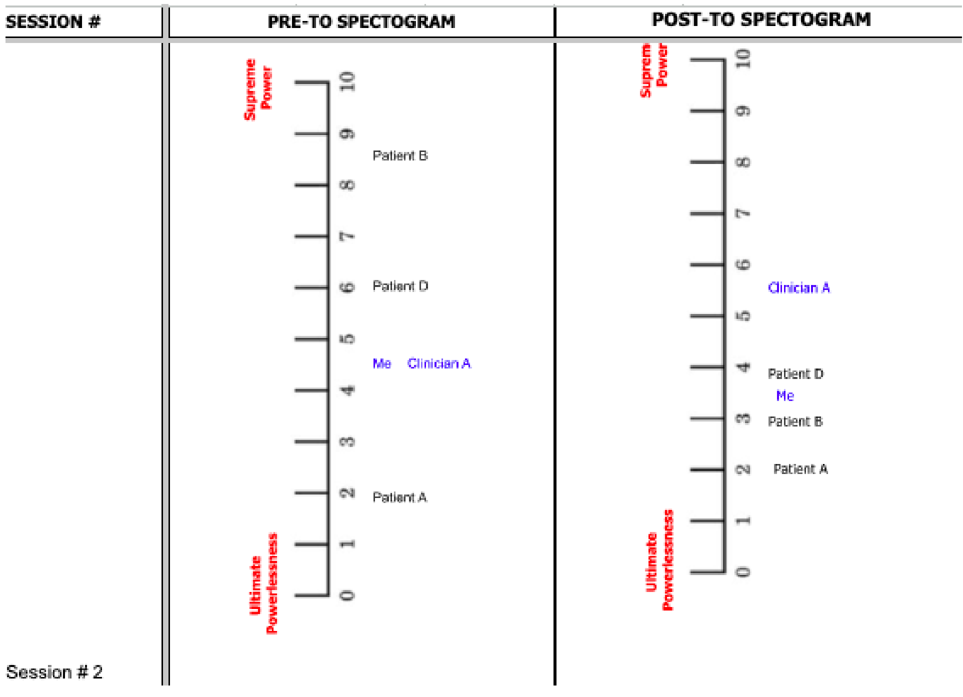
Appendix A

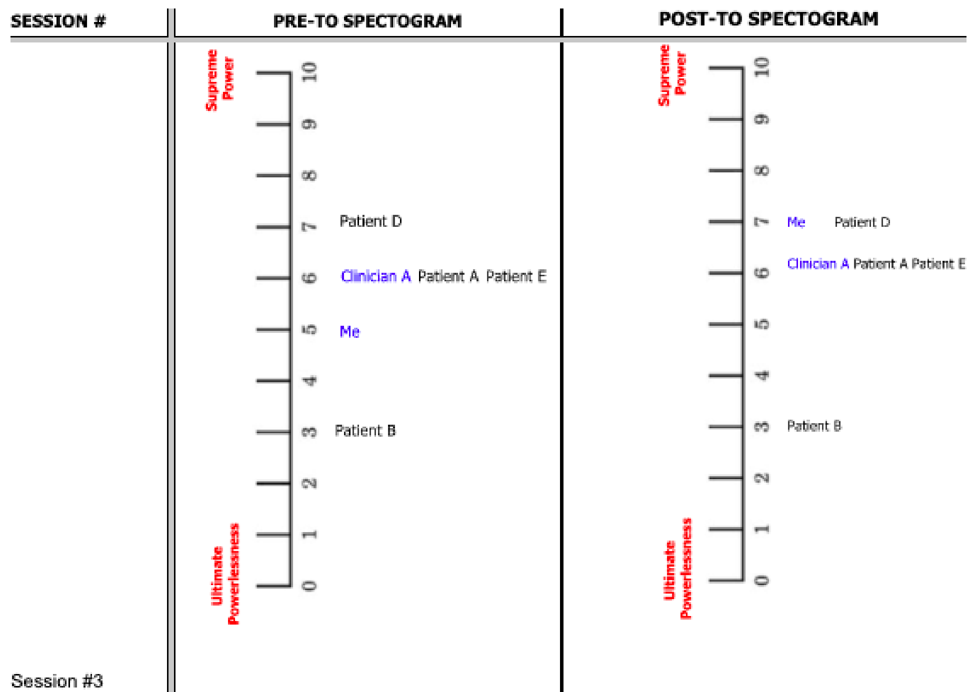
Template of subjective and objective observations for 'Power-Play'

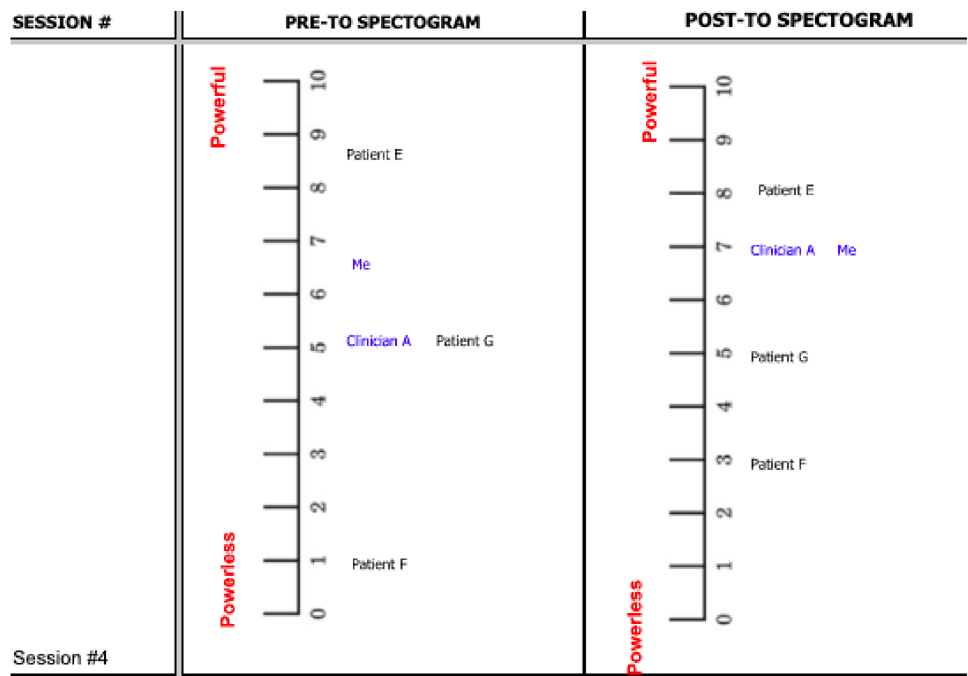
Verbatim	What did I see, feel, and hear?	What did I perceive the group to see, feel, and hear?
	See: Feel: Hear:	See: Feel: Hear:

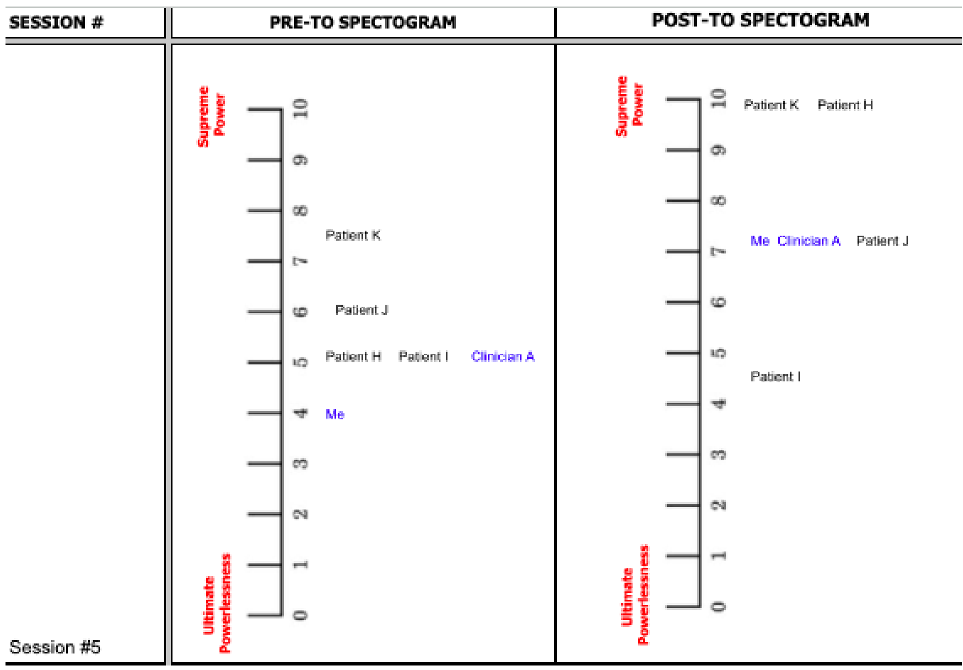
Appendix B

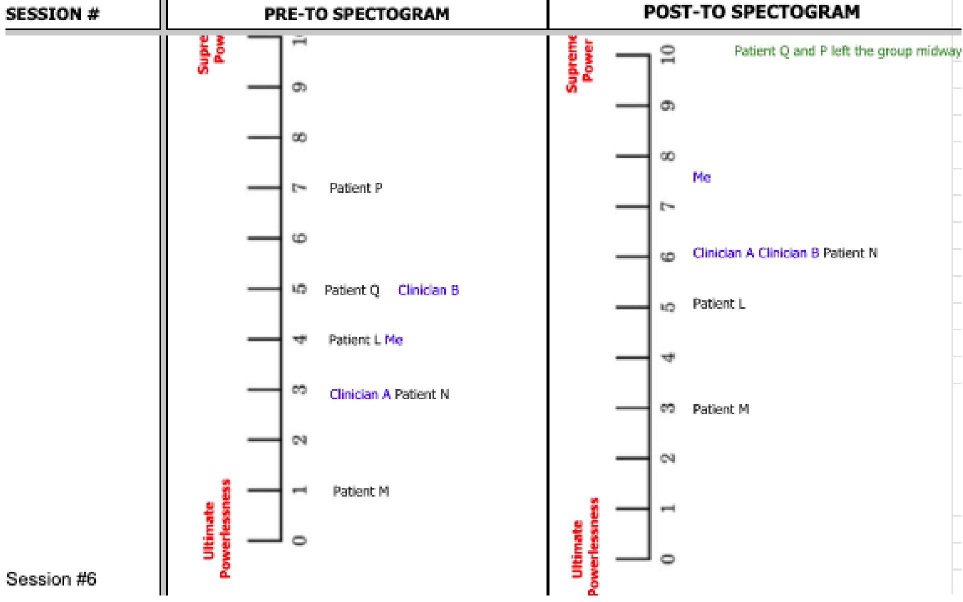





SESSION #
PRE-TO SPECTOGRAM
POST-TO SPECTOGRAM
Supreme Power
Ultimate Powerlessness
10
9
8
7
6
5
4
3
2
1
0
Patient D
Clinician A Patient A Patient E
Me
Patient B
Me Patient D
Clinician A Patient A Patient E
Patient B
Session #3

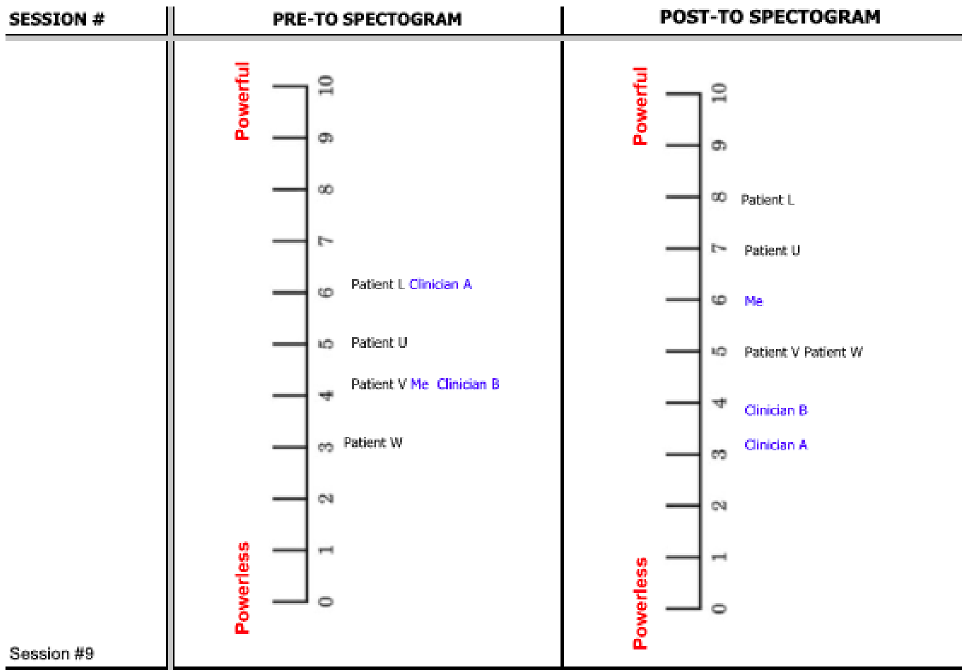

SESSION #
PRE-TO SPECTOGRAM
POST-TO SPECTOGRAM
Powerful
Powerless
10
9
8
7
6
5
4
3
2
1
0
Patient E
Me
Clinician A Patient G
Patient F
Patient E
Clinician A Me
Patient G
Patient F
Session #4

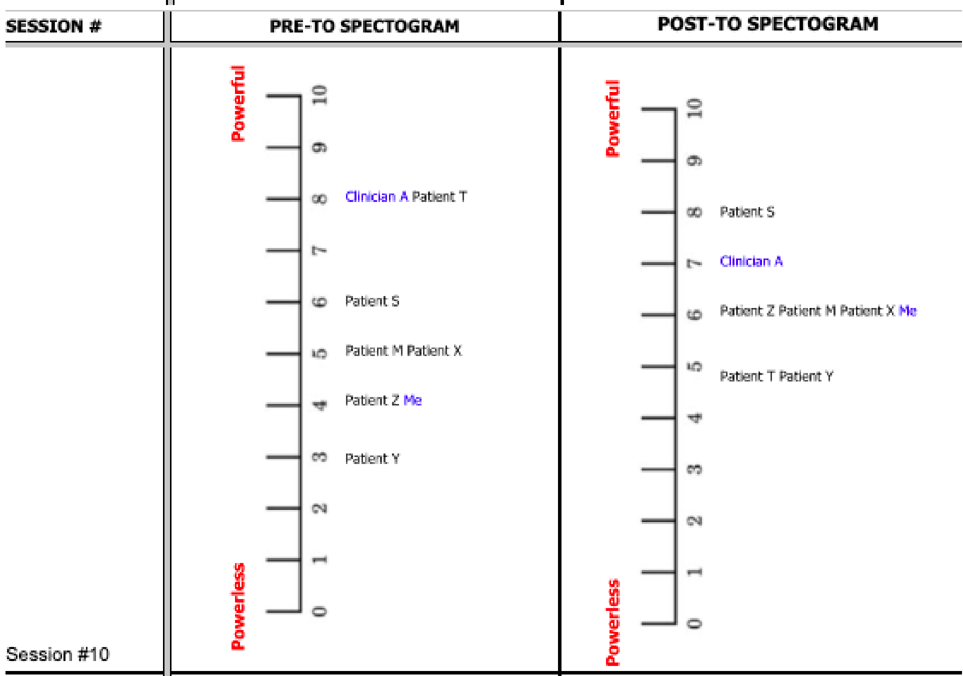

SESSION #
PRE-TO SPECTOGRAM
POST-TO SPECTOGRAM
Session #5
Supreme Power
Ultimate Powerlessness
0 1 2 3 4 5 6 7 8 9 10
Patient K
Patient J
Patient H Patient I Clinician A
Me
Supreme Power
Ultimate Powerlessness
0 1 2 3 4 5 6 7 8 9 10
Patient K Patient H
Me Clinician A Patient J
Patient I


SESSION #
PRE-TO SPECTOGRAM
POST-TO SPECTOGRAM
Session #6
0 1 2 3 4 5 6 7 8 9
Ultimate Powerlessness
Patient P
Patient Q Clinician B
Patient L Me
Clinician A Patient N
Patient M
0 1 2 3 4 5 6 7 8 9 10
Ultimate Powerlessness
Patient Q and P left the group midway
Me
Clinician A Clinician B Patient N
Patient L
Patient M

SESSION #	PRE-TO SPECTOGRAM	POST-TO SPECTOGRAM
Sesson #7	Supreme Power 10 9 Patient R 8 Patient P 7 Clinician C 6 Me 5 Clinician B 4 Patient M 3 Patient L 2 Patient F 1 0 Ultimate Powerlessness	Supreme Power 10 9 Patient L 8 7 Patient P Patient R 6 Me 5 Clinician B Patient F 4 Patient M Clinician C 3 2 1 0 Ultimate Powerlessness

SESSION #	PRE-TO SPECTOGRAM	POST-TO SPECTOGRAM
Session #8	Supreme Power 10 9 8 Patient T Patient P 7 6 Patient M Patient N 5 Patient O Clinician B Me 4 Clinician A 3 2 Patient L 1 0 Ultimate Powerlessness	Supreme Power 10 9 Patient T 8 Patient N Patient P Me 7 6 Patient O Patient M 5 4 Patient L Clinician A Clinician B 3 2 1 0 Ultimate Powerlessness


SESSION #
PRE-TO SPECTOGRAM
POST-TO SPECTOGRAM
Powerful
Powerless
10
9
8
7
6
5
4
3
2
1
0
Patient L Clinician A
Patient U
Patient V Me Clinician B
Patient W
Patient L
Patient U
Me
Patient V Patient W
Clinician B
Clinician A
Session #9


SESSION #
PRE-TO SPECTOGRAM
POST-TO SPECTOGRAM
Powerful
Powerless
10
9
8
7
6
5
4
3
2
1
0
Clinician A Patient T
Patient S
Patient M Patient X
Patient Z Me
Patient Y
Patient S
Clinician A
Patient Z Patient M Patient X Me
Patient T Patient Y
Session #10

Appendix C

Embodied Mapping Sample Video: https://youtu.be/11fRg33eIMA

- Assisted by Aabshaar Wakhloo, a dancer/performer and body- based practitioner based in New Delhi, India: https://www.aabshaar.co.in/
- Original music composition by Ashim Bery, an independent percussionist/ handpan artist based in New Delhi, India