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Drama therapy to empower patients with schizophrenia: Is justice possible?

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ABSTRACT

This article develops an empowerment model for treating individuals with schizophrenia, exploring developmental transformations drama therapy techniques. The author contrasts the dominant medical model of schizophrenia treatment, which primarily seeks symptom control, with the emerging recovery model of schizophrenia treatment, which is focused on empowering patients. The author then builds a theoretical framework for an empowering drama therapy, rooted in Winnicott's notion of transitional space and Johnson's developmental transformations. These clinical precepts are synthesized with the social justice theories of Rawls and Flax, Boal's political theatre, and the absurdist "Before the Law" parable of Kafka. Two case examples of an empowering developmental transformations drama therapy are presented, exploring clinical sessions with schizophrenic patients in two different cultures. Emphasis is placed on key techniques: "pre-empting"; "transformation to the here and now"; and "therapist as subject." The article concludes by suggesting types of research that can test the potential of an empowering drama therapy to fit within the medical model.

Individuals diagnosed with schizophrenia are among the most disempowered and stigmatized members of society (Wahl, 2012; Ngui, et al., 2010). Due to the severity of the disease and the limitations of pharmacological treatments they all too frequently carry a negative prognosis. This article will explore how drama therapy can empower these individuals, assisting their recovery and reintegration into society. Drama therapy techniques in which the drama therapist becomes the patient's "play object" and encourages patients to play higher-status roles can promote insight and help patients to become more active participants in their recovery.

This paper develops a model of drama therapy in which the drama therapist assists the patient in confronting the stigma associated with his or her status as a patient. It draws together the psychoanalytic theory of Winnicott and Flax, the developmental transformations drama therapy techniques of Johnson, the political philosophy of Rawls, the political theatre work of Boal, recent clinical research on treatment outcomes, and case examples from drama therapy sessions with chronic schizophrenic patients in the United States and the Czech Republic. The thesis of the article is that drama therapy, which takes place in the playspace mutually created by drama therapist and patient, can become a locus of justice, encouraging the patient to re-engage with society.

1. Challenges and opportunities In the treatment of schizophrenia

1.1. The prevalence and limitations of the medical model

Many mental health practitioners and researchers view schizophrenia primarily in genetic, biological, or neurological terms without reference to social causation (Insel, 2010). Consequently, in the "medical model," treatment often focuses on the symptoms of the disease and "containing" persons with mental illness, as opposed to working with them as complete human beings responding to a social milieu. In fact, the main – and sometimes only – treatment for schizophrenia is psychotropic medication (Kane & Correll, 2010). Many psychiatric facilities practice mental-health triage, diagnosing quickly, then racing to stabilize and discharge their patients (Berger and Vuckovic, 1994). "There is also pressure to 'shoot with the big guns' immediately, such as. . using high doses of medications in an effort to get a rapid clinical response" (Lewin & Sharfstein, 1990; p. 123). Fleck (1995) observed that in contemporary psychiatry, precise descriptive classification is the

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main purpose of the clinical enterprise. "The patient as a sick person was replaced by the patient as a container of symptoms to be subdued" (p. 196). Even after discharge, patients' lives are typically managed in the community just as they were inside institutions, with treatment often limited to symptom containment via medication.

Although psychotropic medication – on which many billions of dollars are spent globally every year – can be useful in reducing the positive symptoms of schizophrenia, it frequently causes severe side effects, most notably involuntary movements and metabolic changes (Tollefson, Beasley, Tamura, Tran, & Potvin, 1997). Further, as demonstrated in the landmark longitudinal studies known as CATIE (Lieberman et al., 2005) and CUtLASS (Jones et al., 2006), even the current generation of antipsychotic medications may fail to help schizophrenic patients. Also, these medications have been shown to be ineffective in the cognitive rehabilitation of individuals with schizophrenia (Hurford, Kalkstein, & Hurford, 2011). Although for many years, pharmaceutical companies have dominated the treatment of schizophrenia due to their large marketing and research budgets, alternative treatment approaches have emerged to address the limitations of the medical model.

1.2. Empowering psychiatric patients through the recovery model

In the last few years, disability and mental health rights advocates have helped craft an array of treaties, national laws and organizations that have, at least on paper, advanced the rights of individuals with mental illness. In particular, as of February 2016, 162 countries had become parties to the Convention on the Rights of People with Disabilities (CRPD), the purpose of which is "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity." (CRPD, Art. 1.) The CRPD protects the rights of people with disabilities to equal recognition under the law (Art. 12), access to justice (Art. 13), and to live in the community with choices equal to others (Art. 19.).

In the United States (which has signed but not yet ratified the CRPD), an array of laws protect the rights of persons with mental illness and prohibit discrimination against them. Under the Americans with Disabilities Act (ADA), the government must provide services to qualified patients with disabilities in the most integrated setting appropriate to their needs. ADA, 42 U.S.C. § 12132 (1990). In the case of *Olmstead v. L.C.*, 527 U.S. 581 (1999), the United States Supreme Court found a right to community treatment under the ADA, pursuant to which states are required to explore treatments less restrictive than long-term hospitalization. In 1990, the same year the ADA was enacted, the United States Supreme Court held that "[t]he forcible injection of medication into a non-consenting person's body represents a substantial interference with that person's liberty." *Washington v. Harper*, 494 U.S. 210, 229 (1990). The Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. § 10801, mandates that each state confer upon an agency the authority to pursue legal, administrative and other appropriate remedies to ensure the protection of individuals with mental illness. Finally, mental health parity laws have been enacted at the federal and state levels, requiring health insurers to cover mental health treatment in the same manner as medical treatment, Mental Health Parity and Addiction Equity Act, 42 U.S.C. § 300gg-26, and these laws are being vigorously enforced, particularly in New York State.

As the rights of mental health patients have expanded, a new psychosocial model has begun to emerge, backed by scientific research. The hypothesis that psychiatric disorders may be exacerbated by external influences such as traumatic events (Mack 1994) is supported by neurological research that suggests that disempowerment and the long-term experience of "social defeat" may increase the risk for schizophrenia (Gevonden et al., 2014; Luhrmann, 2007; Selten and Cantor-Graae, 2005; Selten, van der Ven, Rutten, & Cantor-Graae, 2014).

These political and scientific developments support the recovery model, which posits that the main goals of mental health treatment should increase patients' ability to function in the community, empowering them and improving their overall quality of life (Frese, Knight, & Saks, 2009). Researchers have operationally defined the recovery model concepts, such as empowerment and self-stigma (the prejudice that people with mental illness turn against themselves), and studied how these factors influence treatment outcomes. (Rogers, Chamberlin, Ellison, & Crean, 1997). These studies have shown that patients' experiences with serious mental illness, the service system, and social stigma often undermine their sense of self-efficacy, control, and independence (Coursey, Keller, & Farrell, 1995). Moreover, a perception of empowerment on the part of the patient, which is manifested through perceptions of therapist permission and ability to say critical things in therapy, has been shown to be an indicator of better mental health and is associated with shorter hospital stays. (Coursey et al., 1995).

> The characteristic clients most desired in a therapist was friendliness. It is not clear whether these clients were referring to characteristics such as warmth and acceptance, a collaborative/egalitarian rather than authoritarian style, empathic resonance, engagement rather than detachment, or other specific attributes of their therapists. All these qualities have extensive empirical support for enhancing therapeutic effectiveness in schizophrenia and other disorders. (p. 297)

Recovery-oriented care is characterized by shared decision making. In other words, the person in treatment should have the greatest role possible in collaborating with the provider to define the goals of treatment and plan for ways to reach these goals (Silverstein and Bellack, 2008).

A review of research conducted by Cavelti, Kvrgic, Beck, Kossowsky, and Vauth (2012) concluded that personal (as opposed to merely clinical) recovery from schizophrenia – which includes components such as finding hope for the future, taking control of one's life, and empowerment – is indeed possible and can be measured.

Self-stigma, which is defined as internalization of negative stereotypes about schizophrenia and self-blame (Corrigan, Larson, & Rusch, 2009) and is common and sometimes severe among people with schizophrenia, can be significantly reduced by empowering patients (Brohan, Elgie, Sartorius, & Thornicroft, 2010). Because an avoidant coping style erodes self-efficacy and empowerment, schizophrenia treatment should focus on anticipated stigma to improve recovery (Vauth, Kleim, Wirtz, & Corrigan, 2007). Following a recovery approach in mental health services by focusing on internalized stigma reduction also has the potential to reduce depression in patients with schizophrenia and thus improve their quality of life (Sibitz et al., 2011). Patients who reported that they experienced less coercion were more satisfied with their treatment, and thus less at risk of involuntary readmissions to hospital (Katsakou et al., 2010), and patient satisfaction with treatment is correlated with fewer hospital readmissions and fewer days readmitted (Druss, Rosenheck, & Stolar, 1999).

The mental health system frequently forces patients to give up their power and relate to the world only through their illnesses, reinforcing the experience of social defeat. In *Asylums* (1961), Goffman described role dispossession, a state in which individuals can no longer identify with roles other than that of pariah or outcast. To counter this tendency, researchers have called for the development of techniques that empower patients to reframe their life

experiences by reconstructing their personal narrative. (Silverstein & Bellack, 2008; p. 1115). Each of us has a status, and every inflection and movement implies a status (Johnstone, 1981).

Drama therapy can serve an important function in the stigma reduction process. As shown below, in the mutually created playspace, the drama therapist can nudge the patient out of the "outcast" role and into stronger, more capable and empowered roles. Three key features of an empowering drama therapy rooted in the recovery model, discussed below, are (a) the patient's ability to critique the therapist; (b) shared decision-making; and (c) playing with different statuses.

2. Towards an empowering drama therapy

2.1. From Winnicott's *transitional space to the playspace*

The concept of the playspace in drama therapy owes a great debt to Winnicott (1971), who conceptualized three psychological spaces: (1) the inner space of the psyche, including the ego; (2) potential (or transitional) space, which is an extension of the ego boundaries bordering on the external world; and (3) the external world. Transitional space is located in the gap between the individual and his or her environment and is filled with promise and danger. Patients with schizophrenia may be thought of as frozen in the transitional space, unable to connect with the external world; they become stuck, seeing the world as an intrusive delusion (Giovacchini, 1986). Additionally, such patients may lack bridges between lower and higher psychic levels.

> Since these patients have remained fixated in an in-between transitional space, they have not developed a continuum between their inner mental life, the transitional space, and the external world. This lack of continuity is a reflection of the structure of the psychic apparatus and helps explain the sudden fluctuations between sophisticated rational behavior and bizarre primitive reactions. (Giovacchini, 1984, p. 93)

Winnicott (1971) posited that since psychotherapy takes place in the overlapping play areas of the therapist and patient, the goal of the therapist is to bring the patient into a state of being able to play. Extending this concept to the institution, play on the inpatient psychiatric unit can embody Winnicott's conception of transitional space (Casher, 2013).

Winnicott hypothesized that the primary task of the mother, next to providing opportunity for illusion, is disillusionment (Winnicott, 1971). Analogously, although the drama therapist must initially create a safe space for the patient, the patient must eventually fall into disillusionment with the therapist (Winnicott, 1989). In this separation-individuation process the patient no longer idolizes the therapist or believes that the success of his or her treatment is dependent upon the actions of the therapist. Disillusionment leads to the destruction of previous object relationships, allowing the creation of new ones (Deri, 1978). In the disillusionment stage of therapy, the therapist must embody the opposite of the maternal function, concerning herself with the patient's developing autonomy and entrance into and exploration of the external world (Giovacchini, 1984a, 1984b). Just as one feels healthy disillusionment when waking from a dream or when the lights come on after a play, the patient experiences healthy disillusionment about the threatening power of inner monsters or gross projections into the outer world (Pedder, 1977).

Whereas, for Winnicott, the transitional space was an abstract concept, in drama therapy the transitional space – referred to hereafter as the playspace – is a concrete, three-dimensional space, in which the shortcomings and empathic lapses of the therapist give the patient optimal frustration, make possible internalizations by the patient (Khan, 1978) and promote the development of healthy psychic structures in the patient (St. Clair, 1986).

2.2. The playspace in developmental transformations drama therapy

Developmental Transformations drama therapy (DvT) occurs through embodied encounters between therapist and client in the playspace (Johnson, 1991, 1992, 2009). DvT sessions consist entirely of dramatic, improvisational interaction between therapist and client, with the therapist an active participant in the play, intervening through his or her own immersion in the client's playspace. DvT groups typically begin with the therapist inviting the group members into the playspace, and then engaging in unison movement in a circle, which represents the earliest developmental level of play behavior. Over time, images begin to arise, followed by more organized roles, which are then worked on through the play, which may then evolve into more free-flowing improvisation. The therapist does not typically impose preset dramatic structures, but rather gradually intervenes to increase – or decrease, as necessary – the developmental level of the group's play, across five dimensions: (1) ambiguity of spatial structure, task, and role; (2) complexity of spatial structure, task and role; (3) media of expression (movement, sound, image, role, verbalization); (4) degree of interpersonal demand and interaction; and (5) intensity of affect expression (Johnson, 1982). Group members exit the playspace via a closing ritual, which may involve depositing images, roles into a "magic" chest or walking through a "magic" curtain.

Whereas Winnicott's transitional space is a *psychological* area of flux and chaos bridging internal and external worlds, the DvT playspace is the *physical* embodiment of transitional space, in which the therapist allows free play within well-defined parameters.

> The playspace embraces the constituent elements of roles: pure movements, sounds, gestures, stillness, and suspense, and so may remain vague, illusory, and undefined. The playspace is where drama therapy takes place, and therefore the drama therapist's primary task is to introduce and sustain the playspace for the clients. Emphasis is placed on working inside the playspace, so extensive introductions, limit-setting or summarizing discussions after the play are not encouraged. (Johnson, 1991, p. 289)

The DvT playspace, as a moral and ethical relationship among group participants, is founded on three basic rules: (1) a restraint against harming others; (2) an acknowledgement of discrepant communication (the ability to signal, in the play, that the play is not real); and (3) mutual agreement (Johnson, 2009).

In the DvT drama therapy playspace, patients frequently evoke images that become objects to be destroyed. The drama therapist is always in role, leading the group through improvisational exercises of increasing levels of complexity, from unison sound and movement, to images, characterization, then structured and eventually unstructured role playing (Johnson, 1982, 1986). In the flow of the session, images and scenes become containers for the patients' unintegrated thoughts and feelings.

Three DvT techniques are especially important for empowering the patient:

- ***First***, in "pre-empting" (Johnson, 1992), the therapist takes on the attributes, position or even identity of the rigid roles typically taken by the patient in order to force him or her into the complementary role they have difficulty taking on. For example, if a patient often plays dependent or needy roles, the therapist may take on that role first, in order to nudge the patient into an independent, confident role. Because psychiatric

patients typically enter the drama therapy room in a disempowered position, the therapist should "pre-empt" this role whenever possible.

- ***Second***, in "transformation to the here and now" (Johnson, 1993), a scene is transformed into a commentary on the actual dynamics among group participants. By allowing emotional distancing, this technique adds to the patient's confidence that it is safe to explore his or her inner world.
- ***Third***, in the "therapist as subject" (Johnson, 1986), the therapist becomes the major focus of the drama, in a sense the patient's "play object." The therapist purposely takes on roles that are consistent with the transferential images of her that are held by group members (*e.g.*, the strong parental figure, the naughty child) and then casts the patient in the complementary role. The therapist can even allow the patient to criticize or insult the therapist-in-role in the playspace, resulting in the therapist being used as a projection screen. At times, the therapist's authority may even be challenged to the point of his or her being "annihilated" by the group within a particular scene. It is important to emphasize that although physical touch may be involved, no inappropriate touching or physical harm can be allowed to occur. By "surviving" this "annihilation" and thus providing a safe container for the projection and release of all kinds of unconscious (and often disturbed) thoughts within the transitional space, the drama therapist helps patients develop creativity, spontaneity and relatedness.

Applications of these three techniques will be explored in the case examples discussed below. By means of these techniques, the therapist can foster empowerment by creating a "socially just" playspace, within which therapist and patient can exist on an equal level.

2.3. The playspace as the locus of justice

A drama therapist working with patients with schizophrenia in hospitals or clinics must maintain her spontaneity and creativity despite the inherent difficulties of working within sometimes dehumanizing institutions. The institution's leadership may view drama therapy as a "time-filler" between "real" treatment sessions, and patients may be so psychically degraded by their experiences in the mental health system that they have little energy or enthusiasm for creative arts therapy groups. These realities, while discouraging, can supply potent material for drama therapy sessions in terms of images, roles and scenes to re-enact, as appropriate. That said, the drama therapist needs a strong personal commitment and should view herself as an advocate for the patient. At a minimum, the drama therapist must have empathy for the plight of the patient, who may arrive at the facility disheveled, disoriented, lacking friends, family support, and financial resources. The drama therapist must also recognize that clinical conditions encountered in both inpatient and ambulatory settings may be "the result of inequalities or abuse of power in relationships and an accompanying sense of powerlessness and helplessness" (Mack, 1994, p. 178). To lessen the risk of reinforcing these inequalities and abuses, the drama therapist should develop an awareness that she is vulnerable to feelings of disgust and irritation towards the patient, and that these feelings often arise in the playspace, where they can be the subject of play (Forrester and Johnson, 1996; Galway, Hurd, & Johnson, 2003; Schnee, 1996).

Groups within an institution may serve as a forum in which the tensions of the institution can be expressed, explored and resolved, functioning like the valve on a pressure cooker, thus promoting safety (Klein & Kugel, 1981, p. 322). The DvT playspace, which encompasses the personality and aura of the drama therapist and her actions in the group as well as in the institutional milieu, can provide an alternative to the frequently harsh world of the institution. At the beginning of DvT groups, the therapist shows – rather than tells – patients that it is acceptable to be playful and that they can safety join the therapist in play. Although it is advisable to have a good deal of structure at the beginning of the session, in particular during the physical "warm-up" phase, the therapist's vocal tone should be friendly and the therapist can and should joke with the group, even about such trivial matters as rolls of the neck or stretches of the arms and legs. The therapist should strive to draw in resistant members through humor rather than strict commands, and to channel resistance into sounds, movements, characters and scenes within the playspace. Once the therapist establishes these rules of the playspace, patients will quickly learn that it is possible, indeed enjoyable, to express their feelings, even resistant or aggressive ones, and that they may, in role, safely challenge the therapist within the playspace. When the therapist loosens her "command" of the playspace, even when it seems mildly chaotic or undefined, she signals her faith in her patients. This dynamic allows the patient to define the terms of the playspace and thus helps the patient begin the processes of internalization and empowerment.

An empowering drama therapy can enhance the patient's ability to deal with internal and external pathological elements that threaten to engulf the self. Glass (1985) drew an analogy between the delusional world of the person with schizophrenia and a tyrannical regime, suggesting that a schizophrenic person is victimized by delusional introjects. In democratic psychological systems, on the other hand, consciousness is a composite of part-identities functioning independently. The therapeutic process with schizophrenic individuals must therefore be built on a commitment to self-governance and the inner democracy of the self (Glass, 1985).

By allowing expression of divergent emotions and images, the DvT playspace constitutes a democratic psychological system in which real-world power inequities can be temporarily suspended in favor of a moral and ethical sense of community founded on principles of justice. Flax (1993) described justice as a transitional space:

> Justice can be better understood and approximated if we think of it as sets of interrelated practices. These practices have the best possibility of developing and being sustained and effective within transitional spaces. Such spaces are generated by, depend upon, and reflect far more than the operation of any form of reason; in fact the domination of certain forms of reason may inhibit or block their development. (p. 332).

The unequal power relationships of the "real world" are suspended in the playspace, as are socially accepted notions of "reason," which typically place the schizophrenic person at a disadvantage. The justice modeled in the DvT playspace thus teaches individuals how to tolerate differences between self and other without domination and how to challenge or play with limits required by the outer world, while confining to the transitional space the playing out of hurtful fantasies. These can run the gamut from gently bossing others around to annihilating others via "zapping" them out of a scene.

As noted above, the DvT playspace assumes the existence of a moral and ethical relationship within the group. The philosopher Rawls (1999) used the phrase "justice as fairness" to describe a moral system in which: (i) each person has an equal right to the most extensive basic liberty compatible with a similar liberty for others; (ii) everyone has fair equality of opportunity; and (iii) social inequalities must benefit the least-advantaged members of society. Rawls postulated that these principles of justice are ones that individuals would choose were they behind "a veil of ignorance,"

without knowledge of their actual social circumstances. Justice as fairness in the DvT playspace dictates that everything that happens in the playspace should benefit all group members, even though all may not be "equal" in society or the playspace. More concretely, in the playspace individuals can shed their real-life roles behind a "veil of ignorance" and take on new roles. Even patients who do not appear to be the most active participants in the session can benefit from being in the playspace – and may surprise the therapist with their strong imagery and roles.

A credible theory of justice must, however, take into account the possibility that achieving justice may be an illusory goal. In Kafka's absurdist novel *The Trial*, Josef K. experienced the futility of standing "before the law" in a vain attempt to achieve justice.

> "Everyone strives to reach the Law," says the man, "how does it happen, then, that in all these years no one but me has requested admittance." The doorkeeper sees that the man is nearing his end, and in order to reach his failing hearing, he roars at him: "No one else could gain admittance here, because this entrance was meant solely for you. I'm going to go and shut it now." (Kafka, 1998)

This sort of awareness of the potential futility of seeking justice can provide therapeutic disillusionment and be liberating. By shedding the role of the omnipotent clinician, the drama therapist can forge a more honest relationship with the patient in the playspace.

An empowering drama therapy also builds on the work of Boal (1995), who sought social change via the Theatre of the Oppressed, which uses dramatic techniques to transform passive spectators into engaged "spect-actors" who rehearse strategies for personal and social change. (Schutzman & Cohen-Cruz, 1994). Moving from The Theatre of the Oppressed to The Rainbow of Desire, Boal (1995) eventually worked with oppressions that are not concrete or visible, noting that "the cops are in our heads, but their headquarters and barracks must be on the outside," and that "the task was to discover how these 'cops' got into our heads, and to invent ways of dislodging them" (p. 8). Boal's method was to embody these "cops" and thus to transform them (Boal, 1995; Sajnani, 2009). Likewise, within the DvT playspace, patients may play concrete cops or hospital staff, or conceptual cops, *i.e.*, embodiments of fear, anger, or other intense emotions.

3. Case examples

The following two examples illustrate patient empowerment and the development of justice within the playspace. The group drama therapy sessions, which included patients with schizophrenia, were held in different types of institutions in different countries with different mental health systems. Nevertheless, each group played with the theme of powerlessness and enacted the journey of a psychiatric patient, who experienced initially cruel but then humane treatment.

3.1. First case example: drama therapy session in U.S. psychiatric hospital

This session took place on one of the many acute psychiatric wards of a large public general hospital in New York City, and included six patients, each of whom had attended at least one previous session of the weekly drama therapy group which employed DvT drama therapy techniques. The members, each of whom had a diagnosis of schizophrenia and had been in the mental health system for a number of years, had been stabilized on medication and most were capable of communicating well verbally. The group contained one man and five women, and was diverse racially and ethnically. The ward that day was, as usual, loud and chaotic, and it took some time to corral patients into the group room. Because a number of other patients had been discharged from the ward that morning, group members were somewhat frustrated that they were still in the hospital. In particular, Ralph, a middle-aged Latino man with a booming voice, verbalized to me his frustration with still being in the hospital as we walked down the long hallway from the nurse's station to the group room. Barbara, a shy African-American woman, also told me that she was hoping to be discharged soon. It seemed that most of the patients wanted to be somewhere else, or, like Barbara, were anxiously waiting to talk with their doctor. I knew that this would probably be the last drama therapy session for some of these patients, and felt pressure to make it "meaningful" for them.

After starting late, we began, as always, sitting quietly in chairs in a circle for a moment, which allowed us to disengage from the clamor of the ward and concerns about discharge. I asked each patient to say his or her name, and then led a brief physical warm-up consisting of playful stretches and facial gestures. This elicited smiles from the patients, and I felt that they had the sense that they were in their own "space" and this was their special "thing," different from everything else they did or had to do on the ward. I asked them to stand and step into the playspace. I started a simple sound-and-movement exercise, raising my arms above my head and saying, "Aaaah," in a sigh of relief. Then I asked the patients to repeat my sound and movement, in unison. Not surprisingly, Ralph was the loudest, but others took his cue and almost matched his volume level. The patients were familiar with this technique, and each relished the chance to lead the group with his or her gesture and sound.

I asked each person to take a turn saying to the group a phrase that someone had said to him or her in their lives, with the rest repeating the phrase in unison. Among the phrases they offered were "Can I borrow some money," "Go to your room" (from Ralph), and "Mop the floor" (from Barbara), which the group members repeated, without much enthusiasm. I wondered if I had made a mistake by forcing the group to shift abruptly from the nonverbal mode to the verbal.

I asked if anyone wanted to set up a scene based on his or her statement. Barbara tentatively volunteered her statement, "Mop the floor," which I found somewhat disappointing. I looked at the patients to see if any other ideas might be on offer. After a few moments of silence, it seemed that the energy had plummeted and the group was coming apart at the seams. I considered reinitiating the simple sound-and-movement exercise that had earlier engaged the group, but decided to press on. I asked the members if the phrase "mop the floor" brought to mind a situation a member of the group had been in. Barbara said that the floor was dirty – which it was – and it would be nice if someone cleaned it. We had transformed to the here-and-now, which re-energized the patients, and now in role as upper-class people, they made statements about how the dirty floor offended them. Ralph then shouted, in a commanding role, "This floor needs to be mopped!" I asked meekly, "Is the janitor around?," hoping that someone would step into that role, but no one volunteered.

It seemed clear at that moment that I needed to play the low-status role, so I spun around and emerged as a janitor, with hunched back, scowl, and imaginary mop in hand. I barked out of the corner of my mouth, "I'm gonna clean up this mess," and "I'm gonna make this floor really, really clean." Patients began laughing at my character, and Barbara said, "You're just like the real janitors, except you do your job." There was a lot of energy at that moment. Ralph transformed into my boss, repeatedly shouting "Mop the floor!" and pointing to spots I had missed. Others became co- or sub-bosses and pointed to other big messes to be cleaned. I mopped with bigger and bigger strokes until the patients, in role as busy people, began to block my path. They yelled at me that they had places to go –

their offices, restaurants, home – and didn't appreciate the inconvenience I was causing with "all this mopping." I asked where we were and someone called out that we were in the halls of the hospital in which we were located. The group had transformed again to the here-and-now, and shifted from a structured spatial format to a somewhat unstructured mode, but the energy was still very high.

As the patients, still in role as busy people, moved around me, I yelled at each, "Don't step there, it's wet!" This elicited laughter and further heightened the energy in the group as the members jumped out of the way of my imaginary mop, saying, "Don't be so rude!" Then Ralph shouted, "I know what the problem is! He's working with a dry mop and empty bucket!" The patients pointed their fingers at me and spontaneously repeated the phrases "Dry mop!" and "Empty bucket!" I continued mopping with my imaginary mop, angrily shook my head at the patients, and said, "I have no problems at all. You're all in *my* way!" Numerous patients whispered to each other, "He's mentally unstable", "He's delusional!", and "He needs help!" The group had transformed me into a mentally unstable janitor. Barbara calmly noted that "It's a good thing you work in this hospital, since you need to be taken to the psychiatric emergency room."

The patients surrounded me, took away my mop and bucket, and led me to the psychiatric emergency room, where they became an examining team of doctors. I repeatedly asked, "Why can't I just go home?" to no avail. Ralph took on the name and persona of his actual doctor, spouting clinical jargon and proclaiming to the others, "I think he needs to be hospitalized!" The others were less forceful, but no more helpful. When I asked each of the patient-doctors if he or she had a minute to talk to me, the reply was the same: "Not now, I have to go to a meeting!"

The team of doctors split into two opposing factions: one, led by Barbara, wanted to be lenient with me, while the other, led by Ralph, wanted to come in with the big guns: electroshock, Haldol, and camisole (straitjacket). Barbara said, "Maybe he just needs a vacation." Ralph played the role of an arrogant, callous doctor with relish, perhaps giving a faithful rendering of what he himself had experienced at the hospital. He demanded that his orders to restrain the patient (me) be followed, not matter how much it hurt, finally overruling the others and injecting me with "a high dose" of psychotropic medication. When I grimaced in pain from the injection, he smiled and yelled, "If you keep resisting, you're only going to get more!" I collapsed into a chair amid the huddle of doctors.

The doctors then deliberated in their team meeting about what to do with me. Ralph wanted to keep me in the hospital at least for a 72-h observation period. I implored them to treat me well. Barbara, acknowledging my distress, promised me a nice room with a view, decent food, and "Maybe even drama therapy instead of medication." Then, to the surprise of all, she stepped forward, took charge, and said they would let me go and send me on vacation, and the others agreed. I rose from the chair, and thanked each doctor for listening to me.

It was then time to end the session, so I asked each patient to take a step back, let their characters go, and throw their roles and all the images we had created into the magic chest in the center of the room and raise it up to the ceiling. I asked the patients to look each other in the eye and say their real names. We sat for a moment and I asked if anyone had anything to say about the session. I did not expect anyone to comment, but several group members said how much they enjoyed playing the role of doctor. Barbara added, "I never knew how difficult their decisions are."

3.1.1. Discussion

The patients in this group enthusiastically and compellingly played high-status roles in this session, portraying events they had themselves probably experienced: being called crazy, being taken to the psychiatric emergency room, injected with drugs, and examined by multiple very busy and somewhat callous doctors.

As we shifted out of the sound-and-movement phase, I felt a sense of disappointment with Barbara's line, "Mop the floor," because I had been hoping for an explicitly "meaningful" phrase that could start what I was hoping would be an impactful, "meaningful" scene. Although my somewhat premature shift into verbalization had momentarily lowered the energy in the group, I realized later that I had been too quick to discount Barbara's suggestion, which ended up as the catalyst for the session. One reason may have been that I wrongly perceived it to be "dull" on the surface. Also, perhaps I was not aware of my bias against taking the suggestion of Barbara, a shy African-American woman, and my inclination to go with the lead of a forceful man like Ralph. In fact, the group's energy may have declined as a result of my unconscious discounting of Barbara's idea. But after recognizing that Barbara's phrase had all kinds of deeper meanings – and employing three key techniques – I was able to lead the group into a much deeper level of play than I had imagined possible.

The turning point in the session was when I assumed the role of the janitor. None of the group members wanted to play such a low-status role, perhaps because it reminded them of their own low status in the hospital and in society. In that moment, the group needed me to "pre-empt" the low-status role, so that they would necessarily have to take on higher-status roles.

The patients transformed several times to the "here-and-now," with the patients commenting on the dirty surroundings and incorporating it into the play. They remained in the playspace, but by identifying me as the patient and shouting what were at first abusive epithets ("He's crazy"), they mimicked what happened to them every day.

The extended scene that occupied the second half of the session involved the patients using the therapist as subject, acting out their aggressive fantasies of "getting back at" the doctors they perceived had treated them badly. Although I lodged as many complaints about my treatment as I could to the "doctors," I avoided presenting a caricature of a psychiatric patient. Rather, I was an ordinary person with problems who found himself in a bad situation.

The themes of power and powerlessness permeated the session, with the patients exploring the role of doctor and temporarily experiencing the feeling of being one-up over a staff member, thus gaining a new perspective on their usually second-class status. Ralph's injection of me was climactic in the scene. After experimenting with a litany of punitive interventions, the doctors realized that humane ones were more effective – and what they wished to receive themselves. The group tacitly played with cultural imbalances on multiple levels: all of the ward's actual janitorial staff were Latino, but I, a white therapist, played the role of janitor, and all of the doctors on the ward were white males, but the majority of the patient-doctors were non-white females.

This session implicitly dealt with problems on the ward, with much playing out of complaints about slow discharge and harsh treatment. The patients relinquished their "crazy" roles, empowering themselves by taking on the thinking and rule-making roles of doctors, temporarily becoming part of the system. The story of the hapless janitor elicited the therapeutic persona of each of the patients. They engaged in shared decision-making, played with different statuses, and even critiqued the therapist. Initially they decided that their "patient" was sick, using the following logic: "This person is in the hospital so they must be crazy." They clearly knew the rules of the institution, the psychiatric lingo, and the regulations governing how long a person can be kept in the hospital. Eventually the patient/doctors decided to change the rules and let their patient go, sending him on a much-needed vacation.

3.2. Second case example: drama therapy session in Czech psychiatric clinic

This session, also utilizing DvT techniques, took place in a psychiatric day clinic in Prague, the Czech Republic. The clinic, which had been founded after the fall of Communism a decade earlier, was situated in a quiet residential neighborhood on the outskirts of the city. The drama therapy group, which was conducted in the Czech language, had been meeting once per week for ninety minutes for five months. I led the group along with two co-therapists, Beate and Viktor, who spoke both Czech and English. At the time, I possessed basic Czech language skills. Six male patients with schizophrenia, all of whom were regular attendees of the group, participated in this session. Two patients, including Jirka, had were highly verbal and were relatively high-functioning, but the others were relatively low-functioning, including Edward, Pavel, and Jan, a young man of Roma background. The Roma – known as gypsies – are a minority in the Czech Republic and across Europe that is subjected to a great deal of discrimination.

I began the group, as usual, with breathing and relaxation exercises, inviting group members to focus on sounds coming from outside the room, then on sounds inside the room. Then we rolled our necks, stretched our arms and legs, and made facial expressions showing various emotions suggested by group members. The patients called out and conveyed the usual: happy, sad, angry, and tired. This energized the patients, especially when I asked them to make eye contact with each other. We then stood up and pulled down the imaginary magic drama therapy chest and curtain from the ceiling and stepped inside the playspace.

I began a simple movement, lifting an imaginary object above my head, and asked the group to mirror me. I then "passed" the movement to a patient, whom I asked to start a different movement for the group to mirror. We progressed around the circle several times in this manner, mostly doing simple movements with our arms and legs, sometimes repeating movements. The session felt more like an exercise class than a drama therapy group, until Viktor began marching like a soldier. This raised the energy of the group, for they enjoyed the rhythmic marching. Several patients began to wield imaginary swords, waving them in the air and at others. Jirka and Beate fenced in an almost dainty manner, then Jirka and Viktor lunged at each other like swashbuckling pirates. The images were brief and held only for a few seconds. I did not want to "push" the group into a scene, but rather gave the patients time to allow images and roles to emerge slowly. In a way, my limited language skills were an asset, forcing me to listen and watch group members very carefully, so as not to miss any key verbal or nonverbal signs.

When the sword fighting images began to dissipate, I asked the patients to take their swords and throw them up to the ceiling, which they did. I explained that the swords could change to something else and that we could pull it down. Jirka said that the "stuff up there" smelled too bad for us to take down. The other patients looked uncertain and took a step back; they were perhaps growing wearing of his dominance of the group. Beate pulled down a piece of the "stuff" and ran away from the group. We pursued her and caught her in a net. When I asked the patients what we should do with her, Pavel, a relatively low-functioning but imaginative member, movingly suggested that we sing a lullaby to her, which we did. We eventually formed a small orchestra playing for Beate.

Jirka, who clearly wanted the group to follow his lead, then said he had some sort of ESP "stuff" in his hand. I asked him to show it to me and after he dangled it in front of my eyes, I fell into his trance. I became a monster (the patients named me "Golem," after the famous Czech Jewish legend), and chased after the patients. After they unsuccessfully tried to pull the *shem* (a kind of Golem "battery") from my mouth, they ran away, giggling with child-like delight. In a plaintive voice, as the Golem, I said that they seemed too tired for me to do anything "bad" to them, and that I only wanted to play. I let them pull out the *shem*, then asked what we should do. Jirka said we should dig a hole and bury the ESP "stuff," which we did. The other patients did not connect with his "ESP" image. I suggested that we remember where we left the ESP stuff, but dig deeper to see if we could find anything else.

Pavel found an imaginary bottle of champagne in the ground, which we opened and passed around, each taking a drink. With each sip we toasted to various things suggested by group members: love, health, friendship, and camaraderie. We did so many toasts that we became drunk, leaning on each other and slapping our hands together. At this point there was a great deal of energy in the group; we had become a bunch of rebellious teenagers. I pre-empted the "irresponsible" role by becoming the most rebellious, obnoxious teenager.

I yelled that I wanted to drive home from our party, but Edward chased me and took away my car keys, admonishing me not to drink and drive. As a snotty teenager, I told him to leave me alone, then "borrowed" Jirka's car, but crashed it while driving home. He was upset and said it would cost thousands of dollars to repair. The patient-teenagers were mad at me and said I would have to work off the damage, even if it took me 300 years working every single day. I told them I didn't want to have to work so hard and became a pickpocket. After stealing their wallets, I ran home.

As I lay sleeping off the effects of the party and my driving escapades, the patients, now police inspectors, visited me at my apartment and interrogated me about the car, which they said had been stolen by someone who looked a lot like me. I said I had been cleaning at home all day in anticipation of my mother's visit and hadn't stolen anything. When they became more suspicious, I tried to sneak out of the apartment, but they caught me.

Jirka suggested that I needed to go to the psychiatric hospital and the other group members enthusiastically agreed. I became the therapist-as-subject, and they had placed me in the role of psychiatric patient and projected their frustrations onto me. The patients became doctors, hauled me to the psychiatric hospital in an ambulance, and gave me an injection of a powerful antipsychotic drug. After I again tried to escape, they gave me electroshock therapy and then, at Jan's suggestion, a lobotomy. They relished each progressively crueler intervention and became frustrated that I did not "improve." Even after the lobotomy, I stood up and again tried to pick their pockets.

The patient-doctors, clearly frustrated with their unsuccessful interventions, finally decided to give me talk therapy, asking me "What is your problem?" I explained, "I'm American and I'm just trying to get home." We had transformed again to the here-and-now. The patients knew that I was in the Czech Republic on a one-year research project. In the milieu, patients had often been curious about the U.S., a country that had come to dominate popular culture (and, in the post-Cold War era, had political dominance as well), often asking me what it was like. Now, they could see my "American-ness" as a problem. The patients discussed my case and concluded that my chief problem was my "delusion" that I was American, but helpfully explained that they could "therapize" it out of me. The doctors continued the "talk" therapy, trying to convince me that I was actually Czech. At first I admitted that I was 60% Czech, but that didn't satisfy them. I gradually increased my percentage of "Czech-ness," until I confessed, "Maybe I'm now 90% Czech." This elicited happy cries of, "He's cured!"

At that moment, it was time to end the group. We stood in a circle, gathered the images and characters we created by calling them out, and then placed them in the magic chest and raising it to the ceiling. The patients made contact with each other and each said their real name as a means of ensuring that we had de-roled.

3.2.1. Discussion

The images and scenes played out in this session reflected the social and political context of the clinic and the country. In 1989, Czechoslovakia (a country founded in 1918) had gone through the "Velvet Revolution," in which it broke from 40 years of Communist totalitarianism. Before Communism, the Czechs had also lived more than half a decade under brutal Nazi rule. Yet the culture had always embraced the arts, in particular theatre, and the President at the time was the former dissident and renowned playwright Vaclav Havel. Most Czech social institutions – and the entire mental health system – were completely transformed after 1989. The clinic in which the group took place was opened during this tumultuous transitional phase. Many Czechs were still coming to terms with the consequences of having been in a repressive "Eastern European" country that was behind "the Iron Curtain" for 40 years. The patients in the clinic were thus dealing not only with their own mental health issues and associated stigma, but also with the stigma associated with the social and political history of their country.

This double-edged stigma was played out in the session, with my outsider status taking on a great deal of importance. In the first phase, the patients quite obediently engaged in basic physical and nonverbal exercises. The patients cast me in the role of the Golem, the mythical Prague monster made from clay that usually protected the Jewish community. Like the Golem, I had gone from protector to villain for this group. But like Rabbi Loew in the classic story, they were able to tame the monster by pulling the *shem* from its mouth – and they made sure to bury the "stuff" from which the monster came. In taking on the role of the bad teenager, I was attempting to pre-empt the "pariah" role and force group members into playing higher-status roles.

After I upped the ante on the "deviant" role, by taking more risky actions and defying the pleas of the group to stop, the idea quickly emerged among the patients that my behavior meant that I was a psychiatric patient. They were clearly projecting onto me the labeling they had endured. Their next step was to bring me to the psychiatric hospital, a place each of them had experienced numerous times.

The turning point in the session was the lobotomy, a quite sadistic procedure. This violent image came from Jan, who until that point in the session had not spoken at all, and it took the other members aback. He was a member of a social group, the Roma, that often were victims of violence. After he repeated the word, "lobotomy," the group acquiesced and performed the procedure, validating his image. Throughout the sequence of draconian interventions, the patients released a great deal of emotion and energy. As the reaction of their patient – me – changed from defiant to pained, the patient-doctors paused and considered whether there was another way to "fix" me. In particular, Jan, having seen on my imploring face the results of his lobotomy, helped me up from the operating table and supported me with his arm as the other patients discussed what to do with me. There would be no more harsh treatments. The group had quickly shifted from brutal to humane, almost like the political system of their country. Ironically, Jan had been the most brutal, but became the gentlest at the end.

After we transformed to the here-and-now, in defining my character's "pathology" as not believing that I was Czech, group members implicitly acknowledged my outsider status – which mirrored *their* outside status. My Czech language limitations in grammar and vocabulary were a "disability" with which they could help me both literally (by speaking Czech slowly) and metaphorically, by helping me become more Czech. Perhaps the patients empathized with my character because they also had trouble expressing themselves in their culture, and were not considered "full" people by virtual of their diagnostic label. In reaching a consensus that I did not need to be 100% Czech, the patients may have realized that despite what others thought about them, they could feel that they were "good enough," even if they too were not "100%."

In this session, the patients played out the same type of staff-patient role reversal as did a group in a very different cultural context, which may illustrate the universality of the themes. In both sessions, the patients played with stigma, cruelty and humanity in the context of the mental health system, and were momentarily powerful.

4. Conclusion: hope in a Kafkaesque system

Tremendous change is occurring in mental health systems around the world, particularly in the United States, where the Affordable Care Act, enacted in 2010, has brought health insurance, and thus meaningful access to health care, to millions of people. At the same time, the pressures of managed care (which have been building since the 1980s) and the drive for "value-based" care have privileged treatment modalities whose success can be measured. In the mental health system, outcomes have traditionally been evaluated using metrics that focus on containment of individuals with mental illness and their symptoms.

Although it has become *de rigeur* for clinicians and policymakers to rail against the mental health system as "broken," this "brokenness" presents an opportunity to forge a new paradigm that places the empowerment of patients at the center. Drama therapy, in particular DvT, can help individuals with schizophrenia confront the stigma of their status as patients and feel empowered.

This article has presented a theoretical model of drama therapy grounded in the work of a quintet of diverse writers: the psychoanalyst Winnicott, the feminist psychoanalyst Flax, the philosopher Rawls, the absurdist writer Kafka, and the theatre artist Boal. What each shares is an assumption that, although it is only through an act of self-deception that we may develop a sense of social justice, it is vital that we cultivate that sense. For Winnicott, that sense is embodied in the transitional space, which is the bridge between self and other. For Flax, it is a space of social justice. For Rawls, it is the veil of ignorance, which allows us to view all humanity as equal via the lens of the original position. For Kafka, it is an uneasy *feeling* that we are on the verge of finding the answer, combined with the *knowledge* that it will always remain out of reach. For Boal, it is where we come to terms with external and internal "cops." The DvT drama therapist cultivates these senses, then uses disillusionment to empower her patients.

DvT drama therapy requires the drama therapist to create a playspace in which three rules govern: a restraint against harm; discrepant communications; and mutual agreement. To empower patients within the playspace, however, the therapist must foster the patient's ability to critique the therapist, promote shared decision-making, and play with different statuses.

Although the DvT drama therapist must always be mindful of the dynamics of oppression that she may represent for patients due to her job title, gender, race, ethnicity and other personal characteristics, rather than shy away from her perceived higher status, she can play with it. The DvT technique of pre-empting can be used to place the patient in higher-status roles, in particular roles that are at the top of the hierarchy within the institution in which the session is taking place. By transforming to the here-and-now, the therapist can explore dynamics occurring within the group and play with status differences. And using the technique of "therapist as subject," by acting as the client's play object, the therapist can help the client dislodge the self-created fetters of oppression.

The medical model has not been overwhelmingly successful in treating schizophrenia, perhaps because it has not dealt with the power dynamics that cause it to stigmatize persons diagnosed as schizophrenic. Yet social and economic forces dictate that it is not

realistic for drama therapy – and the creative arts therapies generally – to displace the medical model, for there is no "Big Therapy" to take on "Big Pharma." Nevertheless, the medical model must take into account objectives other than symptom containment by medication. Promisingly, a landmark study in the U.S. recently showed that the most effective treatment for first-episode psychosis includes a combination of psychotherapy, family education and support, vocational and educational recovery, along with the "usual treatment," low-dose antipsychotic medication (Kane et al., 2015). Moreover, mental health parity laws make it more likely that therapy performed by licensed therapists – including creative arts therapists – will be reimbursed by health insurance, which will increase access to these services.

Another positive development is that cultivating schizophrenic patients' feelings of empowerment has been shown to be an important – and measurable – goal of mental health treatment (Rogers, Ralph, & Salzer, 2010). Although several qualitative and quantitative studies have measured the efficacy of drama therapy-related techniques, these studies have employed symptom-based measures rooted in the medical model rather than measures based in the recovery model (Butler, 2012; Röhricht, Papadopoulos, Holden, Clarke, & Priebe, 2011). Promisingly, Moran and Alon (2011) concluded from preliminary research that playback theatre, in which real-life stories are enacted, can enhance recovery processes. It therefore would be desirable to build a base of qualitative and quantitative research testing the recovery-enhancing and empowering capabilities of drama therapy utilizing existing instruments that measure recovery and empowerment. Further research should be conducted to test the potential of an empowering drama therapy to fit within the medical model.

The case examples described above highlight drama therapy techniques in which clients play powerful, "one-up" roles, which can be potent tools for empowering patients, instilling hope that they can overcome their self-stigma. That similar images, roles, and stories were developed in two sessions in seemingly disparate cultural contexts suggests that these images, roles, and stories may have universal aspects. A common theme is that the patients bear the internal scars of the mistreatment they have received within the mental health system. In being temporarily empowered within the DvT drama therapy session, the patients cultivated their humanity and saw that the "best" treatment was the most humane. If patients can experience social justice in the playspace, they are more likely to experience social justice in the world.

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