Spring 5-20-2023

USING DRAMA THERAPY TO FOSTER PEER SUPPORT AMONG NURSE LEADERS

Chyela Rowe
chyela@gmail.com

USING DRAMA THERAPY TO FOSTER PEER SUPPORT AMONG NURSE LEADERS

A DISSERTATION

(submitted by)

CHYELA ROWE

In partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

LESLEY UNIVERSITY
May 20, 2023

STATEMENT BY AUTHOR

This dissertation has been submitted in partial fulfillment of requirements for an advanced degree at Lesley University and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this dissertation are allowed without special permission, provided that accurate acknowledgment of sources is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his or her judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: 

Graduate School of Arts & Social Sciences
Ph.D. in Expressive Therapies Program

DISSERTATION APPROVAL FORM

Student Name: Chyela Rowe

Dissertation Title: Using Drama Therapy to Foster Peer Support Among Nurse Leaders

Approvals

In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

Dissertation Committee Chairperson: Jason Butler, PhD
Dr. Jason D. Butler 3/29/2023

Internal Committee Member: Michaela Kirby, PhD
Dr. Michaela Kirby 3/29/2023

External Committee Member: Lely Kelly, PhD
Dr. Lesly Kelly 3/29/2023

Director of the Ph.D. Program/External Examiner: Michele Forinash, PhD
Dr. Michele Forinash 3/29/2023

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate School of Arts and Social Sciences.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Jason Butler, PhD
Dissertation Director

I hereby accept the recommendation of the Dissertation Committee and its Chairperson.

Deanna Yameen, PhD
Dean, Graduate School of Arts and Social Sciences

ACKNOWLEDGEMENTS

To Mom
To David, Avalon, Oliver, Jonah, and Pippin
And to my supervisors, professors, colleagues, co-workers, and friends
Alongside the fire of pandemics, injustices, cyber wars, politics, death, and hurts of all kinds,
Thank you for staying close by as I carried my own hot coals of change.

_____

Look me in the eye and tell me
Resilience isn't forged in fire.
I took the charred bits of myself and wrote my way out.
On the edge of my scrawled story,
Scorched and tender as it may be in spots,
Is me—purveyor of what I've found amidst pain,
The poem.

My ending is a happy one.
My ending is a happy one.

_____

RESILIENCE
By Meredith Jade (River City Street Poet) 2022
www.rivercitystreetpoet.com
Reprinted with permission.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

ABSTRACT

This study explored the use of drama therapy to support the social-emotional experiences of nurse leaders at a mid-sized regional hospital system in the Southeastern United States. Nurse leaders have experienced profound changes to their work environments in recent years. Burnout has been at an all-time high among healthcare workers globally and organizational supports for employees are both inadequate to meet the needs and under-resourced. The research questions explored 1) whether the drama therapy peer support initiative improved outcomes and 2) whether there was a significant relationship between measures, and 3) what nurse leaders described as facilitators and barriers to participation. To answer these questions, pre- and post- surveys were sent to nurse leaders (N = 32) who participated in the drama therapy program. Survey measures included Maslach Burnout Inventory-HSS, Toronto Empathy Questionnaire, and WHO-5 Wellbeing Index. The validated measures were helpful for providing baseline data that could uniquely inform the development of future support programs for nurse leaders at the study site. In addition to the quantitative measures, participants responded to brief qualitative questions on the pre- and post- surveys related to experiences, barriers, and facilitators associated with the initiative and the topic of peer support generally. Facilitator field notes were analyzed to assist with qualitative analysis and interpretation of data.

Keywords: Drama Therapy, Nurse Leaders, Burnout, Empathy, Well-Being

Author Identity Statement: The author identifies as a straight cis-gender, woman who is multiracial with European-American ethnicity, mother, spouse, daughter, and a first-generation student, with invisible illnesses.

CHAPTER 1

Introduction

Globally, economic investment in mental health care is not a priority, despite overwhelming demands for mental health to be recognized as a human right (Mahomed, 2020). According to the World Health Organization (WHO) (2022), mental health is more than the absence of illness. Additionally, responses to mental health needs are inadequate in every country and therefore calls to strengthen resources are necessary to meet the critical needs that affect everyone, everywhere, including the mental health of those who are providing healthcare. The WHO strategic global priorities, released prior to the COVID-19 pandemic, are critically needed now more than ever:

> "1. Deepen the value and commitment we give to mental health. 2. Reshape environments that influence mental health, including homes, communities, schools, workplaces, healthcare services, natural environments. 3. Strengthen mental health care by changing where, how, and by whom mental health care is delivered and received" (WHO, 2022, June 16, paragraphs 10-17).

Given the stark realities of the global mental health crisis, and heightened calls for change, it has become even more important to understand what factors might support or inhibit health caregivers to prioritize mental health intentionally and systemically.

If mental health is more than the absence of illness, it can be puzzling to understand how mental health perspectives are so marginalized in the practice delivery cultures of western medicine. Western healthcare, as a professional practice can be traced back over 2,500 years to Hippocrates, where the systematic approach started with philosophical aims to preserve and improve life (Applebee, 2006). With the ever-

evolving complexity of social systems in the West, our healthcare systems have also seen dramatic shifts (Giddens & Mansfield, 2023; Russell et al., 2022). What may have started as altruism in the structuring of care to save more lives, has morphed into a burden of productivity targets that have little regard for the mental, emotional, and physical health of caregivers. The competing economic, legal, scientific, political, social, cultural, and individual needs within healthcare environments make the problem of addressing work related stress a unique challenge.

The experience of work-related stress and burnout among nurses, advanced practice providers, and physicians – is a persistent problem worldwide (Büssing et al., 2017; Clough et al., 2019; Kratscheid et al., 2017). Burnout is marked by emotional and physical exhaustion, depersonalization, and feeling ineffective at work (Brady, et al., 2020; Sibeoni et al., 2019; Maslach et al., 2018). Symptoms of extreme stress or burnout can vary from person to person, but they include increased risk of serious health outcomes and suicide (Dutheil et al., 2019; Kalmoe et al., 2019). In healthcare, stress and burnout can also adversely affect patient health, making the issue of addressing these negative consequences of the work a focus area within many domains of health systems (Dyrbye et al., 2014; Mulder et al., 2020; Shanafelt et al., 2012; Sullivan et al., 2018; Williams, et al., 2007; Yates, 2020).

Since the onset of the COVID-19 pandemic, the breaking point for those working in healthcare has been profoundly evident, particularly for nurses and doctors who have continued to leave their professions in unprecedented numbers. For those who have remained in their jobs, critique of conventional wellness programs that rely on incentives or self-care are more recently regarded as insufficient for meeting current needs (Byers et

al., 2021; Klein et al., 2020). In comparison to how the public have experienced the traumas of war, the recent pandemic, coupled with political and social unrest, has shown similar increases in stress, anxiety, and depression (Murthy & Lakshminarayana, 2006; Traunmüller et al., 2020). For healthcare workers in particular, negative impacts on individual and collective well-being calls for adaptive ways of giving and receiving psychological, social, and emotional support in a work context (Dimino et al., 2021; Dohrn et al., 2021; Hales & Nochajski, 2019).

Creative approaches to well-being have been featured in medical and nursing literature related to the impact of collective traumas from the COVID-19 pandemic (Albal et al., 2021; Giordano et al., 2020; Griffith & Semlow, 2020; Zimmerman & Mangelsdorf, 2020). Arts engagement and therapies are also recognized by the WHO as having intrinsic health benefits that help with social, emotional, and empathetic understanding (WHO, 2022). Given this global attention and critical need for a variety of mental health supports, it is conceivable that many drama therapists or applied theatre artists or educators around the world are working to support the mental health and well-being of nurses and others working in healthcare. Regardless, empirical studies in English documenting outcomes, impact, or effectiveness of that work are scant, highlighting a particular need for drama therapy research and scholarship focused on work-related well-being issues in healthcare.

CHAPTER 2

Literature Review

Burnout in healthcare is not a new issue. Research spanning nearly 50 years has shown a critical need to address systemic drivers leading to work stress among nurses, where even prior to 2020 prevalence rates ranged between 35 and 45 percent (NASEM, 2019). Staffing shortages, increased workload, emotional distress, social unrest, and disillusionment are among the list of issues compounding an already critical need (Schlak et al., 2022). The COVID-19 pandemic only accelerated the subject of burnout to the forefront of global consciousness with calls for pay equity, greater safeguards for the health and safety of workers, and a more explicit focus on mental health (Gee et al., 2022). The International Council of Nurses homed in on the primary issue, which is to decrease workload by improving staffing and thereby improve the work environment (Buchan, et al., 2022). Without these changes, Buchan et al. predicted a global shortfall of approximately seven million nurses, with surveys of nurses in the US showing 11% of those leaving the workforce are nurse leaders with the most years of experience.

Prior studies measuring the impact of unprecedented events and diseases on employee well-being have contributed to recommendations for taking action to protect the mental health of nurses, but industry change is slow (Fink & Milbrath, 2023; Hill et al., 2022). Nearly two decades prior to COVID-19, there was a SARS-Co-V-1 novel coronavirus outbreak. Several studies documented the psychological impact on nurses and doctors who responded to infectious respiratory disease outbreaks such as the SARS-CoV-1 outbreak in Canada and Hong Kong between 2002-2004 (Lancee et al., 2008; Maunder et al., 2006; McAlonan et al., 2007), and outbreaks of Middle East Respiratory

Syndrome (MERS or MERS-CoV) with high peaks between 2013-2015 (Khalid et al., 2016; Kim et al., 2016; Lee et al., 2018; Park et al., 2018). These studies provided insight into the long-term impact of stress related to higher-risk work conditions during infectious respiratory epidemics and pandemics, showing commonalities with COVID-19 pandemic stressors.

For example, Maunder et al. (2006) administered surveys to care team members across 13 hospitals in Toronto and Hamilton, Ontario, Canada who were involved in the treatment of SARS patients (N = 769). The study compared adverse outcomes and potential mediators of such outcomes in relationship to exposure to SARS patients, age, job type, years of experience, and subjective impact. Participants were mostly nurses (73.5%) with the remaining participants representing 17 different job types, including physicians (2.9%), clergy (8.3%), and respiratory therapists (2.3%). Important findings from this study reinforce the idea that adverse outcomes such as increased substance use, missed or decreased work schedules, psychological distress, posttraumatic stress, and burnout had less to do with proximity to high-risk patients than with the presence and quality of institutional and personal support.

Statistical analysis showed a correlation between the duration of perceived risk and maladaptive coping (Spearman ρ = 0.28, p = 0.001) as well as perception of adequacy of training, protection, and support (Spearman ρ = -0.27, p = 0.001). Data also showed a significant linear increase in prevalence of multiple adverse outcomes as the duration of perceived risk continued over time (Spearman ρ = 0.23, p = 0.005), with spikes evident at 10-12 months and 18+ months following the onset of perceived risk. These results point to the importance of institutions mitigating perceived risk through

providing adequate protection, offering ongoing education, and fostering a culture of support as preventative measures for reducing symptoms of burnout. Overall, the recommendation from Maunder et al. (2006) was for proactive, careful institutional planning that would bolster support programs including peer support or "buddy" systems, collaborative decision making, and robust training opportunities. The most important recommendation was that these supports be established prior to outbreaks to mitigate adverse outcomes.

In research by both Khalid et al. (2016) and Kim et al. (2016), factors influencing resilience and a desire to continue working in high-risk environments were rather simple and included positive attitude, peer support, and availability of personal protective equipment. When considering the degree of intensity that physicians and nurses experience daily, it seems important to weigh the value of research with such practical insights into prevention and coping strategies for work-related mental health distress. Yet, as has been widely noted by many authors, the global response to the COVID-19 pandemic revealed little or no change in systemic preparation for high-impact health events (Adams & Walls, 2020; Bansal et al, 2020; Ehrlich et al., 2020; Huang et al., 2020; Lai et al., 2020; Xu et al., 2020; Zhang et al., 2020).

Nurse Leader Roles and Stressors

The American Organization for Nursing Leadership (2023a) defines nurse leaders as clinical leaders, managers, directors, and executives in healthcare who play essential roles in the transformation of healthcare. This group of leaders provides guidance, correction, support, and oversight to the largest proportion of the healthcare workforce (U.S. Bureau of Labor Statistics, 2020). In a cross-sectional correlational study by

Nurmeksela et al. (2021), researchers discussed how among the responsibilities of nurse managers and directors are tasks that impact patient health outcomes, patient and employee safety, financial strategy, employee retention and well-being, and workplace culture. Furthermore, Nurmeksela et al. explained how this variety and scope of job responsibilities places nursing leaders under the evaluation of patients, through patient satisfaction surveys, administrators, who monitor financial and human resource metrics, and accrediting bodies, that monitor aspects such as quality, safety, and ethics. This variety of roles, tasks, and evaluation standards can sometimes be in competition or even conflict, leaving nurse leaders with an unrealistic drive towards perfectionism coupled with a perpetual sense of failure (Bellack & Dickow, 2019; Loveridge, 2017).

In Goldsby et al., (2020), the focus of their proposed model of work stress mitigation for nurse leaders centered the issue of time and workload. This three-part model for supporting the well-being of nurse leaders included psychosocial care, time management, and self-leadership principles. Comprehensive lists of suggested behaviors were given for setting boundaries around time and tasks, such as finishing small tasks before working on larger ones or scheduling time to attend to emails at the same time each day. Self-leadership suggestions included strategies for developing positive habits for a practicing insight, goal setting, self-cueing, rewards, and even self-correcting rather than self-criticizing feedback. An important part of this comprehensive model included tools such as using visualization to calm anxieties and imagine an achievable goal to help focus attention. Interrogating dysfunctional beliefs and assumptions was also suggested for addressing distortions that are commonplace for those who work in intense environments.

In a recent burnout prevalence study of nurse managers, (Membrive-Jiménez et al. 2022), low levels of personal accomplishment as measured by the Maslach Burnout Inventory (Maslach & Leiter 2018), were associated with nurse leaders expressing a desire to leave their leadership roles. The authors concluded that characteristics of emotional stability contributed to a greater sense of work-related personal accomplishment and encouraged the use of mindfulness and resilience interventions to strengthen nurse leader well-being. Similar concepts of personal accomplishment were present in Christiansen et al. (2022), where nurse leaders indicated an intent to stay in leadership roles and indicated being motivated by factors such as being able to help future nurses, feeling like they are good at their job, and the enjoyment of helping others.

Overall, it is clear in the literature that nurse leaders are well versed at articulating the challenges of their roles (Aydogdu, 2023), and are in favor of improving opportunities for psychosocial support (Labrague et al., 2018), better staffing ratios and distribution of workload requirements, (Petersen et al., 2023) and increasing opportunities for developing leadership and resilience skills that will support the sustainability of working in such complex environments (Penconek et al., 2021).

Burnout Treatment and Prevention

Organizational strategies often put the burden of care on individuals to address workplace stress through personal self-care or low-cost mindfulness strategies such as apps, breathing practices, and meditation (Card, 2018). Many healthcare systems offer employee wellness programs intended to promote resilience, the personal ability to "bounce back" from adversity (Epstein & Krasner, 2013; Morgan et al., 2018). Resilience is often described by characteristics such as emotional and cognitive flexibility, or a sense

of mental toughness. But typical employee resilience programs struggle to improve employee well-being when barriers persist from lack of engagement, rapidly changing work systems, and high demands on employee time (Brown-Johnson et al., 2019; Buck et al., 2019; Card, 2018; Kelly, 2020; Zwack & Schweitzer, 2013).

Structural changes to time-related factors may be necessary to increase engagement in well-being programs but awareness of how cognitive flexibility supports well-being could potentially increase engagement as well (Back et al., 2016). The relationship between healing and cognitive and emotional flexibility was presented by Hinton and Kirmayer (2017) in a theoretical perspective paper, specifically around the use of ritual healing. Drawing on theories of embodiment and anthropology of the senses, the authors proposed a perspective suggesting the use of symbolic objects and rituals to prime cognitive, emotional, and biological systems. According to the authors, these processes may aid a flexible response to challenges and stressors. Flexibility was defined as, "the ability to consider different actions, adopt multiple cognitive frames, attitudes, or 'mind sets,' explore possibilities, and experience diverse modes of being-in-world" (p. 5). Described as a mechanism of change, metaphor was specifically examined within contexts such as religious rituals, language cultures, identity development, and psychopathology. Likewise, ritual experiences that engaged multiple senses (i.e.: taste, smell, sound, visual stimulation, and touch) were described as having the capacity to promote flexibility while experiencing change within and across sensory modes. Overall, this body of theories related to cognitive and emotional flexibility has potential to help inform the development of interventions related to both resilience and burnout in the field of medicine. Studies such as these have also led to programs and trainings being

promoted by hospital administrators to teach adaptive response skills to clinical staff (Sherlock & John, 2016; Taku, 2014).

In Clough et al. (2019), researchers documented physician attitudes toward personal resilience strategies, (N = 274), identifying types of barriers to participation in support activities. The highest perceived barrier, which was ranked number one by all three sample groups, was time constraints. Other perceived barriers included availability of services, negative evaluation of services, and fear of being stigmatized for admitting a need for services. With these common barriers in mind, the following sections will provide a brief overview of how self-care practices, peer support programs, and drama therapy can function collectively to address symptoms of burnout.

Self-Care

Self-care is a broad term that often references the well-being practices of exercise, mindfulness, nutrition, and other individual choices that promote mental health and resilience in challenging work environments (Lewis et al., 2022; Michaeli, 2017). It is promoted as a necessary part of care-giver well-being within clinical education, through professional credentialing organizations, and by institutions that manage the risk and profits of healthcare practice (Dev et al, 2018; Hricová, 2020; Klein et al., 2020). However, from the clinician perspective, self-care is given a disproportionate amount of attention, often seeming to shift blame for burnout onto the provider (Kuhn & Flanagan, 2017). Research to support self-care as burnout prevention is mixed, and sometimes incomplete (O'Dowd et al., 2018; Waddimba et al., 2016). For example, extant studies are often quasi-experimental or involve relatively small sample sizes (Locke & Lees, 2020; Vetter et al., 2018).

In a mixed-methods study by Lemaire and Wallace (2010) in Western Canada, self-care data were collected from a sample representing 55 health centers and acute care sites. Results of the study identified some common self-care coping skills associated with lower frequency of emotional exhaustion such as making a plan of action, spending time with family, talking to a spouse or colleague, exercising, using humor, or taking time out. Whereas coping styles at work—such as keeping stress to oneself, dismissing the stress by concentration on the next task, or ignoring stressors—correlated with a higher frequency of emotional exhaustion, pointing to the importance of fostering open communication and time for reflection to be imbedded in workplace culture in order to facilitate self-care opportunities.

In a mixed-methods study by Klein et al. (2020), researchers sought to survey advanced practice registered nurses (APRNs) and physician assistants (PAs) to understand how they might participate in stress-reduction activities at work. The study used the Maslach Burnout Inventory (MBI-HHS) to measure levels of burnout and was offered via online surveys to nearly 4,000 Advanced Practice Providers (APP) who worked in four American states. Responses were received from 31% of those who received the survey invitation. Among the 1,218 responses, 70% provided a qualitative response to the additional question, "what do you personally do to reduce stress at work?" (p. 434). The results of the MBI-HHS were described as showing high levels of burnout in respondents, though the details of those results were not provided in connection with the qualitative responses.

The bulk of the data presented the qualitative responses related to self-care strategies at work. Responses were coded into four broad categories of self-focused

(67.5%), relational-focused (16%), job-focused (11.5%), and nothing/suppression (5%). While the results would indicate that most respondents are using some form of self-care at work to mitigate stress, the usefulness of these results are limited as it was unknown if those strategies had any effect on levels of burnout. Likewise, as the results of the MBI-HHS were reported as being high, it was difficult to discern if the adequacy of encouraging self-care practices would be sufficient to meet the need based on the data reported (Klein et al., 2020).

Peer Support

Institutional and co-worker support seem to be significant contributors to lowered burnout, but the actual mechanisms of support are often varied and subjective. And, according to Boland et al. (2019), social isolation outside of the workplace is correlated with higher burnout in Emergency Medical System providers. Shapiro and Galowitz (2016) presented research that established peer-support programs as a critical component for promoting well-being, as have others (Johnson, 2019; Peterson et al., 2008). In the wake of the prolonged COVID-19 healthcare environment, the experiences of trauma, complex grief, and chronic exhaustion have sparked many studies calling for more robust peer support programs for nurses and nurse leaders (Dohrn et al., 2021; Gee et al., 2022; Godfrey & Scott, 2021; Holman et al., 2021; Jung & Baek, 2020; Labrague, 2021).

Studies which identify clear mitigation strategies such as fostering empathetic interpersonal leadership skills are either elusive, or the recommendations have failed to be a priority to organizations despite ongoing evidence (Smallwood et al., 2013). Studies that have sought to understand the mediating effects of empathy in relationship to symptoms of burnout over the last decade are not uncommon (Duarte & Gouveia, 2017;

Gleichgerrcht & Decety, 2013; Hunt et al., 2017; von Harscher et al., 2018; Yuguero et al., 2017). Empathy is defined as understanding or feeling the same emotions as another person or having the ability to comment accurately on the emotional experiences of others and is considered an important skill or behavior for those in care-giving professions (Teding van Berkhout & Malouff, 2016). In recent years, industry professionals have recognized the value of fostering empathetic leadership and consider the skill as a work-place well-being imperative (Van Bommel, 2021). Healthcare environments rely on nurses and leaders whose interpersonal skills with peers contribute to productive, highly effective team-based care. According to Lawson and Weberg (2023), this is particularly relevant through transformational changes, when reliance on routine is ineffective and focusing on shared purpose to build interpersonal trust alongside rapid change is essential.

Evidence of team-based or group peer support as a component of transformational change in healthcare settings is little more than anecdotal. But examples of support through resiliency skill-building workshops such as the Community Resiliency Model show promise (Grabbe et al., 2020). In this study, nurses were taught principles of sensory awareness to activate the parasympathetic, or energy restoring qualities of the autonomic nervous system in response to work-related stressors. However, participation rates were at 12%, illustrating a common limitation of well-being program research and implementation. It will be important going forward to understand how programs are effective at fostering supportive peer encounters. Future research will also help the profession understand whether these programs mitigate the risks of burnout and other

work-related mental, physical, and social health issues, as well as revealing what barriers and facilitators exist in relation to developing peer support programs.

Arts & Well-Being

The World Health Organization has recognized the creative arts as being an integral part of health and well-being through arts education, promotion, and interventions for over a century (Fancourt, D., & Finn, S., 2019). The concept of arts in health has grown in popularity in recent decades, with reported benefits to well-being through activating environments through aesthetics (Huet, 2015; Sonke et al., 2009). The National Organization for Arts in Health published a white paper outlining strategic priorities for researching arts-based interventions and addressing healthcare burnout (Steinhaus et al., 2020) and a report by the Association of American Medical Colleges outlines the importance of arts-based methods within integrative health and learning environments (Howley et al., 2020).

Tuisku et al. (2016) was a unique arts in healthcare study that compared the impact of passive and active arts engagement on employee stress recovery and work engagement. The study included survey responses from 769 nurses (70%), physicians (10%), social workers (7%) and secretaries (12%). Most were female (92%), representing the overall structure of personnel. The large scale of the study was intriguing in comparison to most arts intervention studies which have on average fewer than 40 participants (Martin et al. 2018). Employees responded to an anonymous questionnaire sent to all personnel email accounts (N = 2,217) from the medical unit at Helsinki University Hospital. The questionnaire included scales from the Recovery Experience Questionnaire (Sonnentag & Fritz, 2007), which was used to measure six engagement

variables associated with employee well-being: detachment, relaxation, mastery, control, engagement, and recovery. The Ultrech Work Engagement Scale (Seppälä et al., 2009), measured elements of work engagement such as vigor, dedication, and absorption. Scores from these measures were compared to the employee's responses to a question asking how often they engage in creative (active) or receptive (passive) leisure activities. Examples such as reading, listening to music, watching live performances, and visiting art exhibits were given for receptive activities. And creative activity examples were writing, musical expression or composing, producing visual arts, acting, and dancing. An ANCOVA showed a significant difference between the work engagement scores of those who participated in weekly receptive and creative cultural activities and those who did not ($F = 4.65$, $p < 0.05$, *df* not reported). In addition, scores for relaxation ($F = 4.20$, $p < 0.01$, *df* not reported), mastery ($F = 10.5$, $p < 0.001$, *df* not reported), and control ($F = 4.20$, $p < 0.05$, *df* not reported), were significantly higher for the group who participated in both receptive and creative activities at least once each week. The concept of this study is novel and offers empirical insight into an underrepresented aspect of medical provider well-being, which may be fostered through either passive or active participation in arts and culture activities (Tuisku et al., 2016).

An example of a supportive, integrative arts and well-being program in medical student education was described in Patel et al. (2021). In this study, students and residents were provided one afternoon per month free of clinical obligations in order to participate in facilitated arts-based well-being support programming at the Hunter Museum of American Art. Facilitators were arts educators, applied theatre professionals, and medical faculty using narrative based, emergent curriculum design which

incorporated expressive arts activities with each session. The stated goals of this program were to offer opportunities to further develop observation as a diagnostic skill through facilitated engagement with visual arts. Other program goals were to promoting resiliency, multicultural understanding, building community, and burnout reduction. Participants provided feedback to facilitators by way of survey responses indicating three mood or feeling words before and after sessions. Of the 73 surveys reported in this paper, common responses before sessions began were: tired (37%), excited (26%), happy (16.4%), and curious (15.1%). Following the sessions, participants most commonly reported feeling relaxed (79.5%), happy (20.5%), and creative (12.3%). This report did not have adequate data to indicate effectiveness of arts-based programming as a reliable tool for mitigating burnout symptoms, but it did provide descriptions for how to implement the suggested program planning within an integrative medical education well-being curriculum. As physicians and medical training programs explore all options for addressing burnout, programs such as these offer creative alternatives to conventional well-being tools.

Perhaps the most relevant publication is a description of the arts-based programmatic response by administrators at the 457-bed NYC Health + Hospitals/Jacobi campus in Bronx, NY following what was described as a harrowing toll of the COVID-19 pandemic surge of 2020 in New York (Geiss et al., 2022). The employee wellness program, called The Helping Healers Heal Program (H3), deployed a range of creative arts therapy trained behavioral health staff and interns to support their fellow co-workers in a program they titled Summer of Hope. The interventions expanded on already existing peer support initiatives and provided additional arts and mental health focused

engagements. The interventions were grouped in themes of belief, affect, social, imagination, cognition, and physical, with the whole construct identified as BASIC Ph for short. The program incorporated opportunities for collective grieving through candlelight vigils, weekly meditations, poetry-based mindfulness exercises, music and drumming, community murals, dance, yoga, movie nights, and self-care expos to name a few examples. To maintain a culture of psychological safety, employees were not required to sign-in when participating in the programs, but employee surveys responses (N = 32) showed 94% agreed or strongly agreed that the events helped alleviate their stress. The authors did report, however, that employees often stated that they did not have time to participate in the support programs, pointing to time-related issues as a recognized pervasive barrier to well-being programs.

Drama Therapy History and Current Approaches

Drama as theater or performance, has been described by historians around the world as an integral artistic and expressive form for understanding and communicating emotions, social issues, and existential questions that shape how we observe and present ourselves in the world (Amine, 2018; Chattopadhyay, 2013; Ybarra, 2020). In Western culture, discussion of the artform as an intentionally transformative practice for emotional and spiritual healing dates as far back as approximately 350 BC with Greek philosopher Aristotle discussing how tragedy and comedy induce understanding and the release of deep feelings (Aristotle, 2013; Jones, 2007).

The emergence of drama therapy as a more intentional health practice for social and emotional well-being in the West was heavily influenced by the work of J. L. Moreno through his development of psychodrama, a foundational practice of group

psychotherapy based on dynamic role plays, projection of internal characters, and active witnessing (Moreno, 1946; Moreno & Jennings, 1934). Other arts-informed theories of psychotherapy that developed throughout the 20th century included ideas such as archetype and imagination (Jung, 1915; 1936) and adaptations of Moreno's empty chair approach influenced Gestalt theories of psychotherapy (Perls, 1951). Particularly in and around World War II, there were other explorations of the therapeutic qualities of theatre (Curran, 1939; Reider et al., 1939), or puppets (Cohen, 1944; Lyle & Holly, 1941).

In the post-war era, other inquiries included dramatizing psychodynamics in group therapy, and as part of occupational therapy (Solomon & Fentress, 1947; Solomon, 1950). Some went further by suggesting new therapeutic theories associated with drama (Lefevre, 1948), and to discuss diagnostic implications (Lassner, 1947). When considering the history of the mid-20th century, from the perspective of what tools were used for alleviating the social and emotional impact of the global collective traumas of world war; theatre, and dramatic processes such as spontaneity (Horwitz, 1945), story (Davidoff, 1939), and play (Bixler, 1949), had the attention of dramatists, researchers, educators, and clinicians. However interest has remained little more than conceptual in mainstream healthcare.

More contemporary theories and approaches to drama therapy have proliferated with the establishment of professional organizations, graduate training programs, and international professional conferences that have supported the development of drama therapy as credentialled standards-based mental health care professions (BADth, 2020; NADTA, 2022; WADth, 2021). With these steps toward professionalism, therapeutic approaches to drama therapy continued to be critiqued, with a particular focus on

intersectionality (Beauregard et al, 2017; Kaur, 2021; Sajnani et al., 2016), influence from arts and culture sectors (Bailey, 2022), and deepening practice within political and social activism frameworks, such as Boal's Theatre of the oppressed (1979), and hip hop culture being accepted within mental health approaches (Nazaire, 2021).

Core Processes

Despite the range of historical, theoretical, and cultural paradigms that are represented within the profession of drama therapy, many of the techniques used within drama therapy sessions are recognizable across cultures and nationalities (Jennings & Holmwood, 2016) and can be described from a core processes framework (Frydman et al. 2022). The idea of drama therapy core processes was first articulated in the literature by British Dramatherapist, Phil Jones who proposed that there are elements of drama therapy practice that transcend modalities and approaches and are present within any drama therapy encounter (1991, 1996, 2008, 2014, 2016). Jones' theories and descriptions of these therapeutic properties have influenced practitioners, scholars, and researchers for over three decades (Armstrong et al., 2016; Cassidy et al., 2014; Mayor & Frydman, 2021; Pendzik 2006; de Witte et al., 2021).

In a Delphi study by Frydman et al., (2022), the team pursued further inquiry into the drama therapy core processes with aims of moving towards operationalized definitions. The results of this study drew on the expertise of five drama therapists, scholars, and educators in North America who in two rounds of discussion, produced seven tripartite definitions that offered articulation of what each process is, what it does, and how it can be observed. These seven drama therapy core processes were: active witnessing, distancing, dramatic play, dramatic projection, embodiment, engagement in

dramatic reality, and multidimensional relationship. In the third round of the study, the newly articulated schematic was sent to 25 additional drama therapist evaluators who rated their agreement or disagreement with each core process definition on a 7-point Likert scale and gave qualitative feedback with suggestions for changes or edits of the definitions. In the final round of the Delphi study, the original panelists incorporated the feedback from additional evaluators to produce the final schematic. With this revised core-process schematic, researchers, educators, and scholars are situated to better explore the impact and effectiveness of drama therapy across a variety of approaches and applications.

Multidimensional Relationship. Building from Jones' (2016) ideas of the triangular relationship, how drama therapy core processes are used can vary widely depending on the therapeutic goals and objectives of the participant or group. What the participants and drama therapist bring into a drama therapy encounter can also impact what techniques are used in the session. Examples such as culture, identities, artistry, emotional and cognitive states, personality, physical conditions, dis/abilities, guiding philosophies, theoretical frameworks, skill, and experience are all aspects of "self" that can influence the therapy (Sajnani et al., 2017). This dynamic inter-relationship between those aspects of the therapist, participant(s), and the dramatic reality is described as a multidimensional relationship in the recently devised core processes framework (Frydman et al., 2022). How one might engage with the dramatic reality is largely a matter of choice, which is negotiated between the therapist and participant(s) depending on the context such as participant age, resources, space, time, and other preferential factors. Some drama therapy approaches look very similar to a traditional theatrical

production with a stage, costume, and scripted scenes (Cook, 2021; Kaynan & Wade, 2018; Pendzik, 2021), while others might be almost entirely based on guided improvisational play methods (Johnson, 2021), or narrative, (Dunne et al, 2021; Savage, 2018), or through defining and engaging with roles, (Williams, 2017; Truax, 2020), and other forms of performance and play that might use comedy, clowning, puppets, or masks (Bornmann, 2022; Gordon et al., 2018; Ilievová et al., 2015; Kostidakis, 2021). In essence, it is important to understand that the dramatic reality portion of the multidimensional relationship in drama therapy is less about the particular tools and techniques of theatre and more about the ways a variety of drama therapy activities might engage the imagination of the participant(s) in a way that brings about therapeutic change.

Drama Therapy Research

Despite the historical context and broad practice of socially engaged and applied theater over the last century, the earliest empirical drama therapy study located in a general review of drama therapy empirical literature (Armstrong et al. 2019) was published nearly three decades after Moreno developed psychodrama. In that study, Nitsun et al., (1974) studied the effectiveness of drama therapy as a treatment to support self-esteem and emotional symptoms associated with schizophrenia. But overall, drama therapists have largely relied on theoretical and case study literature to describe therapeutic impact. Empirical research demonstrating the efficacy of drama therapy for the treatment of social and emotional issues did not really emerge until the 1980's (Johnson, 1988; MacKay et al., 1987), and remained scant until recent years (Armstrong, Frydman & Wood, 2019). The lack of significant studies undoubtedly compounds the

limited recognition of drama therapy as an effective well-being resource (Armstrong, Frydman & Rowe, 2019).

However, global interest in conducting empirical drama therapy research has increased in recent years, with more rigorous studies being published on a variety of topics in ever-expanding therapeutic contexts. Some studies may be relevant to the social-emotional experiences of nurse leaders, such as those that explored drama therapy in relationship to emotions. For example, a study in Canada utilized trained raters to assess emotional arousal, an experience associated with psychotherapeutic change (Armstrong et al., 2015). In this study, raters watched recorded videos of participants in drama therapy sessions where core processes of dramatic projection and embodiment were part of the therapeutic intervention. Joy and sadness were the main emotions observed, though the primary aim of the research was to show that a connection could be observed between the use of core process variables and emotional arousal, which is an indicator of possible therapeutic change.

Anger was the emotional subject of another study by Blacker et al. (2008), where drama therapy was used through activating exercises, role-play, and metaphors, in combination with cognitive behavioral approaches in a prison setting in the UK. In this study, the aim was to measure emotional regulation skill development by assessing levels of response before and after the nine-day program with participants ($N = 52$). Results showed significant change in all subscale measures of state anger, trait anger, anger expression, and anger control. Nearly a decade later, a similar study by Keulen-de Vos, (2017) showed effectiveness of drama therapy to assist forensic clients with personality disorders to experience emotional vulnerability within the drama therapy session. This

area of inquiry may be of interest when considering the cognitive and emotional experiences of nurse leaders, as this study explored the interpersonal abilities of participants to empathize with others and experience emotional vulnerability. In this study, those skills were considered important outcomes for this population, who were described as having suppressed emotions, making emotional attachment skill development a therapeutic objective. Interestingly, the study did not support a beneficial outcome in relationship to participants who exhibit over-controlled or avoidant behavior related to anger responses. Though the hypothesis related to anger was not supported, the results pointed to the importance of understanding factors that assist with the titration of strong emotions for some participants who struggle with emotional vulnerability. This concept is important to consider in contexts, such as hospitals, where intense emotional and interpersonal experiences are commonplace.

In a qualitative study using analysis of interviews with three drama therapists, the drama therapy core process of engagement in dramatic reality in relationship to depression was the subject of inquiry (Chapman, 2014). Dramatic reality is understood as the "transition from external reality to a liminal state, bringing the imaginal realm into outward expression," (Frydman et al., 2022, p. 8). Participants were asked to reflect on their experiences with using this core process within individual and group therapies for the treatment of depression. Participants shared that an important aspect of the relationship between imagination and depression was the often-observed limited ability for imagining new realities while depressed. Furthermore, analysis of the interviews revealed common themes relating physical, emotional, and cognitive benefits that were possible as a result of therapeutic engagement with in-session imagined realities. And

Chapman stated, the use of this core process, “seems to work particularly well in group sessions as it brings people together to share the experience. The group environment targets the social isolation and shows individuals that they are not alone and are in fact surrounded with people sharing similar difficulties,” (p. 139).

More recently, drama therapy and closely-aligned applied theatre studies have sought to better understand how theatre-based approaches might support those who experience anxiety, trauma, and stress through the processes of actively witnessing their shared stories being played back within a drama therapy session (Ray & Pendzik, 2021; Munjuluri et al., 2020), or increasing playfulness or humor as a way for participants to access a capacity for resilience (Vávra et al., 2020; Versluys, 2017), using theatre improvisation to reduce social anxiety (Felsman et al., 2020; Felsman et al., 2023), or to improve social cognition (Tang et al., 2019), and using drama therapy to help with the experience of traumatic changes associated with refugee migration (Yusek, 2020).

One study demonstrated the use of drama therapy for supporting mindfulness and well-being with adolescents in an outpatient drama therapy group in the United Kingdom (McLachlan & Laletin, 2015) In this mixed methods study, adolescents ($N = 4$) who were part of an extended mental health day program for the treatment of mood disorders participated in a five-week course of drama therapy mindfulness groups. The drama therapists incorporated sculpting, visualization, and learning a script with breathing and relaxation meditation techniques. Likely due to the small sample size and relatively short duration of the treatment, the quantitative measures of mindfulness, anxiety, and depression did not show any significant change between pre- and post- measures. However, all participants indicated the intervention was relevant, helpful, and enjoyable

in the qualitative feedback, and three participants showed such improvement in depressive symptoms that they were recommended for discharge from the day program.

One drama therapy qualitative study specifically had a well-being objective. In Snow et al. (2003), adults with developmental disabilities participated in a therapeutic theatre program. Outcomes from this study showed increased socialization, enhanced communication and interpersonal skills, improved self-confidence, more spontaneity and freedom of expression, increased sense of responsibility and maturity, a sense of accomplishment, and an expanded, more positive sense of self. Though the reported results were encouraging, the design of the study was limited to the unique context of the participant group.

In recent years, drama therapy empirical research has included investigations of drama therapy as a mechanism of change (Armstrong et al., 2016; Kejani & Raeisi, 2020; Mayor & Frydman, 2021). Furthermore, an emerging focus in the field of drama therapy is the use of drama therapy to address health and well-being issues related to cultural humility, equity, and diversity topics related to gender and sexuality (Beauregard et al., 2017; Frydman & Segall, 2016; Wade), race, (Maynard, 2018), and accessibility (Mayor, 2019; Melvin, 2021; Wade, 2020). In each of these studies, empirical evidence points to the unique therapeutic nature of drama and theatre-based processes to support participants with complex social, emotional, and psychological experiences.

Drama in Healthcare Education

In the field of medical education, self-care curricula are ubiquitous, however, programs for teaching skills such as cognitive flexibility are largely unavailable. A learning resource described in Houser et al. (2018) was based on educational methods

using the role-reversal component of psychodrama, which they described as “reverse role-play” (p. 2). The objectives of this burnout prevention curriculum were to allow students to rehearse responses to stressful scenarios from other perspectives besides their own, thereby exercising cognitive flexibility. The resilience trait of cognitive and psychological flexibility was described in this study as the ability “to hold multiple views or to change or reframe a thought, situation, or perspective” (p. 1). However, engagement with the literature was limited in this study. A more robust review of theoretical and empirical literature related to the educational objectives may have drawn more explicit connections between the role-reversal method and cognitive flexibility. Nevertheless, the framework for providing a workshop to medical providers was descriptive and could be adequate for use in future research related to the effectiveness of drama therapy for psychodrama approaches to burnout prevention.

Three additional studies in healthcare education used embodied and enacted approaches. Viscardis et al. (2019) described a program where multimedia storytelling was used to help doctors, nurses, social workers, occupational therapists, and health educators (N = 39) to critically challenge internally held ableist attitudes towards patients within their areas of practice. However, results of the arts-based study have yet to be published. Lim et al., (2011) and Lundén et al., (2017) used applied drama interventions as techniques for teaching physicians or nurses necessary job skills. The dramatic techniques used in Lundén et al. (2017) were chosen to stimulate memories and experiences that would be the subject matter in the group enactments intended to foster collaborative skill building. In this arts-based qualitative study, post graduate radiographers, nurses and nurse anesthetists (N = 22) participated in forum theater; a

theatre-based process whereby group members alternate in the role of protagonist in an improvised scene, playing out variations of story and action (Boal, 1995). In these workshops participants were asked to recall memories of a time in which they may have experienced conflict with a colleague. These stories were shared in small groups, then enacted with the protagonist reversing roles to help participants experience empathy for the imagined antagonist. Themes from the enactments and notes from the group reflections provided valuable information about dynamic barriers to professional collaboration. These findings relate to other common themes found in the body of literature related to staff burnout, such as inadequate supervision, moral distress related to observing medical errors or a colleague showing disrespect to patients, and lack of peer support. In the reflection phase of the study, participant responses pointed to key learning areas of self-reflection, bonding and teamwork, awareness and empathy, and fun and engagement, suggesting participants found the forum theater exercises useful in building collaborative skills.

Lim et al. (2011) also used drama as a way to build communication skills and develop empathy as a component of medical student education in Otago, New Zealand. Each year students complete standardized measures of empathy, as well as clinical and competency skills assessments. Scores from these standardized assessments were used as comparison scores for Students in the 5^{th} year psychological medicine module (N = 72) who participated as the experimental group. The previous year group scores were the control. In the study, the experimental group in the theatre-based program structure showed significant improvements in empathy scores following the drama education group ($p < 0.01$) as well as improved confidence in communicating with patients (p <

0.001). Though both of these studies offer creative solutions for using dramatic enactment for building clinical skills, they do not show any long-term effectiveness of the trainings.

Summary

While a lot is already known, there is yet more to learn on the subject of stress and burnout in healthcare. Based on the body of literature reviewed in this chapter, there are a variety of disciplinary perspectives on both cause and potential cure of burnout. The role of creative arts, and specifically drama therapy for the support of those working in healthcare is largely unknown. Programs such as the one described in Wei et al. (2020) offer inspiration for hospitals to continue evolving with the ever-changing needs of our nursing and clinical workforce. At the same time, the literature makes it clear that alleviating symptoms of burnout and striving for well-being can be amalgamated within every component of the health system. Plans for future research and innovative structural change will likely need to take place within clinical education, hospital systems, and the wider culture of medical care.

CHAPTER 3

Methods

Objectives and Study Aims

The purpose of this study was to measure outcomes from a drama therapy-based peer support educational initiative for nurse leaders, which included a workshop and optional follow-up coaching sessions. Measures of nurse leader burnout, well-being, and empathy took place at two time points to assess change: before and after participation in a drama therapy peer support workshop and subsequent optional coaching sessions. The aim of this study was to collect information that may help inform curricular and program development related to nurse leader well-being in a work-based context, and to guide future research questions.

Research Questions

1) Does the implementation of a drama therapy peer support initiative improve well-being, empathy, and burnout for nurse leaders?
2) What is the relationship between nurse leaders' empathy, burnout, and well-being before and after participating in a drama therapy peer support initiative?
3) What do nurse leaders describe as perceived barriers and facilitators associated with participation in the drama therapy peer support initiative?

The Intervention

The drama therapy nurse leader peer support initiative included a series of professional development engagements provided by the hospital's Arts Therapies and Well-Being Program; a creative arts therapist-led service that supports on-the-clock self-care opportunities for employees through arts-based recharge rooms and facilitated team-

based well-being education. The intervention associated with this research was offered at the request of the Chief Nursing Officer (CNO) as a professional development activity to support the well-being of nurse leaders at this site and would have been offered to nurse leaders regardless of any research activities. Participants who were scheduled to attend the drama therapy peer support workshop were informed of the option to participate in this research study prior to the start of the workshop.

Facilitators and Intervention Structure

Curriculum design and facilitation was provided by Laura L. Wood, PhD LMHC, LCAT, RDT-BCT, CCLS, in collaboration with the primary investigator, Chyela Rowe, MA, RDT/BCT. Dr. Wood is an Associate Professor at Lesley University and Coordinator of the Drama Therapy Program. She is a Licensed Mental Health Counselor, Registered Drama Therapist/Board Certified Trainer and trained in the Internal Family Systems Model. She has 14 years of clinical experience. Chyela Rowe is a Registered Drama Therapist/Board Certified Trainer, and manager of the arts therapies and well-being program at a regional hospital in the southeastern United States. She has over 20 years of experience facilitating drama therapy and expressive arts therapies in clinical and community settings. In the United States and Canada, drama therapy sessions are facilitated by credentialled master's or PhD mental health professionals who maintain practice standards and ethics through credentialing with the North American Drama Therapy Association, which defines the practice as follows:

> Drama therapy is an embodied practice that is active and experiential. This approach can provide the context for participants to tell their stories, set goals and solve problems, express feelings, or achieve catharsis. Through drama, the depth

> and breadth of inner experience can be actively explored, and interpersonal relationship skills can be enhanced (NADTA, 2022, paragraph 1).

The drama therapy nurse leader peer support initiative consisted of a one-day workshop, offered on three different dates, with the expectation that the nurse leaders would attend one of the three dates. Leaders were also invited to attend up to three optional follow-up coaching sessions on their own or in small groups of peers. The same information and concepts were presented at each workshop by the same co-facilitators, so leaders were only required to attend one of the all-day sessions. The following parameters were requested by the CNO:

- All nurse leaders were invited to participate in a compulsory 1-day drama therapy professional development workshop to practice self-care and peer-support skills for reducing burnout and implementing peer support within their teams.
- Workshops took place on Fridays to accommodate work schedules, and proposed dates avoided school breaks and holiday schedule disruptions.
- The workshops were facilitated in-person, and on-site in a large meeting room. Content of the workshop was protective of participant privacy by using evidence-based practice appropriate for the population to ensure minimal risk.
- Adjustments to the workshop schedule were made as needed due to leader changes, staffing issues, and other work-related priorities.
- Following attendance at a workshop, participants were invited to schedule up to 3 optional follow-up coaching sessions on their own or with other peer leaders in small groups. They were given options to attend virtually or in-person. Sessions took place within the 8 weeks following workshop attendance.

The primary component of the intervention was the 1-day drama therapy workshop. The workshop was a professional skill building intensive, intended to help nurse leaders practice social-emotional skills needed to promote and sustain well-being in their roles as leaders. Because the workshop was structured as an all-day engagement, the modules were built around a typical 7:30 am arrival to work for nurse leaders. Work hours may vary for nurse leaders, depending on roles and setting, but this workshop was designed to end at approximately 4:30 pm, representing an average workday for salaried employees who work a five-day work week. An hour-long lunch break and two shorter rest breaks were also built into the schedule.

A secondary component to the curriculum design was to offer follow-up coaching that would help participants ground concepts and have ongoing support for implementing new peer support strategies in their specific work context. Participants had the option to schedule up to 3 follow-up coaching sessions. The follow up sessions were offered as virtual or in-person options to receive skill coaching from one or both facilitators. Participants had up to 8-weeks to schedule and complete the three follow-up support sessions that could be 30-minutes or 1-hour each, depending on availability and schedules. Both workshop and coaching curricula used an iterative facilitation process that was reflexive and responsive to participant feedback, allowing facilitators to improve the quality of the program with each delivery. Content of the workshop and coaching sessions were protective of participant privacy by using evidence-based practice appropriate for the population to ensure minimal risk.

Curriculum Design and Theoretical Frameworks

The curriculum included components that draw on several andragogy, or adult learning theories, with particular emphasis on experiential, transformative, and social theories of learning (Mukhalalati & Taylor, 2019). The drama therapy framework provided an engaging, social learning process that took place across five modules (see Table 1). Each module took into consideration methods that allowed for both collaborative and individual learning, integration of ideas, and practice of concepts.

Drama therapy objectives were based on theories and research related to populations who received drama therapy for the treatment of stress or trauma (Ali et al., 2018; Frydman & McLellan, 2014; Sajnani & Johnson, 2014), depression and anxiety (Javidi et al., 2022; Versluys, 2017), and other psychological, emotional, and social issues that affect well-being (Dent-Brown & Wang, 2006; Melvin, 2021; Williams, 2017). However, without robust empirical evidence of drama therapy for the treatment of either burnout or other topics with nurses, the drama therapy curriculum drew on trauma-informed concepts and theories within drama therapy (Johnson, 2021; Jones, 2007; Sajnani & Johnson, 2014). The curriculum also used the psychotherapeutic paradigm of internal family systems (IFS) theory (Schwartz, 2021) as applied within drama therapy approaches (Wood, 2015) as the primary framework. Other elements referenced cognitive-based drama therapy used to address the impact of complex trauma on executive functioning (Frydman & McLellan, 2014), neural integration (Wood & Schneider, 2015), grief learning and processing (Jose, 2016; O'Connor & Seeley, 2022), mindfulness and self-compassion (Larkin, 2022), and application of drama therapy core

processes as conceptualized by Frydman et al. (2022) to guide the use of drama therapy methodologies within the theoretical frameworks.

Use of materials such as watercolor paints, modeling clay, oil pastels, markers, twisting wire, and writing journals, were provided to each participant to assist with story-making, projection of ideas, and for multi-sensory neural integration and processing options throughout the educational components. Google Slides were used to share concepts, definitions, and graphic representations of ideas as guideposts and reference material throughout the workshop. Participants used a paper sign-in sheet for facilitators to track attendance. Refreshments and lunches for all participants were catered and paid for by the primary investigator.

Workshop Content and Modules. Upon arrival at the workshop, participants were given 30 minutes to complete the optional survey, have coffee and pastries, and socialize with peers. The facilitation began with a welcome and facilitator introductions followed by basic drama therapy warm-up and activation exercises, such as an embodied spectrogram, where participants place themselves on an imaginary Likert-style line across the room. This technique centers the core drama therapy process of dramatic play, which Frydman et al. (2022) defined as, "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" (p. 8). Furthermore, dramatic play,

> "Allows the participant(s) and drama therapist(s) to explore aspects of reality (such as time, place, events, consequences, attitudes, actions, and held ideas). It creates an environment for cognitive, emotional, developmental, and interpersonal

> flexibility and generates new possibilities and empowerment without real-life consequences" (p. 8).

The spectrogram offered an active and experiential way of visualizing one's perspectives and experiences in relationship to other group members. This warm-up also helped facilitators assess participant familiarity with the concepts that would be presented throughout the workshop and observe group dynamics.

To facilitate individual engagement with internally held ideas of self as they relate to the social and emotional concepts of work stress and peer support, participants were given the opportunity to find an object in the room and introduce themselves through projective storytelling. A collection of basic medical supplies, such as bandages, alcohol swabs, gloves, hand sanitizer, and masks were used as props for the exercise. Directions were given to participants in this way: "For example, one might say, I am like an exam glove; I offer protection and can expand my capacity when needed," (facilitator example quote). This drama therapy technique of dramatic projection, facilitates engagement as it:

> "Achieves aesthetic distance away from or toward the dramatic material; externalizes inner experiences, dynamics, or other issues and creates dialogue between internal material and external expressions; the external expression and exploration of personal material helps participants to develop parts of self, insight, perspective, and behavioral change," (Frydman et al., 2022, p. 8).

Modules 1 and 2. In the first module, participants established community agreements, articulated expectations, and discussed concepts such as safe-enough (Rousseau et al., 2022), and the interaction was primarily a discussion-based format with group agreements such as keeping discussion content confidential, or being open and

respectful of differences, being written on easel pad paper for everyone to use as a visual reference throughout the workshop. Education also included learning related to concepts of perfectionism, boundaries, vulnerability, emotional regulation, and how they relate to leadership.

The second module provided psychoeducation to orient participants to the value of recognizing social-emotional concepts and how they might be observed in a work context. The drama therapy concepts of embodiment and active witnessing were introduced in preparation for peer-to-peer conversations and sharing. To assist leaders with the titration of emotion and cognition in an embodied exercise, they were asked to use sticky notes to write what they were grieving in relationship to work changes and events throughout the pandemic, and then walk to the front of the room and place the notes on a designate page of easel paper that had, "what are we grieving?" written at the top of the page. When they finished, they were given time to attend to sensations and engage with the heightened experience as they used reflective journaling, art materials, and peer conversations to integrate their experience of contemplating grief and embodying the act collectively. The materials that were created were used to help participants practice sharing stories about feelings, work struggles, and other topics that might arise in a peer support encounter through embodied storytelling.

Modules 3 and 4. In the third and fourth modules, participants were introduced to basic concepts of Internal Family Systems (IFS) theory (Schwartz, 2021); a trauma-informed psychotherapeutic approach that was developed with the Gestalt (Perls, 1951), or perhaps more accurately, psychodrama concepts of "empty chair" in mind (Moreno, 1946; Moreno & Jennings, 1934). This framework encouraged participants to imagine

conversations with parts of themselves within roles of a hurt “exile” or the protective “manager” and “firefighter” parts that serve to guard the hurting “exile.” With an objective to develop empathetic self-compassion (Larkin, 2022), while also exercising executive functioning skills through theory of mind and inhibitory processing (Frydman & McLellan, 2014), participants engaged in activating their imaginations, enrolling as, and narration of, parts of self. This framework aligned well with drama therapy core concepts and techniques that use engagement with dramatic reality, such as occurs with empty chair or role play exercises. The IFS concepts were presented as an example model for developing self-compassion and self-leadership perspectives, both involve the practice of self-awareness and cognitive empathy skills. This lesson also helped make the connection between self-care and peer support more concrete.

Participants were presented with concepts of neural integration for the purposes of mapping connections between thoughts and feelings throughout the drama therapy exercises (Wood & Schneider, 2015) and then were guided through exercises that used embodiment through a mindfulness-based body scan, dramatic projection by developing a parts map, and distancing through creating a story illustration with art materials or sculpting. Distancing is understood as a drama therapy core process that, “Allows the participant(s) to move between feeling and thinking, helping participant(s) to fully feel, express, and tolerate emotions and/or expand perspective, awareness, and capacity for self-regulation” (Frydman et al., 2022, p. 8). Sculpting is a common drama therapy technique that facilitates the titration of emotion and cognition by imagining an emotional scenario and then staging the tableau by showing it through held postures or poses (Emunah, 2020). Sculpting can involve other group members which helps show complex

ideas and feelings through group sculpting. This technique offered participants opportunities to engage with their emotional experience of the subject matter while choosing their level of distance from the emotions. Participants were invited to share their insights with another group member while practicing active witnessing approaches. These drama therapy processes supported the grounding of IFS concepts and rehearsal for peer support conversations. The modules facilitated engagement with empathy skills and worked to strengthen team dynamics.

Module 5 and Wrap Up. In the fifth module, participants learned concepts of habits, routines, and rituals (Le Cunff, 2022) and were guided to develop a micro-habit plan towards making incremental changes. This plan was intended to give participants tools for putting learned skills into practice outside of the workshop. An example for how to develop a micro-habit was presented in this way: to set a goal, such as "increase my creative thinking to help with reducing stress when problems arise," a micro habit to help reach that goal might be to create a scribble story (Wood & Pignatelli, 2019) each day for two weeks and spend a few minutes journaling about what thoughts and ideas arise from the exercise. At the end of the workshop, participants spent time developing micro-habits and making visual representations of the day's learning through embodiment, such as sculpting, through projection with art materials, or through active witnessing and narrative sharing. The participants worked in pairs or small groups to summarize learning. At the end of the workshop, participants who wanted to, were invited to shared artwork or feedback related to their experience. A slide was put on the screen with a QR code to a google form for participants to request follow-up coaching.

Table 1

Drama Therapy Peer Support Workshop Outline

Time	Topic	Objective/Content/Subject	Learning Experience / Method	Evaluation
30 m	IRB Approved Study Survey / Welcome	- Facilitate study participation - Welcome participants into a relaxing environment	- QR code for accessing surveys - Coffee/snacks/pastries - Socialize - Prepare for workshop	Attendance sign-in; Survey; Observe dynamics
30 m	Intro & Assessment	- Orient to approach, objectives - Use imagination to explore aspects of reality with cognitive/emotional flexibility - Foster group awareness - Assess understanding of workshop topics/module concepts - Externalize inner experience; create self-dialog; insight and perspective of self	- Welcome; Facilitator introductions - SPECTROGRAM: using **dramatic play** to assess the familiarity to module topics by using **embodiment** in Likert-style scale response - PROJECTIVE STORY: find an object; introduce self as object – **dramatic projection**	Active participation in workshop activities; Reflecting individual experience
30 m	**Module 1:** Self-grounding and cohort strengthening	- Establish confidentiality and group-process agreements to maintain a safe-enough environment for social-emotional processing and skill building - Review goals of the program - Assess values; vision for peer support and well-being at work - Define, discuss in relationship to leader roles: perfectionism, boundaries, vulnerability, emotional regulation, rupture/ repair	- Discuss concepts, list agreements, goals, as a visual reference - Orient participants to journal, art materials for use throughout the workshop - Psychoeducation - Draw connections to how these concepts interact with their sense of self at work.	Acknowledge community agreement for confidentiality; Active participation in Module 1 discussion
1 h	**Module 2:** Psychoedu-cation	- Tie social-emotional concepts to leadership, well-being - Model brief embodied exercise for engaging with emotional topic as a team/group - Practice titration of emotion and cognition; empathy	--Identify blocks in these domains in relationship to leadership. - Collective grief – **embodiment** and **distancing** exercise with sticky notes - **Active witnessing**, reflective journaling, peer conversations	Active participation in Module 2 exercises and expression of connection to concepts
15 m			**SHORT BREAK**	
1.5 h	**Module 3:** Identification of emotions and creating a self-led relation-ship	- Discuss Internal Family System paradigm (IFS) “manager,” “exile,” and “firefighter”; relate to stress responses - Integrate concepts of self-led energy; Engage with emotions related to experiences at work; practice regulation skills	- **Engagement in dramatic reality** in a guided “body scan” mindfulness exercise - **Distancing**: use visual art materials to create a “parts of self” map - **Dramatic projection**: role play or enact parts of self with a peer	Articulating the ways parts of self can connect, describing the nature of the journey
1 h			**LUNCH (provided)**	

1.5 h	**Module 4:** Listening and resiliency training	- Practice attending to emotional and cognitive processes through self-compassion - Develop constructive skills for framing social-emotional experiences related to work - Plan customized strategies for personal resilience support systems	- Practice **active witnessing** and listening exercises in relationship to parts of self - Use a narrative-based approach to **dramatic play** to re-story an issue at the hospital - **Projection:** work with peers to develop a compassion wheel - Use visual art materials to build a personal resilience toolkit	Noticing how active witnessing integrates self-compassion and care for others; Developing tools for future use
15 m			**SHORT BREAK**	
1 h	**Module 5:** In action	- Review skills; practice plans - Understand the difference between habits, routines, and rituals and how those behaviors connect to developing new skills for peer support and well-being - Set goals for implementing peer support - Establish rationale for follow-up coaching sessions	- Work in small groups to present the concepts learned in earlier modules using **embodiment** and **dramatic play** to summarize learning. - Groups will work together to set goals and identify micro-habits to work on prior to coaching sessions.	Concepts will be presented and reflected in dramatic forms Articulation of goals will be documented and shared
30 m	Wrap-up: Questions, scheduling	- Address remaining issues; clarification; schedule follow-up to participate in small-group coaching sessions	Participants who wish to stay will have the opportunity to ask questions and schedule coaching sessions with facilitators.	Optional coaching sessions scheduled
			WORKSHOP END/HOME	

Follow-Up Coaching Sessions. The second part of the peer support program took place in the eight weeks following participation in a workshop and was optional for all participants. Following participation in one of the workshops, participants were invited to schedule alone, select a peer, or small group of peers to connect with for ongoing peer support. With the brief under one hour format, the coaching session methods used simple drama therapy techniques such as role play and narrative approaches. The coaching sessions were adaptable and customized for the needs of each participant.

Table 2

Follow-Up Coaching Session Outline

Time	Objective	Content/Subject Matter	Learning Experience / Method
30m – 1h	Customizing Learning: Coaching Session #1	- To foster integration of learning from workshop. - To address habits that limit peer support encounters. - To implement helpful peer support routines.	- Participants will **engage with dramatic reality** and use **distancing** and **dramatic projection** processes to work with a partner or small group of peers. - Participants will use material from the dramas to outline a customized plan.
30m – 1h	Integrating Through Practice: Coaching Session #2	- To facilitate perspective and new understanding about peer support. - To integrate principles of peer support into team culture.	- Participants will share experiences from peer support encounters and practice **active witnessing**. - Participants will discuss what works and does not work and adjust the peer support plan as necessary.
30m – 1h	Sustaining Through Accountability: Coaching Session #3	- To present outcomes of peer support activities. - To develop plans for scaling the peer support program to their teams	- Participants will use **embodiment** and **dramatic play** as storytelling related to peer support activities

Study Procedures

Inclusion Criteria

Study participants were limited to leaders who support nursing operations within a mid-sized regional hospital system in the Southeastern United States. All participants were employees of the health system and attended a drama therapy peer-support 1- day workshop as a professional development activity. Those who met the inclusion criteria were invited to participate voluntarily in the research surveys associated with the peer support program.

Exclusion Criteria

Employees who stepped down from their leadership role or who were no longer an employee of the hospital system were not invited to participate in the research or associated activities. Invited leaders who did not attend a workshop were not included in

the research. Survey responses that were missing data for required questions were excluded from the study.

Recruitment

Upon approvals from the Lesley University IRB Number: 21/22-055 and CommonSpirit IRBNet Number 1904497-2 (see Appendix A) to conduct exempt, minimal-risk data research, a list of nursing leaders was assembled by the system's chief nursing officer (CNO) for recruitment. Invited participants were scheduled to attend one all-day peer-support workshop. Due to ongoing staffing shortages, there were some members invited who were performing supervisory or leadership tasks but did not hold the title of director or manager, which was a requirement in the originally approved protocol. Changes to the protocol were made to include all invited members to be able to participate in the research and the corresponding amendment approvals were granted by both IRB's (see Appendix A).

One week prior to the start of each workshop, attendees were sent a recruitment email and follow up reminders (see Appendix B), notifying them of the option to participate in the research pre- survey. Recruitment emails, including instructions for how to communicate questions about the study, were sent to nurse leaders using hospital employee email. Pre- survey links were also included in the calendar invitation, and via QR code in the presentation slides upon arrival at the workshop. Post-program survey links were sent via email and text-message to workshop attendees approximately 8 weeks following workshop participation (see Appendix C).

No identifiable data was collected on the research surveys. Participants created a unique participant ID code as part of the survey to link pre- and post- survey results and

to maintain anonymity of the data. Qualtrics software was used for the surveys through the principal investigator's confidential and secure university affiliated account and sent via employer email. Participants were given approximately one week to complete surveys prior to the start of the peer support workshop, and one week to complete post-surveys following the end of the optional coaching program. With each administration of the surveys, follow-up reminder emails were sent after 4 days, and again 1-day prior to the deadline (see Appendices B and C).

Enrollment

For those who were willing to participate in the research surveys, the pre- and post- survey landing pages included necessary information about the research project scope, purpose, risks, benefits, and resources. Participants were required to check a box indicating agreement to participate in order to access, view, or respond to survey questions (See Appendix D). By clicking on the survey link, checking the agreement box at the start of the survey, and completing the pre-program survey, participants agreed to be included in the study.

Research Protocol

This study used a mixed-methods design, including pre- and post- survey measures to assess participant change in burnout, empathy, and well-being, and open-ended qualitative questions related to participant experiences, barriers, and facilitators related to well-being and peer-support education (see Table 1 for survey questions). The time points for distributing the surveys were before and after participation in a drama therapy nurse leader peer support program. The research study used pre- and post-intervention standardized assessments for five outcome variables to measure whether

there was significant change between time point one and time point two. Thematic analysis (TA) was used to analyze qualitative responses. Facilitator field notes were collected to document in-session responses to the intervention for the purposes of maintaining a reflexive curriculum design, and informing iterative changes needed to maintain the quality of the workshop. Field notes from both facilitators were combined and used as a reference point throughout the data analysis process to help triangulate and validate interpretation of qualitative results. No identifying information was collected or recorded in field notes. Information detailed in Table 1 was collected in the surveys as part of the research study.

Measures

Demographics. To accurately describe the sample, surveys included questions to assess participant demographics. Open field questions where participants were asked to enter a number included age, years as registered nurse, and years in current position. Multiple choice questions which included open field options were provided for gender and race. Level of nursing education was multiple choice, and member of a professional nursing association had yes or no options. See Table 3 for the complete list of questions and answer options.

Burnout. Burnout is a syndrome that is defined as the psychological response to one's daily work environment, particularly when interpersonal intensity is involved and there is an imbalance of demands with available coping resources (Maslach et al., 2018, p. 16). For the purposes of this study, the original version multi-factor Maslach Burnout Inventory Human Services Survey (MBI-HSS) was used, as it was the most appropriate version of the MBI for the sample population. The three psychometric scales within the

MBI measure emotional exhaustion (EE), depersonalization (DP), and lack of personal accomplishment (PA).

Scores are calculated separately for each of these three scales and are not combined to form a single "burnout" score. EE is a 9-item scale that assesses the feeling of being emotionally overextended by work. Higher EE scores correspond with burnout. DP is a 5-item scale that measures responses that are unfeeling and impersonal towards those who are receiving care. Higher DP scores correspond with burnout. PA is an 8-item scale that assesses whether a person feels successful achievement and competence related to their work. Lower PA scores correspond with burnout. The EE and DP scales are distinct but correlated. PA is more closely related to control-oriented coping, and more broadly, EE and DP aspects of burnout are associated with role ambiguity, role conflict, and workload being too heavy.

The psychometric properties have been found to be correlated with depression, but loosely enough to confirm burnout as a distinct phenomenon related to work, whereas depression may be a contributing factor associated with non-work issues (Trigo et al., 2018). The MBI-HSS is a valid and reliable measure of burnout syndrome. Test-retest reliability shows the MBI-HSS has a high degree of stability from a period of one month to a year. Internal reliability is reported as adequate, α = .90 for EE, α = .79 for DP, and α = .71 for PA (Maslach et al., 2018). To administer the MBI for the purposes of this study, an individually prepared manual was purchased by the primary investigator along with a remote online survey license to administer up to 100 surveys (see Appendix E).

Empathy. To measure empathy, an important component of social cognition, the Toronto Empathy Questionnaire (TEQ) was used (Spreng et al., 2009). The TEQ is a 16-

item self-report measure of emotional and cognitive empathy with a robust single factor structure, high internal consistency, construct validity and test-retest reliability (see Table 1 for TEQ questions). Items are scored between 0-4 for response of never, rarely, sometimes, often, and always for 8 positively worded items, and 8 negatively worded items are reverse scored. Average empathy is rated as 45 out of a total possible of 65. The TEQ differs from other measures related to poor interpersonal and social responding, or affective aspects of empathy which are used to screen for autism by combining multiple factors of cognitive, affective, and social empathy from other measures into one unidimensional factor (Allison et al., 2011). The TEQ was initially validated across three separate studies by Spreng et al. (2009) by testing the construct validity of the TEQ in relationship to other self-report measures of interpersonal sensitivity such as the Empathy Quotient (Baron-Cohen & Wheelwright, 2004) and the Autism Quotient (Baron-Cohen et al., 2001). The TEQ correlated positively with the Empathy Quotient, $r = .80$, $p < .001$, and negatively with the Autism Quotient, $r = -.33$, $p < .01$. Test-retest reliability was high, $r = .81$, $p < .001$, and internal consistency was good, $\alpha = .87$. The TEQ is a reliable measure of both emotional and cognitive skills associated with perspective taking and altruism. More specifically, TEQ measures the degree to which respondents have a skill to assess the emotions or mental state of another person based on visual, auditory, or other sensory cues.

Well-Being. The World Health Organization has identified subjective well-being as an important aspect of overall health and quality of life. The WHO-5 Well-Being Index is a psychometrically sound brief self-report measure of subjective well-being and can also be reliably useful as a screening tool for the presence of depression. However,

manifest norms reported in Topp et al., (2015) that were used in this study should be regarded with caution. According to a recent international validation study, Sischka et al., (2020), statistical analysis confirms the usefulness of the WHO-5 for screening depression but suggest more reliability studies using a graded response model (GRM) are needed to validate cutoff points for depression and clinical depression within the WHO-5. The five items on the WHO-5 Well-Being Index can be found on Table 3.

Qualitative Open-Ended Questions. The pre- and post- surveys included three open-field questions each for participants to give qualitative feedback related to their perspectives and experiences. The three pre- survey questions were, 1. What skills do you think will help nurse leaders be able to show support to their peers? 2. What barriers limit your ability to offer support to your peers at work? 3. What do you hope to gain from participating in the drama therapy nurse leader peer support program? The three post-survey questions were, 1. What was your overall impression of the drama therapy nurse leader peer support program? 2. What did you find most beneficial about the workshop and follow-up coaching sessions? 3. What suggestions do you have to improve future well-being support programs for nurse leaders?

Data Collection and Procedures

Data Collection took place via electronic surveys. All nurse leaders were provided a link to the optional survey where participants were required to check a box indicating agreement to the informed consent in order to access, view, or respond to survey questions. Pre-program survey links were also available via QR code for accessing the survey on a mobile device upon arrival at the workshop.

Participants created an unidentifiable participant ID code as part of the survey to link pre- and post- survey results. To fully protect research participant anonymity, post-program survey links were sent via email to all nurse leader workshop participants approximately 8 weeks following workshop participation. Post- survey quantitative results that did not have a correlating pre-survey were excluded. No identifiable data was collected. Qualtrics software was used for the surveys through the principal investigator's confidential and secure university affiliated account and sent via employer email to participants.

Participants were given approximately one week to complete surveys prior to the start of the peer support program, and one week to complete surveys at the end of the program. With each administration of the surveys, follow-up reminder emails were sent after 4 days, and again 1-day prior to the deadline. Survey responses were only accessed by the principal investigator using password protected accounts and storing downloaded data on password protected computers. The data was kept in a secure Google drive folder on the hospital organizational network. No identifiable data was transmitted or stored on personal computers. The principal investigator is responsible for the storage of data, will retain for 5 years after the closure of the study, and then data files will be deleted or destroyed.

Table 3

Survey Data

MEASURE	DATA AND QUESTIONS
Identification Code	Click in the boxes to type your answers. Please remember the three responses: What city, town, or country would you most like to visit? What is your favorite snack? What is your favorite number?
Demographics	**How would you describe yourself? Please enter your responses in the open fields or select an option.**
What is your age?	Continuous variable
How do you identify by gender?	● Cisgender female or woman ● Cisgender male or man ● Non-binary, genderqueer, gender fluid ● Prefer not to say ● Prefer to self-describe [with open text] ● Transgender [with open text]
How do you identify by race? (Select all that apply)	● American Indian or Alaska Native ● Asian or Asian American ● Bi-racial or Multiracial ● Black or African American ● Native Hawaiian or other Pacific Islander ● Prefer not to say ● Prefer to self-describe [with open text] ● Some other race, ethnicity, or origin [with open text] ● White or European American
How do you identify by ethnicity?	Open text
What is your highest level of nursing education?	Diploma; associate; bachelor's; maser's; doctoral
How many years have you been a registered nurse?	Continuous variable
How many years have you been in your current position?	Continuous variable
Are you a member of a professional nursing association?	Yes; No
Maslach Burnout Inventory	**Below there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have had this feeling, indicate how often (Never; A few times a year or less; Once a month or less; A few times a month; Once a week; A few times a week; Every day).**
Sample Questions:	1. I feel emotionally drained from my work. 2. I have accomplished many worthwhile things in this job. 3. I don't really care what happens to some recipients. Copyright ©1981 Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com
WHO-5 Wellbeing Index	**Please indicate for each of the 5 statements which is closest to how you have been feeling over the past 2 weeks: 0 = at no time; 1 = some of the time; 2 = less than half of the time; 3 = more than half of the time; 4 = most of the time; 5 = all of the time**
	1. I have felt cheerful and in good spirits. 2. I have felt calm and relaxed. 3. I have felt active and vigorous. 4. I wake up feeling fresh and rested. 5. My daily life has been filled with things that interest me.

Toronto Empathy Questionnaire (TEQ)		**Rate how frequently you feel or act in the manner described (Never; Rarely; Sometimes; Often; Always)**
		1. When someone else is feeling excited, I tend to get excited too. 2. Other people's misfortunes do not disturb me a great deal. 3. It upsets me to see someone being treated disrespectfully. 4. I remain unaffected when someone close to me is happy. 5. I enjoy making other people feel better. 6. I have tender, concerned feelings for people less fortunate than me
His/her pronoun removed		7. When a friend starts to talk about their problems, I try to steer the conversation towards something else. 8. I can tell when others are sad even when they do not say anything. 9. I find that I am "in tune" with other people's moods. 10. I do not feel sympathy for people who cause their own serious illnesses. 11. I become irritated when someone cries. 12. I am not really interested in how other people feel. 13. I get a strong urge to help when I see someone who is upset. 14. When I see someone being treated unfairly, I do not feel very much pity for them. 15. I find it silly for people to cry out of happiness.
Him/her pronoun removed		16. When I see someone being taken advantage of, I feel kind of protective towards them.
Open-ended questions (pre-).	1	What skills do you think will help nurse leaders be able to show support to their peers?
	2	What barriers limit your ability to offer support to your peers at work?
	3	What do you hope to gain from participating in the drama therapy nurse leader peer support program?
Open-ended questions (post-).	1	What was your overall impression of the drama therapy nurse leader peer support program?
	2	What did you find most beneficial about the workshop and follow-up coaching sessions?
	3	What suggestions do you have to improve future well-being support programs for nurse leaders?

Data Analysis and Statistical Considerations

Survey data was downloaded from Qualtrics into a google spreadsheet and organized into multiple views on separate tabs to prepare data for analysis. Raw data was checked for missing or incomplete data. IBM SPSS Statistics Grad Pack Version 28.0 for Mac was used for statistical analysis. Descriptive statistics was used to assess the group demographics and to compare the differences between pre- and post- measures. Differences in means was compared for each outcome variable using the Related-

Samples Wilcoxon Signed Rank Test and independent samples t-tests to measure whether there was significant change between time point 1 and time point 2.

Due to the conciseness of survey-based qualitative responses, a pragmatic philosophical approach was taken in the qualitative analysis. Drawing from theories of social constructionism – or the social creation of identity, along with critical and feminist theories that recognize dynamics of power and influence within qualitative research (Spencer et al., 2014), qualitative responses were organized in tables in a Word document and thematic analysis (TA) (Braun & Clarke, 2022; Clarke & Braun, 2018), was used for qualitative responses (see Appendix F for qualitative data coding tables).

Field notes were kept by co-facilitators through the entirety of the research project to track barriers and facilitators related to the intervention, and to help maintain the quality of facilitation and curriculum components as part of an iterative design. Field notes comprised of hand-written researcher and co-facilitator thoughts related to scheduling, recruitment, and participation and engagement with concepts. Field notes did not include any participant identifying information, nor did they include context, such as the location or time, that might interfere with the privacy of participants. Notes were written in notebooks or note pads and shared between facilitators verbally throughout and after each workshop, and later in summary via Microsoft Teams chat. Field notes were combined on a table in a Word document and coded to identify common themes. TA was used to synthesize insights from field notes. Results from this study will be used to inform future research questions related to the use of drama therapy in nurse leader peer support programs, as well as to inform program and curriculum development related to nurse leader well-being in a work-based context.

CHAPTER 4

Results

Study participants were nurse leaders who work at a mid-sized regional hospital system, including three hospitals and multiple clinics with over 4,400 employees and 600 affiliated physicians. Within this system, nurse leaders have responsibilities in roles such as administrators, directors, clinical managers, and in a variety of operational support areas such as informatics, quality improvement, human resources, and case management. The hospital system chief nursing officer (CNO) identified 60 nurse leaders to attend the peer support workshop. The leaders were serving in roles such as executives, directors, managers, and coordinators.

Four dates were identified in September and October 2022 and nurse leaders were asked to choose one of the proposed dates to attend an all-day workshop. Prior to the start of the study and throughout the workshop scheduling time frame, six invitees stepped down from leadership roles, and six more either resigned or their positions were eliminated. There were additional significant barriers that limited attendance; most significantly, both October workshops were cancelled due to factors associated with a system-wide ransomware cyber-attack (CommonSpirit Health, 2022). That incident impacted operations from October – November 2022, requiring all employees to cancel non-essential meetings to support downtime procedures: a series of protocols for supporting operations when the electronic health record is not available (Mckeon, 2022). Efforts to re-schedule a peer support workshop in December resulted in last-minute cancellations from all participants. As such, rescheduling was complicated due to time off conflicts, holidays, and other organizational leadership events in January. The third

workshop was scheduled in February 2023. Though the peer support training was promoted as a required professional development activity, 12 leaders had ongoing schedule conflicts and staffing issues that made attending an all-day workshop impossible.

Quantitative Results

There were 28 nurse leaders who attended one of two workshops in September 2022, and eight who attended five months later in February 2023 for a total of 36 workshop attendees. After three workshops were complete, there were a total of 39 pre-survey responses. The surveys were anonymous and could be accessed via either a link sent by email or by QR code displayed on the morning of each workshop. As such, the surveys may have been accessed more than once by the same participant or by participants who were unable to attend at the last minute, which would account for response numbers greater than the number of workshop attendees. Of the 39 responses, seven were excluded from analysis for the following reasons: three respondents chose to decline participation after reading the informed consent page, and four agreed to participate and gave answers to demographic questions but left no responses to required measures.

Participant Demographics

Responses included in the analysis (N = 32) represented 89% of those who were scheduled to attend a workshop. The median age of participants was 52, and the group was largely female (91%), and White (88%). There were no meaningful data from answers to the participant ethnicity question, with 72% of participants leaving the question blank and 25% gave responses that were the same or like White identifying race

demographic answers, therefore ethnicity was excluded from analysis. Most (66%) reported their highest level of nursing education was a bachelor's degree, and 78% had been a registered nurse between 10 – 42 years. However, a large proportion (66%) of participants were newly (≤ 3 years) in their current position, representing a magnitude of staffing changes since the onset of the pandemic. See Table 4 for complete demographic results.

Table 4

Survey Participant Demographics (*N* = 32)

Characteristic	*n*	%
Age		
50 – 63	17	53
26 – 49	15	47
Gender		
Female or Woman	29	91
Male or Man	2	6
Prefer not to say	1	3
Race		
White or European American	28	88
Black or African American	2	6
Asian or Asian American	1	3
Prefer to self-describe: *Heinz 57*	1	3
Highest Level of Nursing Education		
Bachelor's	21	66
Master's	9	28
Doctorate	1	3
Associate's	1	3
Years as Registered Nurse		
22-42 years	15	47
10-18 years	10	31
3-8 years	4	13

Left blank	3	9
Years in Current Position		
<1 year – 3 years	21	66
4-9 years	5	16
14-30 years	6	19
Member of a Professional Nursing Association		
No	17	53
Yes	15	47

Survey Measures

Study participants responded to the MBI-HSS, TEQ, and the WHO5. Within the study participant group, the MBI-HSS pre- survey scores were higher than standardized averages for EE, and DP, and lower than average for PA. The group's WHO-5 score showed a moderate well-being average, slightly above the cutoff score of ≤ 50 but the low range of study participant scores showed a presence of depression and clinical depression among group members. Table 5 shows baseline group mean scores on burnout, well-being, and empathy measures as compared to standardized averages.

Table 5

Standardized Averages Compared to Study Group Pre- Survey Mean Scores

Scale	Standardized Groups*			Pre-Survey (*N* = 32)		
MBI-HSS:	*M*	*SD*	*Range*	*M*	*SD*	*Range*
EE	21.42	11.50	32.92 – 9.92	24.3	10.87	44.00 – 5.00
DP	8.11	6.15	14.26 – 1.96	8.2	5.13	19.00 – 0.00
PA	36.43	7.00	43.43 – 29.43	33.63	6.11	48.00 – 22.00
TEQ	44.54	7.70	52.24 – 36.84	51.66	5.70	60.00 – 37.00
WHO-5: Depression ≤ 50. Clinical Depression ≤ 28.				54.88	20.68	88.00 – 16.00

**Note:* Standardized group data from Krieger et al., 2014; Lara-Cabrera et al., 2022; Maslach et al., 2018; Topp et al., 2015; Spreng et al., 2009.

Relationship Between Measures of Burnout, Wellbeing, and Empathy

To assess the relationship between measure results, a two-tailed bivariate correlation analysis was conducted using SPSS analysis software. The participant group characteristics in terms of race and gender were largely homogeneous, with fewer than 5 participants who did not identify as White and Female. Therefore, to protect the unintentional identification of participant response data, correlation analysis was not conducted using those demographic categories. The remaining participant demographics were analyzed for relationships and there was a significant positive correlation between age and years as an RN (r = .602; p = < .001), and education level and PA (r = .372; p = < .05) but overall, the demographics were not significantly correlated with the measures of burnout, wellbeing, and empathy.

All five scales showed strong correlative relationships on pre-survey measures. The strongest positive relationships, significant at the p = < .001 level, were between EE and DP, and between Well-Being and PA. Likewise, the strongest negative correlations at the p = < .001 level were between Well-Being and EE, Wellbeing and DP, and empathy and DP. The subscale negative correlations between PA and EE and PA and DP were significant at the < .01 level. The empathy scores were not significantly correlated with the wellbeing scores (p = .302), but empathy did show significant negative correlation at the < .05 level, with EE (r = -.424), and a positive correlation with PA (r = .441). Table 6 shows the strength of correlations among pre- survey results on all five scales.

Table 6

Pre- Survey Two Tailed Bivariate Correlations Between Study Measures (*N* = 32)

Variable	1	2	3	4	5
	r	*r*	*r*	*r*	
1. MBI-EE: Emotional Exhaustion	—				
2. MBI-DP: Depersonalization	.694***	—			
3. MBI-PA: Personal Accomplishment	-.465**	-.473**	—		
4. WHO-5: Wellbeing	-.666***	-.614***	.635***	—	
5. TEQ: Empathy	-.424*	-.589***	.441*	.302	—

*$p < .05$. ** $p < .01$. *** $p < .001$.

Pre-Post Analysis

Participation in the post- survey was limited. There was a total of eight responses to the post- survey. One respondent had not completed the pre-survey, so the measure data were excluded from this analysis. A total of seven responses that linked to pre-survey participants were included. Table 7 shows descriptive data for the linked sample results.

Table 7

Related-Samples Change in Group Means Between Pre- and Post- Measures

Scale	Pre-Survey (*N* = 7)			Post-Survey (*N* = 7)			Change		
MBI-HSS:	*M*	*SD*	*Range*	*M*	*SD*	*Range*	*M*	*SD*	*%*
EE	28.86	10.01	44 - 15	25.86	10.96	41 - 11	-3.00	6.4	-10.40
DP	8.14	5.27	19 - 3	9.71	7.23	20 - 0	1.57	3.99	19.29
PA	35.14	5.46	42 - 28	36.00	6.00	44 - 27	0.86	7.11	2.45
TEQ	51	7.92	58 - 37	51.14	5.98	62 - 45	0.14	7.95	0.28
WHO-5	64	17.74	88 - 40	65.14	20.88	96 - 40	1.14	23.29	1.78

The directional change between pre- and post- measures could be observed, showing a slight increase in wellbeing, empathy, and personal accomplishment (see Table 7). As noted, there was a decrease in emotional exhaustion (-10.4%) but the group average DP scores actually increased from the pre- survey to the post- measure (19.29%). However, due to the small sample of linked pre- and post- survey results (n = 7) the pre-post- analysis was underpowered, and no significance was found. Table 8 shows small effect sizes for all five scales using Hedge's g for which the rule of thumb is that .2 is considered small, .5 medium, and .8 large.

Table 8

Related-Samples Wilcoxon Signed Rank Test (N = 7)

Paired Groups	Test Statistic	*SE*	*t*	One-Sided p^{ab}	*g*
EE Pre - Post	7.500	5.906	-1.101	.131	0.29
DP Pre - Post	19.500	5.906	.931	.169	0.25
PA Pre - Post	13.500	5.884	-.085	.380	0.15
TEQ Pre - Post	13.500	5.906	-.085	.482	0.02
WHO5 Pre - Post	11.000	4.743	.105	.450	0.06

a.Significance level is .05
b.Asymptotic significance is displayed

While these results appear somewhat equivocal, comparison to the qualitative responses and facilitator field notes provided further context and insights related to the participant's perceived experience of DP at the point in time when the post-survey responses were collected.

Qualitative Results

Survey participants were offered opportunities to give qualitative feedback in response to three open-ended questions on the pre-workshop survey and three different questions on the post-survey eight weeks later. Responses to the questions were mostly one-word or short phrase answers, apart from a few short paragraph responses. Qualitative responses helped to contextualize participant experiences related to the workshop, as well as the topics of peer support, well-being, and self-care. In the pre-survey, there were 23 responses to question one, 28 responses to question two, and 24 responses to question three. There were qualitative responses from seven post-survey participants.

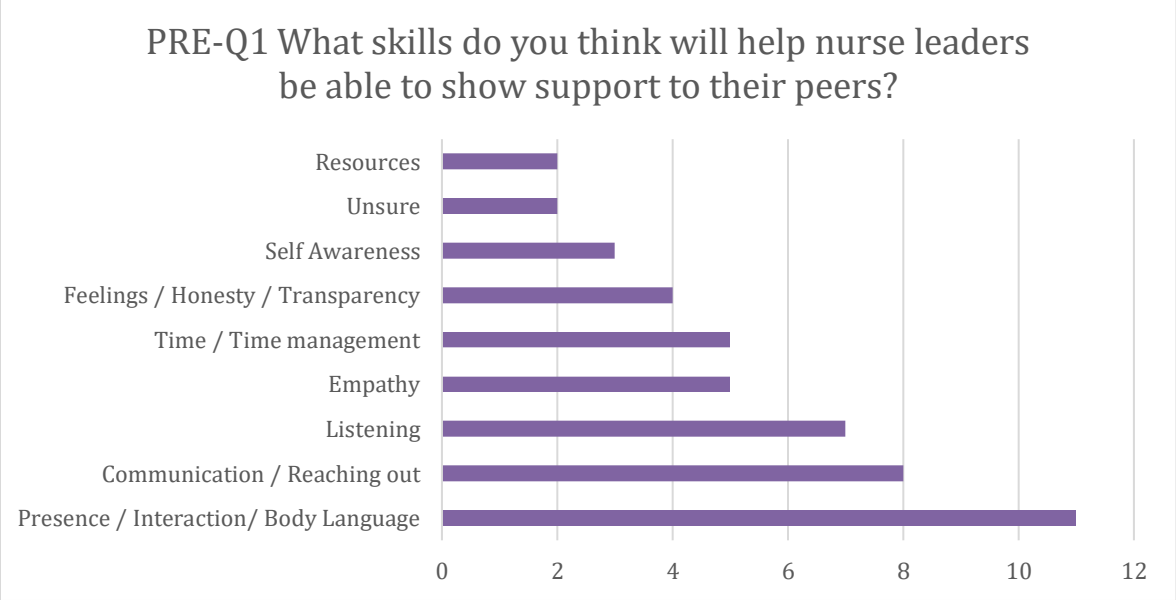
Qualitative Analysis Procedures

Qualitative responses were listed in separate tables for each question. Each response was coded with words or phrases that represented the general ideas (see Appendix F), or in vivo coding, in the case of one-word answers. With the addition of each code, a new column was created next to the list of responses. A number "1" was used to mark the presence of each code on the corresponding row for each response. After coding was complete for each response, the codes were grouped into themes or somewhat distinct ideas related to the research questions. These themes were then considered and adjusted again within the context of facilitator field notes. This reconsideration of themes against field notes provided reflexive analysis within phenomenological and critical theoretical perspectives to further assist with the thematic analysis. Total occurrences were tallied at the end of each theme column to show the weight of themes among participant responses.

Themes in Pre- Survey Question 1

The first question on the post- survey was, what skills do you think will help nurse leaders be able to show support to their peers? There were nine distinct themes that emerged from these responses and the most prevalent ones were: *Presence/Interaction/Body Language (11), Communication/Reaching out (8), Listening (7), Empathy (5), Time/Time Management (5), Feelings/Honesty/Transparency (4)*. The least frequent were the codes, *Unsure (2),* and *Resources (2)*. For the theme related to resources, one participant specified "awareness of resources," suggesting that support resources exist but awareness of those resources is a leader skill that can be cultivated. Another infrequent theme of *Self-awareness (3),* was present with one response being the phrase on its own and the other two stating, "how to not feel rushed," and "learn to listen and be present in the moment." See Figure 1 for a visualization of the occurrences of themes associated with question one.

Figure 1



The relationship between the most frequent themes was summarized in one response that connected presence, communication, listening, empathy, and time as a set of skills that are helpful in peer support:

> Time management. The more time you have to sit and talk with peers, the more you can be there for them and help. You may have pressing matters to take care of but being able to take time and actually listen and hear how others are feeling can benefit peers personally and from a work standpoint.

The connection between time and presence was reflected in comments like, “freedom and margin to reach out,” and “learn to listen and be present in the moment.” Some also commented on the theme of presence in relationship to where meetings take place, suggesting interpersonal skills and location matter. For example, “more in-person meetings,” “being visible,” and, “more time together with other managers - less Zoom,” would facilitate being able to show support to peers.

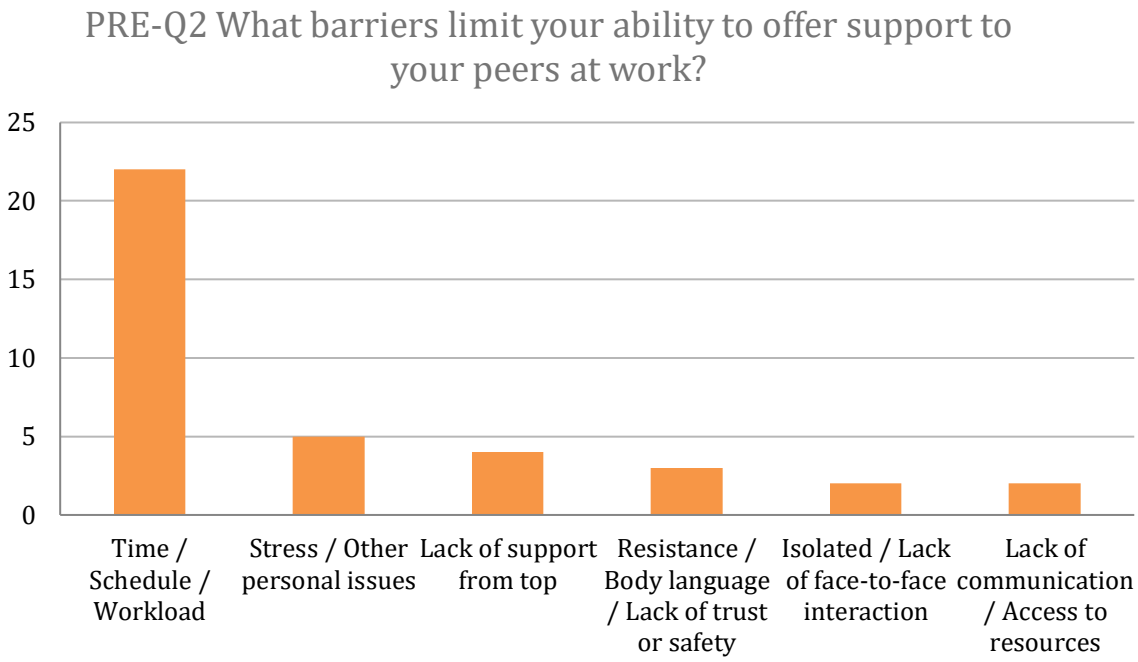
Communication, listening, and empathy were frequently mentioned skills, listed as one-word or short phrases. One participant suggested, “verbal communication, active listening, body language,” another connected, “empathy and listening skills,” and one listed, “empathy, communication.” For the theme of *Feelings/Honesty/Transparency,* responses showed a value for a range of social-emotional skills including, “appreciation, kindness, and trust,” that represent a regard for showing support through positive interactions, as well as “being open, honest, candid, and willing to have real conversations,” representing how support may also include vulnerability or guiding someone through a challenging interaction or subject.

Themes in Pre- Survey Question 2

The second question asked participants to describe barriers that might limit their ability to offer support to peers at work. Six themes emerged from question two responses. See Figure 2 for categories and frequency of themes. While there were more survey participants that responded to this question than the first, the vast majority (79%) mentioned time-related factors including schedule and workload as barriers. Six responses simply used the word, "time," without any qualifying words or phrases. Of those who described time issues with more detail, words such as "availability, commitment, busyness, management, constraints, limitations, inconsistent schedules, deadlines, add-ons, and expected perfection," accompanied time. Each of these ideas are indicative of both internal and external pressures related to how time is used, reflecting opportunities for coaching about workplace culture and individual perfectionism that may inhibit peer support. For instance, one participant expanded the thought and said, "stress and often there is not enough time to offer support," and another said, "work schedule is often without margin to interact or listen." One response described in more detail how the accumulation of responsibilities limits opportunities to foster meaningful interactions by saying,

> Frequent meetings and scheduled events that keep me away from being with peers and patients. Lack of time to speak personally with peers and hear about the wonderful things happening in their lives as well as the not so wonderful.

Figure 2



The issue of only having time for superficial interactions was reflected by other responses that listed barriers such as, "the number of meetings I have," "work demands to allow for real conversations," and "work schedule is often without margin to interact or listen." These critiques of time, schedule, and workload are important and show the constant struggle nurse leaders have as they prioritize work demands and then make choices to either work in a way that supports self-care and personal boundaries, or work in a way that might support the well-being of peers. But the time-related barrier feedback would indicate there is rarely, if ever, sufficient time to do all three.

The other five themes that were identified from responses to this question were perhaps more interconnected than distinct themes. For instance, the connection between *stress/other personal issues* and *resistance/body language/lack of trust or safety* was

close for barriers such as, “emotional stress,” “fear of being labeled or drawn into drama that will add more problems for me,” “lacking verbal communication, nonactive listening, and poor body language,” and “too many unknowns.” Similarly, the themes: *lack of support from top* and *isolated/lack of face-to-face interaction* had some level of connection in listed barriers such as, “very isolated; lack of support from top,” “workload, lack of support from upper management,” “lack of face-to-face interaction,” and “lack of clear communication on how to access resources; barriers like requiring staff to log into email QRG’s with no printable version.” The strong descriptions of what is perceived as lacking from the perspective of senior leader modeling and communication appeared to be important barriers to fostering a culture of peer-leadership.

Themes in Pre- Survey Question 3

There were 24 responses and five themes within the third pre- survey question, which asked participants what they hoped to gain from participating in the drama therapy peer-support program (see Figure 3). Some expressed feeling unsure of what to expect from the program with answers like, “I will be open, but I truly have no idea what to expect.” The two most prevalent themes reflected both interpersonal and self-care objectives. Five responses integrated both by expressing hopes for, “ways to help me positively interact with my staff,” to “learn new techniques to deal with stress and help support others,” or “knowing how to help myself and others,” “how to effectively support peers as well as supporting myself.” One response expressed a recognition of how shared humanity through storytelling can be beneficial for reducing stigmas and making connections with others: “sharing my struggles so my peers in the therapy will see it is everyone.”

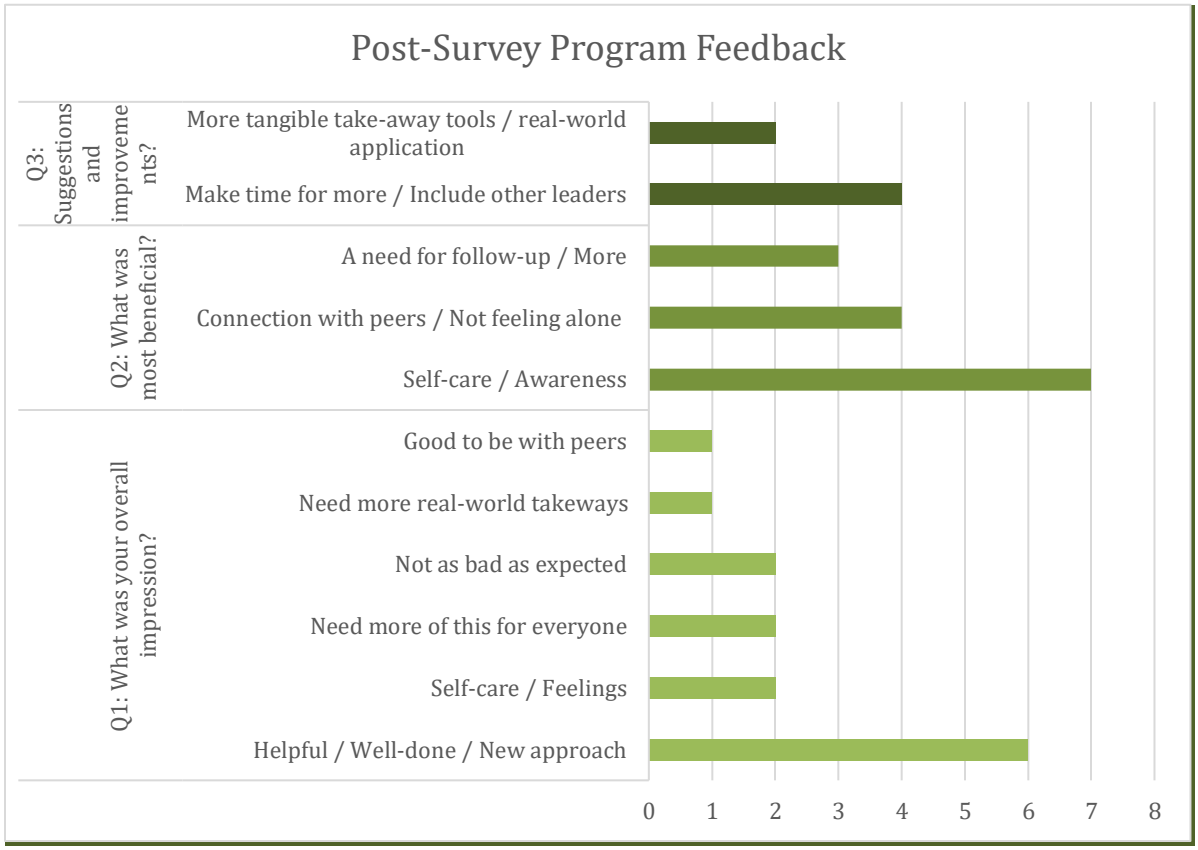
Figure 3

Participants also expressed curiosity for learning how feelings and emotional processes intersect with work, with responses like, “insight to how others are feeling,” “finding peace even on my bad days,” “better deal with uncontrollable circumstances,” “stress reduction,” and “increased sense of peace.” And most of the responses related to wanting to learn skills such as peer-support, leadership, communication, setting priorities, and other coping skills. Examples include, “an understanding of how I can support my co-workers,” “better coping skills; more intentionality,” “ways to support other leaders that are effective without making them feel powerless,” “finding new ways to be a better leader,” and “better grasp and skill for peer support.” Many of these comments use the word “better” or “effective,” which brings up questions around what previous peer-support training or approaches may have been used that were somehow less effective or in need of improvements.

Post- Survey Questions

There were eight responses to the post-survey. One post- survey participant did not include any qualitative responses. Another did not complete the pre-survey, thus that participant's quantitative data was not included in the pre- post- analysis, but the qualitative responses were included since pre- and post- qualitative questions were not comparative. Post- survey qualitative responses to all three questions were organized into 11 themes. See Figure 4 for a visualization of all post- survey program feedback themes.

Figure 4



The first question on the post- survey was, what was your overall impression of the drama therapy nurse leader peer support program? Six of the seven respondents

indicated in some way that the workshop and follow-up coaching peer-support program was “beneficial, helpful, well-done, likable,” and “enjoyable.” Some affirmations were more descriptive, such as, “I feel like talking about how we deal with our feelings is often not discussed. I often put others before myself, so it was nice to be made to look inward.” Three responses were more nuanced, showing a range of discomfort with the style of the workshop in comments such as, “It was not as bad as I expected,” or “I was wary at first, but opened up after I realized that it allowed me to express feelings in creative ways.” and “I liked the program, but I would suggest including more real-world takeaways.” There were some responses that promoted expanding this type of program within the organization, suggesting that it was, “very helpful and could use more often,” and “very beneficial and enjoyable time spent with peers. Every employee should attend a session.”

The second post- survey question was, what did you find most beneficial about the workshop and/or follow-up coaching sessions? Responses to this question revealed unanimous benefit from the self-care and personal awareness outcomes resulting from the program. Comments such as, “the reminder to focus on self-care,” and the “workshop was a nice break from day-to-day job,” were direct reflections of that benefit. Another participant described in more detail how the components of the workshop will support self-care through collective awareness and making more concrete plans for work-life balance:

> My peers are feeling the same emotions that I am feeling. Learning how to take the first steps to improve my wellbeing and then having an opportunity to follow-up. This wasn’t a task to check off a list but a plan to follow to improve my home and work life balance.

And one participant's response showed the complicated relationship between valuing how the program provided tools to promote self-care but finding challenges in developing new paradigms: "I am upset that I did not take advantage of the follow up sessions. One of the things I struggle with is putting myself first." The connection between self-care and peer-support was more salient to two of the participants who observed, "dividing into groups and seeing how I'm similar and different from other leaders was interesting," and "tuning into my body's responses to some of the topics… like my heart rate increased at someone mentioning being a perfectionist, which I did not think was an issue for me, but I had a physical reaction to that."

In the third post- survey question, participants were asked if they had suggestions for improving future well-being support programs for nurse leaders. One participant declined to give a suggestion but said, "Great job! Not my wheelhouse." Other responses were reflective of either one of two themes: *Make time for more / Include other leaders (4)*, or *More tangible take-away tools / real-world application (2)*. Those who wanted to expand the offering said, "continue to do them," or "have it more than just a one-time workshop," and "include other leaders that aren't nurses - mixing the dynamic of leaders and their service lines to help grow relationships and community among our leaders." These responses were reflective of a deeper value for strengthening the collective awareness and culture of social-emotional well-being in a healthcare environment. But one suggestion brought the conversation back to the systemic barrier of time, leaving an open-ended suggestion for all leaders to contemplate in relation to any well-being initiative, "Finding time is always an issue. I feel that we are pulled in twelve directions and don't give the time/importance to supporting each other."

The two suggestions for tangible tools and real-world application were helpful in pointing out concepts that are within the wheelhouse of drama therapy and the broader expressive arts therapy continuum. Implementation of these suggestions would only require minor changes to the program curriculum to offer improvements. One suggestion was, “focus on practicing the suggested tools in real-world situations.” The second suggestion was, “Maybe some tangible take-away tools as reminders of how to put learned concepts into practice (besides the journal; it was great). Example: A key chain with C-words to sit on the desk and flip through as a reminder.” Since art supplies were used in the workshop journaling directives, this creative take-away suggestion could be easily implemented as a component of the workshop or follow-up coaching.

Facilitator Field Notes

Overall, the reflexive curriculum design was intended to be adaptable to the needs of each group. Field notes were shared between facilitators and combined into a document where they were read multiple times and coded for themes and ideas that connected to the research questions and overall study data. The ideas were coded and sorted into two main themes: buy-in and access. The two major themes from the facilitator field notes point to individual barriers and facilitators represented as buy-in, and external or organizational barriers and facilitators related to access. The notes were analyzed through comparison to both qualitative and quantitative data and therefore provided useful context for future curriculum design and well-being program development.

Access. Many participants mentioned barriers and facilitators related to peer support and self-care that were time related. This was consistent with qualitative

responses provided on the survey. The process of organizing, scheduling, and facilitating the peer support initiative certainly was affected by some of these time issues. Facilitator notes tracked multiple changes to confirmations and declines to workshop invitations, changes in meeting rooms due to schedule conflicts, and delayed responses from invited participants. Most of the nurse leaders were ultimately able to attend a workshop, with credit given to the support of the executive leadership of the organization for facilitating their ability to allocate time to attend. This was important because organizational support from the CNO removed any misperception that the leaders could not make time in their schedules to attend an all-day support workshop.

There were several leaders whose schedules or responsibilities, despite best efforts, were too complex or heavy to attend any of the workshop dates. This observation, in relationship to some qualitative comments requesting more frequent workshops, would support ongoing programming that would allow leaders to schedule far enough in advance, or to attend if they have an unexpected last-minute opening. If support engagements are ongoing, rather than special events, they may have a better chance of becoming part of the fabric of the work environment. Another note reflected a suggestion that access to the training for all employees through a half-day format would help leaders be able to better implement the tools. The in-person experience and education was valued and leaders believed it would help establish the language and concepts more broadly if everyone went through the training.

The follow-up coaching sessions were a largely under-utilized resource. There were two workshop participants who scheduled a follow-up session as a one-to-one sessions, rather than with a peer or small group. The direct benefits of those coaching

sessions are unknown based on the post-survey responses. Follow-up coaching is recommended to support skill acquisition and to support the development of new habits and routines. Future programs may need adjustments to promoting and recruitment methods for the follow-up sessions.

Some field notes reflected barriers associated with the more broadly systemic culture of healthcare, such as tensions and complex relationships between nurses and doctors and how those dynamics might be addressed. One note related to the ways leaders related to staff who exhibit disruptive behaviors that may have an underlying relationship to stress and burnout. Yet without access to more resources, punitive measures are perceived as the only tool for leaders to use. This was also reflected in a note regarding the medical model being embedded in the leadership style. Furthermore, a note reflected a participant in-session comment and group agreement that the work demands perfectionism, which makes it challenging to not broadly apply this demand to all aspects of how nurses think and work. The peer support training, including concept education seemed to be a helpful framework for helping the nurse leaders approach topics related to perfectionism and vulnerability with coworkers.

Buy-In. The initial conversations with leaders about how to recruit, organize and design workshop engagements assumed that leaders would prefer to be in groups with peers at the same leadership level, or alternately with peers who work in similar service areas. Due to the scheduling complications, this was not logistically possible and therefore the groups ended up being relatively mixed in terms of role and service area representation. However, facilitators noted that participants found value in being able to hear the experiences of others whose roles or work areas were different. Notes indicated

in each workshop, there were participants who were meeting one another for the first time and rather than being a facilitation challenge, the connection-building between new leaders appeared to offer a substantial benefit by revealing shared struggles and promoting a diversity of support ideas.

Overall, the curriculum components were well-received by participants with active engagement in all modules, including the psychoeducation, arts-based facilitation, peer-guided discussions, and goal-setting components. Some participants verbalized reluctance to "do drama" but were meaningfully engaged in the activities once the dramatic components were contextualized within the workshop objectives. Facilitation methods were reflexive and responsive to what participants needed in each session. Notes pointed to the usefulness of distancing techniques in helping participants titrate emotions and thoughts related to the concepts. For example, it was observed how some participants explicitly verbalized a lack of interested in engaging with topics related to emotions while others found the topics very valuable. The seemingly polarized perspectives opened opportunities to establish dual purpose narratives, allowing participants opportunities to find purpose in helping their staff and/or for self-care purposes. This further opened opportunities for greater buy-in with the initiatives.

The main adaptation resulting from this reflexive design was the inclusion of an embodiment and distancing exercise that focused on the theme of collective grief in the first workshop. This theme was not necessarily anticipated by the facilitators but when participants brought the topic into group discussion, facilitators were able to adapt the exercises to meet a group need. The same exercise was then included in subsequent workshops. Facilitators noted a general exhaustion with the hero narrative with

participants discussing how it complicates the ability to collectively grieve and approach the topic of burnout with nurses. Another insight was related to how framing the workshop as skill building in areas that were within the control of the nurse leaders was helpful for removing the barrier of perceiving systemic issues as being too big or too complicated for them to change.

CHAPTER 5

Discussion

This research study used both quantitative and qualitative survey methods to assess outcomes from a drama therapy-based peer support initiative for nurse leaders at a mid-sized regional hospital system. The research questions were, 1) Does the implementation of a drama therapy peer support initiative improve well-being, empathy, and burnout for nurse leaders? 2) What is the relationship between nurse leaders' empathy, burnout, and well-being before and after participating in a drama therapy peer support initiative? 3) What do nurse leaders describe as the perceived barriers and facilitators associated with participation in a drama therapy peer support initiative?

To answer these questions, pre- and post- surveys were sent to nurse leaders (N = 32) who participated in one of three all-day workshops that were offered between September 2022 and February 2023. Measures used in this research included three Maslach Burnout Inventory – HSS (MBI-HSS) scales measuring emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA), alongside the WHO-5 Wellbeing Index, and the Toronto Empathy Questionnaire (TEQ). The five validated measures were helpful for providing baseline data that could uniquely inform the development of future support programs for nurse leaders at this site. In addition to the quantitative measures, participants responded briefly to qualitative questions on the pre- and post- surveys related to experiences, barriers, and facilitators associated with the initiative and topic of peer support generally. Facilitator field notes were analyzed to assist with qualitative analysis and interpretation of data.

Research Question 1

Regarding change in well-being, empathy, and burnout scores between pre- and post- measures, the post- survey did not yield sufficient responses to offer conclusive results. Of the available results, the pre- and post- linked response group was too small (n = 7) to glean meaningful statistical pre-post outcome data related to the intervention. Thus, change could not be statistically shown. Although the sample was small, the expected directional change of lower EE was observed. There was little or no change to PA, well-being, or empathy scores, but there was a 19.29% *M* increase in DP on the post-survey. This unexpected directional change in DP scores was interesting but not significant enough to make recommendations from a programmatic perspective. More data, such as qualitative interviews or focus groups, would be needed to better understand if the cyber event-related experiences nurse leaders encountered over the course of the eight weeks following workshop attendance had an impact on DP symptoms. Thus, interpretation of these change scores should be regarded as conversation starters for developing future research questions. The issue does point to an apparent gap in the literature, however. Research about the relationship between information security events and employee stress, even among cyber security professionals who are working at the closest proximity to remediation, is not readily available (Singh et al, 2023).

It is also worth noting that low response rates to well-being surveys by hospital employees are not uncommon, particularly for intervention research (Shyiab et al., 2023), for example, a recent large-scale German study related to work stress and sociocultural diversity factors saw a 5.9% response rate from acute hospital doctors and nurses (Schneider et al., 2023). Thus, the low engagement with post-surveys associated with this

study were not surprising. It may be challenging to show statistically significant results to small intervention studies such as this one, but the qualitative feedback was encouraging. Participants expressed enjoyment of the workshops and gave credit to the organization for supporting their mental and emotional wellbeing. According to a longitudinal study by Reitz et al, (2021), the perception of organizational support by hospital employees correlated with lower anxiety and burnout. Likewise, when organizations show support through leadership guided team-building initiatives, the support-giving culture among peers that includes connecting to emotions, and developing self-compassion, can lead to higher nurse retention and better patient care (Carter & Bogue, 2022). Drama therapy may have been a new approach to building these skills, but participant qualitative feedback confirmed a desire at this site for more frequent and ongoing programs of this nature, as well as expanding workshop access to more employees who are not in leadership roles.

Research Question 2

The correlations between measures of burnout, empathy, and well-being were not significant on post survey results due to the small sample and effect size. However, pre survey responses were robust enough to show a significant and strong relationship between the measures. The inter-relationship between the three burnout scales was expected based on decades of MBI-HSS normative studies (Maslach et al., 2018), with the strongest correlations in this study being between the EE and DP scales. The experience of emotional exhaustion is characterized by feeling emotionally drained from the complex interpersonal nature of one’s work. This aspect of the syndrome has been shown to have an impact on the physical and mental health of those who experience high

levels of EE (Petersen et al., 2023; Poghosyan et al., 2009; Shah, et al 2021; Vanheule et al., 2007). Depersonalization has slightly different characteristics which often manifest as cynicism or detachment, which can lead to a lack of caring about oneself or those who are being served. Understanding the slight differences between EE and DP, and how they relate to both employee well-being and patient care, is important and can point to implications for intervention strategies. Maslach et al. (2018) explained how burnout is different from occupational stress that might be associated with more conventional measures of employee engagement and satisfaction that don't account for work intensity. The MBI-HSS research grounds the construct as a concept that, "integrates feelings of exhaustion with staff members' involvement in their work, especially the people with whom they work, and their sense of efficacy or accomplishment" (Maslach et al., 2018, pp. 21-22).

In this study, the inclusion of the TEQ measure was helpful, as the data showed a significant negative correlation between empathy and depersonalization. From an intervention perspective, this provides a focal point for directing future research of therapeutic processes with an objective to reduce symptoms of depersonalization by strengthening cognitive empathy. This is a topic that has been explored in other correlation research on the connections between empathy and burnout (Altmann & Roth, 2020). For leaders, clinicians, and caregivers of all kinds, understanding the relationship between burnout and having a capacity to take on perspectives of others is of particular importance in the context of the intense interpersonal work-related activities that healthcare workers face. Likewise, understanding that cynicism, or relational detachment may be symptoms of burnout rather than personality or behavioral issues can help leaders

take corrective action through bolstering self-compassion and empathy coaching as an alternative to punitive action. For example, in Victorson et al, (2021), a brief two hour mindfulness, gratitude, empathy, and self-compassion course was implemented and resulted in improvements in measures of job satisfaction, stress, and gratitude. And drama-based simulation exercises showed promise when used to teach nursing students empathetic skills (Thomas et al., 2020). However, the post-pandemic focus on mental health may open opportunities for a more detailed exploration into the protective nature of cognitive empathy skills against drivers of burnout.

When considering the WHO-5 results in this study, which also showed a significant and strong positive correlation with PA, and significant negative correlations with EE and DP, the WHO-5 showed promise as an accessible, brief measure for use in well-being research where burnout might be a factor. It is important to note that more research would be required to substantiate this result. According to Topp et al., (2015) the WHO-5 has primarily been used as a generic scale for well-being and not as a diagnostic tool. But research by Krieger et al., (2014) supported the use of WHO-5 for diagnosing depression, and it was also used internationally to measure nurse well-being during the COVID-19 pandemic (Lara-Cabrera et al, 2022). Recent measure validation research across 35 countries by Sischka et al., (2020) upheld Krieger et al. and Topp et al., (2015) in support of the psychometric properties of the WHO-5. Interestingly, the TEQ and WHO-5 did not show a significant correlation in this study. More research with a larger sample would be needed to better understand the relationship between TEQ and WHO-5 in the context of burnout research.

Research Question 3

Responses to pre- survey questions related to barriers showed an overwhelming focus on time, workload, and schedule-related responses. Time factors are known issues that continue to confound support efforts for nurses, clinicians, and healthcare leaders (Petersen, et al., 2023; Shah et al., 2021). Nurse leaders described the complex nature of working in a post-pandemic context where staffing shortages have cut even deeper into time constraints. For many, remote or hybrid work practices have become the norm, with back-to-back virtual meetings leaving little or no time in the day to do rounding or schedule a peer-support conversation with a coworker. This is consistent with current reports and publications in nursing leadership literature (Tamata & Mohammadnezhad, 2023). The limitations on, and sometimes absence of in-person encounters for discussing emotionally sensitive work challenges should not be ignored. Even years before pandemic disruptions, The Nursing Executive Center (2018) advisory board made recommendations for reducing the sense of isolation that compounded burnout for nurses. In their comprehensive research report, the use of 90-second storytelling was one of the burnout prevention recommendations for helping nurses meaningfully connect with peers on a daily basis.

According to Swensen and Shanafelt (2020), interventions for time related issues are largely out of the hands of those offering psycho-social support, and in the hands of industry-wide policymakers and business strategists to correct. However, insights from this study would support the suggestion by Petersen et al., (2023) that supporting coping skills and team collaboration can help. Nurse leaders valued discussion on the topic of time-driven stressors. The drama therapy workshop facilitated engagement with the

barriers listed on the surveys, such as setting boundaries around workload, by role playing communication of feelings related to work pressures, and active witnessing through showing empathetic concern for others' experiences.

Participants also noted a sense of isolation, lack of interpersonal trust, and perception of lack of support from senior leaders as barriers to peer support. Similar to the recommendations by Weston and Nordberg (2022), which were to create a culture shift that normalizes self-care and talking openly about the necessity to ask for help, these issues pointed to a specific need for bolstering interpersonal skills that reduce the stigmas associated with discussing emotional challenges related to working in healthcare. It is worth pointing out that 66% of the participants reported only having been in their leader role for three years or less, meaning they were navigating learning a new job throughout the pandemic, with no opportunities to build supportive working relationships without pandemic-related restrictions and disruptions.

Based on the feedback from participants, the act of empathetically relating to the experiences of others matters to nurse leaders. It reduces stigma, a sense of isolation, and supports a sense of shared purpose. With those results in mind, it would be important to highlight the capacity for nurse leaders to consider empathetic communication as a potentially protective skill that is already within their wheelhouse. Taking the empathy pre- survey results into consideration, with 50% of the nurse leaders showing normal empathy scores and 50% having empathy scores higher than normal range (TEQ $\geq$ 53) it was clear that the leaders were highly empathetic individuals. Thus, empathy skill-building may not have been a necessary objective in the workshop, but they did express wanting more opportunities to be face-to-face with peers, have fewer zooms, and to have

time to listen to one another. It is unsurprising that meaningful engagement with others is an important aspect of experiencing personal accomplishment and lower depersonalization. Feeling "seen" by others and having outlets to discuss shared experiences may also be a factor in why empathy and emotional exhaustion were negatively correlated in this study.

A noteworthy outcome expressed in both qualitative responses and in-session field notes was how different and refreshing the workshops were in comparison to typical well-being tools that focus on supporting employee engagement. In addition to developing self-compassion as a foundational aspect of offering peer support, the focus on interpersonal skills and perspectives on sharing a collective grief process as part of the workshop helped nurse leaders identify strengths and limitations that impact wellbeing at work. Though pre-pandemic burnout research supports engagement initiatives as protective against burnout (Maslach & Leiter, 2017), emerging research has shown a deeper and more profound level of exhaustion and mental health issues among those working in healthcare (Prasad et al., 2021; Shanafelt, et al., 2022; Weston & Nordberg, 2022). This has drawn some to critique positive psychology paradigms that focus on resilience and happiness as markers of well-being (Yakushko & Blodgett, 2021), and has led some to describe the importance of centering the grief process, rather than trying to rush positivity, in order to adapt to changes (Gee et al., 2022; O'Connor & Seeley, 2022; Rahmani et al., 2023).

Responses also offered insight into how the drama therapy initiative facilitated peer support through the use of experiential tools such as sculpting, storytelling, self-compassion, self-leadership concepts, and peer coaching. Feedback also supported the in-

person format of workshops as well as inviting groups of leaders from a diversity of service areas. Drama therapy was new for the participants but responses to qualitative questions about the overall experience in the workshops, along with facilitator field notes, supported the approach as being valuable and potentially helpful for more employees. The perceived benefits of the workshop to individual well-being, reducing symptoms of burnout, and supporting empathy skills were subjective but important to note. Overall, the responses showed a range of engagement in, and personal awareness of what barriers might limit future participation in group experiential peer support initiatives. However, given the small sample of participants who responded to the post- survey, from an empirical perspective there remain substantial unknowns about the experiences of the participant group.

Recommendations for Future Research

Insights from this study helped to show conceptual components of drama and creative arts-therapy based approaches for supporting the psycho-social needs of nurse leaders in an intense healthcare environment. A similar concept was studied by a team of creative arts therapists working in the United Kingdom National Health Service that showed arts-based tools were helpful for team-building and developing psychological safety after adverse events (Havsteen-Franklin et al, 2023). But there is very little empirical research that shows the effectiveness of creative arts therapies for hospital employee well-being. Much more research is needed to better understand the role of drama therapy in treating symptoms of burnout.

A starting point may be to understand the nature of drama therapy process variables in more detail. Articulated in Frydman et al., (2022) the multidimensional

relationship is a core drama therapy process that occurs between the therapist, participant, and the dramatic material. Likewise, how drama therapy core processes are used can vary widely depending on the therapeutic goals and objectives of the participant or group. What the participants and drama therapist bring into a drama therapy encounter can also impact what techniques are used in the session. Examples such as culture (Hobeck, 2014), identities (Musicka-Williams, 2020), artistry (Yusek, 2020), emotional and cognitive states (Bornmann & Crossman, 2011), personality (Doomen, 2018), physical conditions (Bechtel et al, 2020), dis/abilities (Orkibi et al, 2014), guiding philosophies (Stevens et al., 2020), theoretical frameworks (Wood, 2015), skill (Feniger-Schaal & Koren-Karie, 2021), and experience, (Zimmermann & Mangelsdorf, 2020) are all aspects of "self" that can influence the therapy. How one might engage with the dramatic reality is largely a matter of choice, which is negotiated between the therapist and participant(s) depending on contexts such as participant age, resources, space, time, and other preferential factors.

Some drama therapy approaches look very similar to a traditional theatrical production with a stage, costume, and scripted scenes (Cook, 2021; Kaynan & Wade, 2018; Pendzik, 2021), while others might be almost entirely based on guided improvisational play methods (Johnson, 2021), or narrative, (Dunn et al, 2021; Savage, 2018), or defining roles, (Williams, 2017; Truax, 2020), and other forms of performance and play that might use comedy, clowning, puppets, or masks (Bornmann, 2022; Fryrear & Stephens, 1988; Gordon et al., 2018; Ilievová et al., 2015; Kostidakis, 2021). In essence, it is important to understand that the dramatic reality portion of the multidimensional relationship in drama therapy is less about the particular tools and

techniques of theatre and more about the ways a variety of drama therapy activities might engage the imagination of the participant(s) in a way that brings about therapeutic change. But this variety of approaches and techniques can complicate research efforts with limited recognition of the core drama therapeutic processes that may be taking place.

Future research measuring the effectiveness of specific core processes, such as distancing, dramatic projection, and active witnessing that could be used to address characteristics of depersonalization and emotional exhaustion would help support the development of an evidence-based drama therapy protocol for the treatment of burnout. Similarly, it would be helpful to better understand the relationship between drama therapy processes and empathy. Further research is needed to articulate connections. In addition, a more robust qualitative study with focus groups, interviews, or recorded sessions would provide more insight into aspects of the participant experiences that were not able to be adequately captured through survey research.

Limitations

There were a variety of limitations to the current study. The sample size was small, and results are not generalizable. The post- survey data was from participants who attended the first two workshops. Limited engagement with the post- survey may have been from factors associated with the cyber security event that occurred in the month following the first two workshops (CommonSpirit Health, 2022). That event significantly disrupted operational scheduling, documentation, communication, and budgets (Dyrda, 2023). Additionally, because the third workshop was postponed by three months, post survey responses from that workshop will not be available until April 2023. Further analysis of the data will be required should there be additional responses to the post-

survey. The length of the survey was also likely a barrier, given the time constraints on nurse leader schedules. The study design was limited and may have produced more useful change data if the post- survey had been sent out soon after the workshop rather than at the end of the eight-week coaching window.

Other limitations included the lack of diversity in the sample, with a vast majority being White and female, there remain many unknowns regarding how results would differ in a more diverse population. Likewise, socio-cultural psychotherapy paradigms that underpin most drama therapy theories and practices have been developed within a Western, European American perspective over the last century. Further research could support the expansion of sociocultural paradigms in the healing professions to encompass more perspectives on the definitions of, and ways of developing well-being practices would likely offer more accessibility to a wider segment of the population. Finally, the profession of drama therapy is somewhat niche with too few credentialled drama therapists to conceivably be able to offer drama therapy well-being programs to a vast healthcare workforce. Sustainability of this model would require consideration of alternative modes, such as train-the-trainer models or virtual alternatives.

Conclusion

The small, single-group study design was limited and did not have the capacity to predict future impact in other settings or with other groups. The design did, however, emphasize the context of participants within their work environment. In this research paradigm the mixed methods approach had a foundation in critical theories with a social reconstructionist research philosophy to foster reflexivity (Shannon-Baker, 2016). The intent was to inform outcomes through an expressive and dynamic arts-based workshop

to foster in-depth critique of ideas and perspectives relevant to the subject matter that was surveyed. The use of standardized measures in combination with qualitative feedback allowed the study to contextualize participant experience within a larger framework of evidence. The use of arts-based tools was expected to foster creativity and flexibility for the deconstruction and reconstruction of ideas. Group collaboration and discussion exposed participants to a diversity of ideas and components within systems that impact their well-being. As such, attendance and engaged participation was key for measurement to demonstrate outcomes, while pre- and post- intervention surveys provided valuable benchmarks for identifying future research questions and program design.

All five measures were appropriate, and the drama therapy curriculum was beneficial for the leaders who participated in the research. Future research trials with larger, more diverse sample groups are needed to substantiate results. Time-related barriers to well-being are substantial and problems are likely to persist with no clear solution in the current healthcare climate. Efforts must be made to improve scheduled access to well-being resources. The in-person social-emotional development opportunities were valuable, particularly for nurse leaders who work in isolation or primarily through remote meeting platforms. Face-to-face conversations were also beneficial for helping clinical leaders recognize how service areas become like silos, limiting awareness of other leaders who may experience similar stressors when there is little exposure to those working in other areas of the organization. The creative, experiential, and expressive drama therapy-based program allowed leaders to reduce stigmas and develop camaraderie through an enjoyable peer-support program related to emotions, stressors, and challenges associated with working in healthcare.

APPENDIX A

IRB And Amendment Approval Letters

29 Everett Street
Cambridge, MA 02138
Tel 617 349 8234
Fax 617 349 8190
irb@lesley.edu

Institutional Review Board

DATE: 06.10.22

To: Chyela Rowe

From: Ulas Kaplan and Jason S. Frydman, Co-Chairs, Lesley IRB

RE: **IRB Number: 21/22-055**

The application for the research project, "Measuring the Outcomes of a Drama Therapy Nurse Leader Peer Support Program" provides a detailed description of the recruitment of participants, the method of the proposed research, the protection of participants' identities and the confidentiality of the data collected. The consent form is sufficient to ensure voluntary participation in the study and contains the appropriate contact information for the researcher and the IRB.

This application is approved for one calendar year from the date of approval.

You may conduct this project.

Date of approval of application: 06.10.2022.

Investigators shall immediately suspend an inquiry if they observe an adverse change in the health or behavior of a subject that may be attributable to the research. They shall promptly report the circumstances to the IRB. They shall not resume the use of human subjects without the approval of the IRB.

Lesley UNIVERSITY

29 Everett Street
Cambridge, MA 02138
Tel 617 349 8234
Fax 617 349 8190
irb@lesley.edu

Institutional Review Board

9.2.22

To: Chyela Rowe

From: Drs. Jason Frydman & E. Kellogg, Co-Chairs, Lesley IRB

RE: Addendum **of IRB Number: 21/22-055**

This memo is written on behalf of the Lesley University IRB to inform you that your request for amendments to project **IRB Number: 21/22-055**
has been approved.

Date of IRB Approval: 9.2.22

CommonSpirit

FWA Number: FWA 00019514
OHRP IRB Number: IRB00009715

DATE:	August 24, 2022
TO:	Chyela Rowe, MA
PROJECT TITLE:	[1904497-2] Measuring the Outcomes of a Drama Therapy Nurse Leader Peer Support Program
SUBMISSION TYPE:	Amendment/Modification
ACTION:	AMENDMENT APPROVAL
DECISION DATE:	August 24, 2022
REVIEW TYPE:	Expedited Review

Thank you for your submission to the CommonSpirit Health Research Institute Institutional Review Board (CSHRI IRB). The CSHRI IRB has APPROVED your amendment submission. All research must be conducted in accordance with this approved submission. The following documents have been approved or noted as part of this approval:

- Amendment/Modification - 1904497-2_ORIQ-400P15-T01 - Amendment-Modification Request Form 08-22-22.docx (UPLOADED: 08/24/2022)
- Protocol - 1904497-2 MODIFIED Minimal Risk Protocol - Drama Therapy Nurse Leader Peer Support_Updated 8-22-22.pdf (UPLOADED: 08/24/2022)
- Protocol - 1904497-2 MODIFIED Minimal Risk Protocol-with track changes_ Drama Therapy Nurse Leader Peer Support_Updated 8-22-22.docx (UPLOADED: 08/24/2022)

Please note that it is your responsibility to obtain any additional local institutional or departmental required approvals prior to initiating your study.

If you have any questions at any time, please feel free to contact the CSHRI IRB at 1-844-626-2299 or CHIRB@CatholicHealth.net. Please include your project title and reference number in all correspondence with the CSHRI IRB so that we can best assist you.

Thank you.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within CommonSpirit Health Research Institute IRB's records.

CommonSpirit

FWA Number: FWA 00019514
OHRP IRB Number: IRB00009715

DATE:	July 12, 2022
TO:	Chyela Rowe, MA
PROJECT TITLE:	[1904497-1] Measuring the Outcomes of a Drama Therapy Nurse Leader Peer Support Program
SUBMISSION TYPE:	New Project
STATUS:	ACTIVE
ACTION:	APPROVED
APPROVAL DATE:	July 12, 2022
NEXT REPORT DUE DATE:	July 11, 2023
REVIEW TYPE:	Exempt Review
REVIEW CATEGORY:	Exemption category # *2a, 2b*

Thank you for your submission to the CommonSpirit Health Research Institute Institutional Review Board (CSHRI IRB). An individual designated by the CSHRI IRB determined this project to be EXEMPT Human Subjects Research according to federal regulations.

Investigators are required to follow the Institutional and regulatory requirements for all Exempt Human Subjects Research studies approved by the CSHRI IRB:

1. **Amendments/Modifications**
   Revisions to previously approved materials are required to be prospectively reviewed and approved by the CSHRI IRB before they are implemented. Examples of changes that are required to be submitted include, but are not limited to:
   - Changes in study personnel
   - Changes to the data and/or biospecimens that will be accessed, used or disclosed
   - Changes to procedures on how data and/or biospecimens are accessed, stored and transmitted or transported
     Please submit modifications through IRBNet, and use the appropriate revision forms for this procedure.
2. **Periodic Review and Study Closure**
   Your CSHRI IRB CHECK-IN REPORT is due on July 11, 2023 and should be submitted in IRBNet 30 days prior to this 'next report due date.' The CSHRI IRB staff will send reminder emails for completing this CSHRI IRB CHECK-IN REPORT, but the investigator is required to submit the CSHRI IRB CHECK-IN REPORT on time. The CSHRI IRB CHECK-IN REPORT is also required to be submitted when the research has been completed.
3. **Reporting Unanticipated Problems**
   The CSHRI IRB requires prompt reporting (within 10 business days of discovery) of events that are Unanticipated Problems regardless of whether the event occurred at the local study site (internal UAP) or at another participating study site (external UAP). Unanticipated Problems are 1) unanticipated AND 2) serious or life-threatening or potential for increased risk AND 3) possibly or

definitely related to the protocol, as determined by the investigator. A breach of confidentiality is an Unanticipated Problem.

4. **Reporting Protocol Departures**
   All major protocol departures regarding this study must also be reported within 10 business days to this office. Major protocol departures are events that impact the risk and benefit of the research; may impact subject safety, affect the integrity of research data and/or affect a subject's willingness to participate in the research.

While there is no regulatory requirement to document informed consent for studies exempt from IRB review, the CSHRI IRB recommends all studies involving human subjects include an informed consent process whenever practicable.

Please note that it is your responsibility to obtain any additional local institutional or departmental required approvals prior to initiating your study.

The following documents were reviewed in making this determination of exemption:

- Application Form - 1904497-1_CSHRI Research Routing Form - Signed-signed.pdf (UPLOADED: 06/28/2022)
- Application Form - 1904497-1_Facility Department Approval FormORIQ-40060-T01.pdf (UPLOADED: 06/13/2022)
- CSHRI - IRB Application - CSHRI - IRB Application (UPLOADED: 07/8/2022)
- Data Collection - 1904497-1_ Post- survey Response Data Collection Sheet - IRB Review Test Data_ July 9, 2022_17.31.xlsx (UPLOADED: 07/9/2022)
- Data Collection - 1904497-1_Pre-survey Response Data Collection Sheet - IRB Review Test Data_July 8, 2022_18.xlsx (UPLOADED: 07/8/2022)
- Letter - 1904497-1_CNO Leadership Approval Letter.pdf (UPLOADED: 06/13/2022)
- Letter - Lesley University IRB Approval letter -Rowe.doc (UPLOADED: 06/12/2022)
- Protocol - 1904497-1 Minimal Risk Protocol_ Drama Therapy Nurse Leader Peer Support_Updated 7-9-22 .pdf (UPLOADED: 07/9/2022)

If you have any questions at any time, please feel free to contact the CSHRI IRB at 1-844-626-2299 or CHIRB@CatholicHealth.net. Please include your project title and reference number in all correspondence with the CSHRI IRB so that we can best assist you. Thank you.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within CommonSpirit Health Research Institute IRB's records.

Appendix B

Email Recruitment / Pre- Survey Invitation to Participate in Research

Hello CHI Memorial Nurse Leaders,

I am writing to invite you to participate in dissertation research surveys associated with a new nurse leader peer support program.

The drama therapy nurse leader peer support program is being offered by CHI Memorial as a professional development well-being course for all CHI Memorial nurse leaders to address social, emotional, and psychological risks associated with working in healthcare. In this course, a 1-day drama therapy peer support workshop will be required training for nurse leaders, along with optional follow-up coaching sessions to be scheduled over a period of 8 weeks. To better understand the effectiveness of this program, a research study will be conducted and is available for your voluntary participation.

This invitation to participate in research is being sent to all attendees of the nurse leader drama therapy peer support workshop, and even if you decline to participate in the study, you will still receive the post-intervention survey invitation and reminder emails. The reason for this is so that the survey results can remain anonymous for those who do participate in the study.

Information about the research study

The goals of this research study are:

1. To evaluate well-being outcomes from a group drama therapy peer support program for nurse leaders.
2. To understand what interpersonal support skills might be associated with nurse leader well-being outcomes.
3. To explore feedback related to the peer support program and discover barriers and facilitators associated with nurse leader well-being.

Your participation in the research study is completely voluntary and will involve responding to one pre- and one post- survey assessing the outcomes of the program. The surveys will be distributed electronically before the workshop and at the end of the 8-weeks of optional coaching. Each survey consists of 55 questions and takes approximately 15 minutes to complete.

- Former knowledge about drama therapy and peer support are not necessary.
- Participation is strictly anonymous
- You are free to choose not to participate in the research and to discontinue your participation in the research at any time by quitting the survey.
- No identifying details will be collected by the researcher.

Participation in the research is not required and the surveys will not be accessible without your agreement to participate. If you choose not to take the surveys it will not affect your participation in the peer support program, nor will it affect your employment, job performance, or relationship with your supervisor, hospital leadership, or CHI Memorial. You will not be evaluated based on survey participation or responses. All research data collected will be strictly confidential, anonymous, and will only be reviewed by the researcher. No individual responses from the survey will be reported and only de-identified, aggregated data will be presented for quality improvement, in scholarly activities, or for publication.

Potential Benefits of Participating in this Research:

Taking part in this study may involve some emotional discomforts as well as offering certain benefits to you such as improvements to the organization and support environment for the nursing community at CHI Memorial. Responding to the research surveys may provide valuable information related to the quality of peer support programs within the context of your work environment. At a time when alleviating workplace stress is critical, this study may provide evidence to assist in the development of beneficial support programs for nurses and nurse leaders at CHI Memorial. There are no guarantees that you will benefit from taking part in this study. However, your responses will help me evaluate the effectiveness of this program, to further develop peer support programs for nurse leader well-being, and to share its value with the nursing and creative arts therapy professions.

Potential Risks of Participating in this Research:

There are minimal risks and discomforts associated with participation in this research, however survey questions related to well-being and workplace distress may elicit strong emotions. Should that occur, support is available from a member of the well-being committee or spiritual care. To be connected to those resources participants may contact: Betsy_kammerdiener@memorial.org or the Employee Assistance Program:877-679-3819 and https://www.achievesolutions.net/chi

If any problem in connection to the research arises, or if you have any questions, please contact the principal investigator, Chyela Rowe at 423-488-9329 or by email at Chyela.Rowe@commonspirit.org or you may contact the doctoral research supervisor, Jason D. Butler, PhD at 617-349-8242 or by email at jbutler8@lesley.edu

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairperson at irb@lesley.edu

Should you have any questions about your rights, including any concerns or complaints, as a research participant, you may call the Institutional Review Board which is concerned with protection of volunteers in research projects at:

CommonSpirit Health Research Institute Institutional Review Board (CSHRI IRB)
198 Inverness Drive West
Englewood, Colorado 80112
Telephone: toll-free 1-844-626-2299
E-mail: cshri-irb@commonspirit.org

To give your consent to participate in this survey and to begin, please select the link below:

[SURVEY LINK]

Thank you,
Chyela Rowe, MA, RDT, Arts Therapies and Well-Being Program Coordinator
Chyela.Rowe@commonspirit.org

Pre- Survey 4-Day Reminder:

Greetings,

I recently reached out to you with an invitation to participate in a research study associated with the drama therapy nurse leader peer support program. If you have already completed the survey, please disregard this email.

If you have not completed the survey and would like to participate in the study, please click the link below before attending the scheduled drama therapy nurse leader peer support workshop. Information about the research project can be found in the previously sent email, on the landing page of the survey link, or you can call or email me with any questions you may have:

Pre- Survey link:
[SURVEY LINK]

Should you have any questions about your rights, including any concerns or complaints, as a research participant, you may call the Institutional Review Board which is concerned with protection of volunteers in research projects at:

CommonSpirit Health Research Institute Institutional Review Board (CSHRI IRB)
198 Inverness Drive West
Englewood, Colorado 80112
Telephone: toll-free 1-844-626-2299
E-mail: cshri-irb@commonspirit.org

Thank you,
Chyela Rowe, MA, RDT, Arts Therapies and Well-Being Program Coordinator
Chyela.Rowe@commonspirit.org

Pre- Survey 1-Day Reminder:

Hello Nurse Managers and Directors,

I look forward to seeing you at the Nurse Leader Drama Therapy Peer Support Workshop tomorrow. I wanted to follow up with a quick reminder that you have the option to participate in a research study associated with this program. If you have already completed the pre- workshop survey, please disregard this email.

If you have not yet completed the survey, below you can find information about this research study. If you would like to participate in the surveys, please click the link below and complete the pre- survey before attending the scheduled drama therapy nurse leader peer support workshop. The pre- intervention survey will not be available after the start of the workshop.

This invitation to participate in research is being sent to all attendees of the nurse leader drama therapy peer support workshop, and even if you decline to participate in the study, you will still receive the post-intervention survey invitation and reminder emails. The reason for this is so that the survey results can remain anonymous for those who do participate in the study.

Information about the research study

The goals of this research study are:

1. To evaluate well-being outcomes from a group drama therapy peer support program for nurse leaders.
2. To understand what interpersonal support skills might be associated with nurse leader well-being outcomes.
3. To explore feedback related to the peer support program and discover barriers and facilitators associated with nurse leader well-being.

Your participation in the research study is completely voluntary and will involve responding to one pre- and one post- survey assessing the outcomes of the program. The surveys will be distributed electronically before the workshop and at the end of the 8-weeks of optional coaching. Each survey consists of 55 questions and takes approximately 15 minutes to complete.

- Former knowledge about drama therapy and peer support are not necessary.
- Participation is strictly anonymous.
- You are free to choose not to participate in the research and to discontinue your participation in the research at any time by quitting the survey.
- No identifying details will be collected by the researcher.

Participation in the research is not required and the surveys will not be accessible without your agreement to participate. If you choose not to take the surveys it will not affect your participation in the peer support program, nor will it affect your employment, job performance, or relationship with your supervisor, hospital leadership, or CHI Memorial. You will not be evaluated based on survey participation or responses. All research data collected will be strictly confidential, anonymous, and will only be reviewed by the researcher. No individual responses from the survey will be reported and only de-identified, aggregated data will be presented for quality improvement, in scholarly activities, or for publication.

Potential Benefits of Participating in this Research:

Taking part in this study may involve some emotional discomforts as well as offering certain benefits to you such as improvements to the organization and support environment for the nursing community at CHI Memorial. Responding to the research surveys may provide valuable information related to the quality of peer support programs within the context of your work environment. At a time when alleviating workplace stress is critical, this study may provide evidence to assist in the development of beneficial support programs for nurses and nurse leaders at CHI Memorial. There are no guarantees that you will benefit from taking part in this study. However, your responses will help me evaluate the effectiveness of this program, to further develop peer support programs for nurse leader well-being, and to share its value with the nursing and creative arts therapy professions.

Potential Risks of Participating in this Research:

There are minimal risks and discomforts associated with participation in this research, however survey questions related to well-being and workplace distress may elicit strong emotions. Should that occur, support is available from a member of the well-being committee or spiritual care. To be connected to those resources participants may contact: Betsy_kammerdiener@memorial.org or the Employee Assistance Program:877-679-3819 and https://www.achievesolutions.net/chi

If any problem in connection to the research arises, or if you have any questions, please contact the principal investigator, Chyela Rowe at 423-488-9329 or by email at Chyela.Rowe@commonspirit.org or you may contact the doctoral research supervisor, Jason D. Butler, PhD at 617-349-8242 or by email at jbutler8@lesley.edu

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairperson at irb@lesley.edu

Should you have any questions about your rights, including any concerns or complaints, as a research participant, you may call the Institutional Review Board which is concerned with protection of volunteers in research projects at:

CommonSpirit Health Research Institute Institutional Review Board (CSHRI IRB)
198 Inverness Drive West
Englewood, Colorado 80112
Telephone: toll-free 1-844-626-2299
E-mail: cshri-irb@commonspirit.org

To give your consent to participate in this survey and to begin, please select the link below:

[SURVEY LINK]

Thank you,
Chyela Rowe, MA, RDT, Arts Therapies and Well-Being Program Coordinator
Chyela.Rowe@commonspirit.org

Appendix C

Email Recruitment / Post- Survey Invitation to Participate

Hello CHI Memorial Nurse Leaders,

I am writing to invite you to participate in the post- intervention research survey associated with the nurse leader drama therapy peer support program that you participated in this fall. If you declined to participate in the pre-survey portion of the study, you should disregard this email and subsequent reminders. The invitation will be sent to all attendees of the workshop to protect the anonymity of those who did participate in the study.

To give your consent to participate in this survey and to begin, please select the link below:

[SURVEY LINK]

Information about the research study

The goals of this research study are:

1. To evaluate well-being outcomes from a group drama therapy peer support program for nurse leaders.
2. To understand what interpersonal support skills might be associated with nurse leader well-being outcomes.
3. To explore feedback related to the peer support program and discover barriers and facilitators associated with nurse leader well-being.

Your participation in the research study is completely voluntary and will involve responding to one electronic post- intervention survey assessing the outcomes of the program at the end of the 8-weeks of optional coaching. The survey consists of 55 questions and takes approximately 15 minutes to complete.

- Former knowledge about drama therapy and peer support are not necessary.
- Participation is strictly anonymous
- You are free to choose not to participate in the research and to discontinue your participation in the research at any time by quitting the survey.
- No identifying details will be collected by the researcher.

Participation in the research is not required and the survey will not be accessible without your agreement to participate. If you choose not to take the survey it will not affect your employment, job performance, or relationship with your supervisor, hospital leadership, or CHI Memorial. You will not be evaluated based on survey participation or responses. All research data collected will be strictly confidential, anonymous, and will only be reviewed by the researcher. No individual responses from the survey will be reported and only de-identified, aggregated data will be presented for quality improvement, in scholarly activities, or for publication..

Potential Benefits of Participating in this Research:

Taking part in this study may involve some emotional discomforts as well as offering certain benefits to you such as improvements to the organization and support environment for the nursing community at CHI Memorial. Responding to the research survey may provide valuable information related to the quality of peer support programs within the context of your work

environment. At a time when alleviating workplace stress is critical, this study may provide evidence to assist in the development of beneficial support programs for nurses and nurse leaders at CHI Memorial. There are no guarantees that you will benefit from taking part in this study. However, your responses will help me evaluate the effectiveness of this program, to further develop peer support programs for nurse leader well-being, and to share its value with the nursing and creative arts therapy professions.

Potential Risks of Participating in this Research:

There are minimal risks and discomforts associated with participation in this research, however survey questions related to well-being and workplace distress may elicit strong emotions. Should that occur, support is available from a member of the well-being committee or spiritual care. To be connected to those resources participants may contact: Betsy_kammerdiener@memorial.org or the Employee Assistance Program:877-679-3819 and https://www.achievesolutions.net/chi

If any problem in connection to the research arises, or if you have any questions, please contact the principal investigator, Chyela Rowe at 423-488-9329 or by email at Chyela.Rowe@commonspirit.org or you may contact the doctoral research supervisor, Jason D. Butler, PhD at 617-349-8242 or by email at jbutler8@lesley.edu

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairperson at irb@lesley.edu

Should you have any questions about your rights, including any concerns or complaints, as a research participant, you may call the Institutional Review Board which is concerned with protection of volunteers in research projects at:

CommonSpirit Health Research Institute Institutional Review Board (CSHRI IRB)
198 Inverness Drive West
Englewood, Colorado 80112
Telephone: toll-free 1-844-626-2299
E-mail: cshri-irb@commonspirit.org

To give your consent to participate in this survey and to begin, please select the link below:

[SURVEY LINK]

Thank you,
Chyela Rowe, MA, RDT, Arts Therapies and Well-Being Program Coordinator
Chyela.Rowe@commonspirit.org

Post- Survey 4-Day Reminder:

Hello Nurse Managers and Directors,

I recently reached out to you with an invitation to participate in the post- intervention research survey associated with the nurse leader peer support program that you participated in this fall. If you have already completed this survey, please disregard this email.

If you have not completed the post- intervention survey and would like to participate, please click the link below. Information about the research project can be found in the previously sent email, on the landing page of the survey link, or you can call or email me with any questions you may have.

Post- Intervention Survey Link:
[SURVEY LINK]

Should you have any questions about your rights, including any concerns or complaints, as a research participant, you may call the Institutional Review Board which is concerned with protection of volunteers in research projects at:

CommonSpirit Health Research Institute Institutional Review Board (CSHRI IRB)
198 Inverness Drive West
Englewood, Colorado 80112
Telephone: toll-free 1-844-626-2299
E-mail: cshri-irb@commonspirit.org

Thank you,
Chyela Rowe, MA, RDT, Arts Therapies and Well-Being Program Coordinator
Chyela.Rowe@commonspirit.org

Post- Survey 1-Day Reminder:

Hello Nurse Managers and Directors,

This is a final reminder for those who wish to complete the post- intervention research survey associated with the nurse leader drama therapy peer support program. After **[survey closing date]** the survey will no longer be available.

If you would like to participate in this research by completing the post- intervention survey, please click the link below:

[SURVEY LINK]

Should you have any questions about your rights, including any concerns or complaints, as a research participant, you may call the Institutional Review Board which is concerned with protection of volunteers in research projects at:

CommonSpirit Health Research Institute Institutional Review Board (CSHRI IRB)
198 Inverness Drive West
Englewood, Colorado 80112
Telephone: toll-free 1-844-626-2299
E-mail: cshri-irb@commonspirit.org

Thank you,
Chyela Rowe, MA, RDT, Arts Therapies and Well-Being Program Coordinator
Chyela.Rowe@commonspirit.org

Appendix D

Pre- Intervention Survey Consent

You are invited to participate in the first part of a research project titled

"Measuring the Outcomes of a Drama Therapy Nurse Leader Peer Support Program."

The drama therapy nurse leader peer support program is being offered by CHI Memorial as a professional development well-being course for all CHI Memorial nurse leaders to address social, emotional, and psychological risks associated with working in healthcare. In this course, a 1-day drama therapy peer support workshop will be required training for nurse leaders, along with optional follow-up coaching sessions to be scheduled over a period of 8 weeks. To better understand the effectiveness of this program, this research study is being conducted and is available for your voluntary participation.

Information about the research study

The goals of this research study are:

1. To evaluate well-being outcomes from a group drama therapy peer support program for nurse leaders.
2. To understand what interpersonal support skills might be associated with nurse leader well-being outcomes.
3. To explore feedback related to the peer support program and discover barriers and facilitators associated with nurse leader well-being.

Your participation in the research study is completely voluntary and will involve responding to one pre- and one post- survey assessing the outcomes of the program. The surveys will be distributed electronically before the workshop and at the end of the 8-weeks of optional coaching. Each survey consists of 55 questions and takes approximately 15 minutes to complete.

- Former knowledge about drama therapy and peer support are not necessary.
- Participation is strictly anonymous.
- You are free to choose not to participate in the research and to discontinue your participation in the research at any time by quitting the survey.
- No identifying details will be collected by the researcher.

Participation in the research is not required and the surveys will not be accessible without your agreement to participate. If you choose not to take the surveys it will not affect your participation in the peer support program, nor will it affect your employment, job performance, or relationship with your supervisor, hospital leadership, or CHI Memorial. You will not be evaluated based on survey participation or responses. All research data collected will be strictly confidential, anonymous, and will only be reviewed by the researcher. No individual responses from the survey will be reported and only de-identified, aggregated data will be presented for quality improvement, in scholarly activities, or for publication..

Potential Benefits of Participating in this Research:

Taking part in this study may involve some emotional discomforts as well as offering certain benefits to you such as improvements to the organization and support environment for the nursing community at CHI Memorial. Responding to the research surveys may provide valuable

information related to the quality of peer support programs within the context of your work environment. At a time when alleviating workplace stress is critical, this study may provide evidence to assist in the development of beneficial support programs for nurses and nurse leaders at CHI Memorial. There are no guarantees that you will benefit from taking part in this study. However, your responses will help me evaluate the effectiveness of this program, to further develop peer support programs for nurse leader well-being, and to share its value with the nursing and creative arts therapy professions.

Potential Risks of Participating in this Research:

There are minimal risks and discomforts associated with participation in this research, however survey questions related to well-being and workplace distress may elicit strong emotions. Should that occur, support is available from a member of the well-being committee or spiritual care. To be connected to those resources participants may contact: Betsy_kammerdiener@memorial.org or the Employee Assistance Program:877-679-3819 and https://www.achievesolutions.net/chi

If any problem in connection to the research arises, or if you have any questions, please contact the principal investigator, Chyela Rowe at 423-488-9329 or by email at Chyela.Rowe@commonspirit.org or you may contact the doctoral research supervisor, Jason D. Butler, PhD at 617-349-8242 or by email at jbutler8@lesley.edu

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairperson at irb@lesley.edu

Should you have any questions about your rights, including any concerns or complaints, as a research participant, you may call the Institutional Review Board which is concerned with protection of volunteers in research projects at:

CommonSpirit Health Research Institute Institutional Review Board (CSHRI IRB)
198 Inverness Drive West
Englewood, Colorado 80112
Telephone: toll-free 1-844-626-2299
E-mail: cshri-irb@commonspirit.org__

__ I Agree (proceed with survey)

__ I do not want to participate in this research

Next

Appendix E

Maslach Burnout Inventory Remote Survey License

Maslach Burnout Inventory™

Instruments and Scoring Keys

Includes MBI Forms:

Human Services - MBI-HSS
Medical Personnel - MBI-HSS (MP)
Educators - MBI-ES
General - MBI-GS
Students - MBI-GS (S)

Christina Maslach
Susan E. Jackson
Michael P. Leiter
Wilmar B. Schaufeli
Richard L. Schwab

Published by Mind Garden, Inc.

info@mindgarden.com
www.mindgarden.com

Important Note to Licensee

If you have purchased a license to reproduce or administer a fixed number of copies of an existing Mind Garden instrument, manual, or workbook, you agree that it is your legal responsibility to compensate the copyright holder of this work — via payment to Mind Garden — for reproduction or administration in any medium. **Reproduction includes all forms of physical or electronic administration including online survey, handheld survey devices, etc.**

The copyright holder has agreed to grant a license to reproduce the specified number of copies of this document or instrument **within three years from the date of purchase.**

You agree that you or a person in your organization will be assigned to track the number of reproductions or administrations and will be responsible for compensating Mind Garden for any reproductions or administrations in excess of the number purchased.

mind garden

www.mindgarden.com

To Whom It May Concern,

The above-named person has made a license purchase from Mind Garden, Inc. and has permission to administer the following copyrighted instrument up to that quantity purchased:

Maslach Burnout Inventory forms: Human Services Survey, Human Services Survey for Medical Personnel, Educators Survey, General Survey, or General Survey for Students.

The three sample items only from this instrument as specified below may be included in your thesis or dissertation. Any other use must receive prior written permission from Mind Garden. The entire instrument form may not be included or reproduced at any time in any other published material. Please understand that disclosing more than we have authorized will compromise the integrity and value of the test.

Citation of the instrument must include the applicable copyright statement listed below.
Sample Items:

MBI - Human Services Survey - MBI-HSS:
I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some recipients.

Copyright ©1981 Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP):
I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some patients.

Copyright ©1981, 2016 by Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

MBI - Educators Survey - MBI-ES:
I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some students.

Copyright ©1986 Christina Maslach, Susan E. Jackson & Richard L. Schwab. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

Cont'd on next page

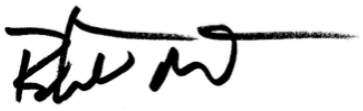
MBI - General Survey - MBI-GS:

I feel emotionally drained from my work.
In my opinion, I am good at my job.
I doubt the significance of my work.

MBI - General Survey for Students - MBI-GS (S):

I feel emotionally drained by my studies.
In my opinion, I am a good student.
I doubt the significance of my studies.

Sincerely,



Robert Most
Mind Garden, Inc.
www.mindgarden.com

PRE – QUESTION #1.

#	**Pre – Q1 What skills do you think will help nurse leaders be able to show support to their peers? RESPONSES**	CODE: Presence / Interaction/ Body Language	CODE: Communi-cation / Reaching Out	CODE: Listening	CODE: Empathy	CODE: Time / Time mgmt	CODE: Feelings /Honesty /Trans-parency	CODE: Self Awareness	CODE: Unsure	CODE: Re-sources
*1	Active listening			1						
*2	Empathy and listening skills			1	1					
*3	Verbal communication, active listening, body language	1	1	1						
4	Communication		1							
5	Being visible	1								
6	Empathy				1					
*7	Freedom and margin to reach out	1	1			1				
8	Empathy				1					
9	Time management. The more time you have to sit and talk with peers, the more you can be there for them and help. You many have pressing matters to take of but being able to take time and actually listen and hear how others are feeling, can benefit peers personally and from a work standpoint.	1	1	1	1	1	1			
*10	Communication; self-awareness		1					1		
*11	Unsure								1	
12	Calmness- no matter what	1								
13	Not sure								1	
14	Listening and resources			1						1
15	Being open, honest, candid, and willing to have real conversations.	1	1				1			
16	Appreciation, kindness and trust	1					1			
17	Active listening; Awareness of resources			1						1
18	How to not feel rushed	1				1	1	1		
19	Learn to listen and be present in the moment	1		1		1		1		
20	More time together with other managers. Less Zoom	1				1				
21	Empathy Communication		1		1					
22	Interpersonal More in person meetings	1								
23	Communication		1							
	TOTALS:	11	8	7	5	5	4	3	2	2

PRE – QUESTION #2.

#	**Pre – Q2: What barriers limit your ability to offer support to your peers at work? RESPONSES**	CODE: Time / Schedule / Workload	CODE: Stress / other personal issues	CODE: Lack of Support from top	CODE: Resistance / body language / lack of trust or safety	CODE: Isolated / Lack of face to face interaction	CODE: Lack of communication / access to resources
*1	Time	1					
2	Time & Availability	1					
*3	Time	1					
*4	Stress and often there is not enough time to offer support	1	1				
*5	Lacking verbal communication, nonactive listening, and poor body language				1		
6	Time commitment	1					
7	Not enough time in the workday to get all the tasks completed	1					
8	The number of meetings I have	1					
9	Inconsistent schedules	1					
*10	Work schedule is often without margin to interact or listen	1					
11	Time. Business	1					
12	Frequent meetings and scheduled events that keep me away from being with peers and patients. Lack of time to speak personally with peers and hear about the wonderful things happening in their lives as well as the not so wonderful	1					
*13	Time management	1					
*14	Time constraints	1					
15	Lack of support from top. Too many unknowns; very isolated		1	1	1	1	
16	Emotional Stress		1				
17	Time/Availability	1					
18	Fear of being labeled or drawn into drama that will add more problems for me		1		1		
19	Workload, lack of support from upper management	1		1			
20	Time	1					
21	Time	1					
22	Lack of clear communication or how to access resources. Barriers to access resources like requiring staff to log in to email QRG's with no printable version			1			1
23	Time	1					
24	Time limitations	1					
25	Time	1					
26	Deadlines. Add-ons. Expected perfection	1	1	1			
27	Lack of face-to-face interaction					1	1
28	Work demands to allow for real conversations	1					
	TOTALS:	22	5	4	3	2	2

PRE – QUESTION #3.

#	**Pre – Q3: What do you hope to gain from participating in the drama therapy nurse leader peer support program? RESPONSES**	CODE: Peer support skills / Insight into other's feelings / Reduce stigma	CODE: Stress mgmt. / Self-care / Coping	CODE: Leadership skills / Communi-cation	CODE: Misc. skills and learning	CODE: Unsure
*1	Ways to help me positively interact with my staff	1	1	1		
*2	Insight to how others are feeling	1				
*3	Learn new techniques to deal with stress and help support others	1	1			
*4	Better grasp and skill for per support	1				
5	Maybe some coping skills		1			
6	Finding new ways to be a better leader			1		
*7	An understanding of how I can support my co-workers	1				
8	Knowing how to help myself and others	1	1			
9	How to effectively support peers as well as supporting myself	1	1			
*10	Sharing my struggles so my peers in the therapy will see it is everyone	1	1			
*11	Unsure					1
12	I will be open, but I truly have no idea what to expect					1
13	Finding peace even on my bad days		1			
14	Ways to support other leaders that are effective without making them feel powerless	1		1		
15	Better deal with uncontrollable circumstances		1			
16	How to better support my team and skills to assist in times of need	1		1		
17	Unknown					1
18	Uncreased sense of peace, better communication skills		1	1		
19	Learn all I can				1	
20	Ways I can improve support to my teams	1		1		
21	Better coping skills. More intentionality		1		1	
22	Learn new skills Networking	1			1	
23	Stress reduction		1			
24	Prioritize				1	
	TOTALS:	**12**	**11**	**6**	**4**	**3**

POST – QUESTION #1.

#	POST – Q1: What was your overall impression of the drama therapy nurse leader peer support program? RESPONSES	CODE: Helpful / Well-done / new approach	CODE: Self-Care / Feelings	CODE: Need more of this for everyone	CODE: Not as bad as expected	CODE: Need more real-world takeaways	CODE: Good to be with peers
1	I enjoyed it. I feel like talking about how we deal with our feelings is often not discussed. I often put others before myself, so it was nice to be made to look inward.	1	1				
2	I was wary at first, but opened up after I realized that it allowed me to express feelings in creative ways	1	1		1		
3	I liked the program, but I would suggest including more real-world takeaways.	1				1	
4	It was not as bad as I expected				1		
5	Well done.	1					
6	Very beneficial and enjoyable time spent with peers. Every employee should attend a session.	1		1			1
7	very helpful and could use more often	1		1			
	TOTALS:	**6**	**2**	**2**	**2**	**1**	**1**

POST – QUESTION #2.

#	POST – Q2: What did you find most beneficial about the workshop and / or follow-up coaching sessions? RESPONSES	CODE: Self-Care / Awareness	CODE: A need for follow-up / more	CODE: Connection with peers / not feeling alone
1	I am upset that I did not take advantage of the follow up sessions. One of the things I struggle with is putting myself first.	1	1	
2	Tuning into my body's responses to some of the topics other talked about. Like my heart rate increased at someone mentioning being a perfectionist which I did not think was an "issue" for me, but I had a physical reaction to that.	1		
3	The reminder to focus on self-care	1	1	
4	Knowing I'm not alone	1		1
5	Workshop was a nice break from day-to-day job.	1		
6	My peers are feeling the same emotions that I am feeling. Learning how to take the first steps to improve my wellbeing and then having an opportunity to follow-up. This wasn't a task to check off a list but a plan to follow to improve my home and work life balance.	1	1	1
7	dividing into groups and seeing how I'm similar and different from other leaders was interesting	1		1
	TOTALS:	7	3	3

POST – QUESTION #3.

#	POST – Q3: What suggestions do you have to improve future well-being support programs for nurse leaders? RESPONSES	CODE: Make time for more / include other leaders	CODE: More tangible take-away tools / real-world application
1	Continue to do them.	1	
2	Finding time is always an issue. I feel that we are pulled in twelve directions and don't give the time/importance to supporting each other.	1	
3	Focus on practicing the suggested tools in real world situations.		1
4	Great JOB not my wheelhouse		
5	Maybe some tangible take-away tools as reminders of how to put learned concepts into practice (besides the journal; it was great). Example: "Key chain" with the C-words to sit on desk and flip through as reminder…		1
6	Include other leaders that aren't nurses. Mixing the dynamic of leaders and their service lines to help grow relationships and community among our leaders.	1	
7	have it more than just a one-time workshop	1	
	TOTALS:	**4**	**2**

FACILITATOR FIELD NOTES

#	Facilitator Field Notes: Laura L. Wood &. Chyela Rowe from August 2022 – February 2023	CODE: Buy-in	CODE: Access
1	Scheduling workshops complicated by staffing issues, workload, lack of availability of meeting rooms on certain dates, and messaging/communication challenges and limitations.		1
2	Several leaders confirmed attendance and then cancelled at the last minute or did not show up to workshops	1	1
3	Several leaders did not respond or engage at all with workshop recruitment and scheduling efforts	1	
4	Senior leader assumptions were that workshops should be organized by leader role, or department grouping but scheduling issues made that impossible. They found a lot of value from being in mixed groups and hearing about other people's experiences in different areas or roles.	1	
5	Grief/loss is huge for most leaders, and they want to have more opportunities to talk about and share losses with one another to help with healing/moving forward from their experiences with so much change and loss	1	1
6	Some are not interested in engaging on an emotional level at all, while others find a lot of value in discussing emotions and feelings with colleagues as the topic relates to their jobs	1	
7	They are exhausted of the hero narrative, and this has contributed to the challenge of approaching the topic of burnout with nurses	1	1
8	They need a high level of buy in to find value in the initiatives	1	
9	Everything we deliver must have a dual purpose: to both be beneficial that they can do as a nurse manager and use with their staff nurses, as well as a tool they can use in their own life. The distance of working under the guise of "you can use this for your staff" is essential	1	1
10	Beyond punitive measures, there are few resources for helping staff proactively when they are struggling		1
11	The medical model approach is embedded in the leadership style		1
12	Make art materials available throughout – key and using art tools to ground as they learn the psycho education is valuable	1	1
13	The outer shell of the nurse is tough, but the window of tolerance is very small so all work must be titrated	1	
14	More success was had when we could frame the workshop as not about changing the hospital but empowering them to look at this workshop as what could be in their control	1	
15	The work demands perfectionism which makes it challenging to not broadly apply this demand to all aspects of how nurses think and work.	1	1
16	This framework is needed to help approach topics such as perfectionism, vulnerability, etc.	1	
17	This training would be helpful for all staff and would allow them to better implement the strategies taught		1
18	A half-day version for staff nurses, not focused on leading exercises but to teach self-care/compassion concepts (parts/IFS, C-words, etc) so everyone can communicate the same language		1
19	Need to better understand the long-term tension and complex relationship between nurses and doctors and how to work with and address that	1	1
20	Follow up coaching was an under-utilized resource and probably could have used a more robust recruitment protocol to encourage engagement. Barriers to this resource remain unclear	1	1
21	Coaching sessions may need to be built-in or encouraged from senior leadership so leaders feel that they can make time to access coaching		1
	TOTALS:	**15**	**14**

REFERENCES

Adams, J. G., & Walls, R. M. (2020). Supporting the health care workforce during the COVID-19 global epidemic. *JAMA, 323*(15), 1439-1440. https://doi.org/10.1001/jama.2020.3972

Albal, E., Sahin-Bayindir, G., Alanli, O., & Buzlu, S. (2021). The effects of psychodrama on the emotional awareness and communication skills of psychiatric nurses: A randomized controlled trial. *The Arts in Psychotherapy, 75,* Article 101826. https://doi.org/10.1016/j.aip.2021.101826

Ali, A., Wolfert, S., Lam, I., & Rahman, T. (2018). Intersecting modes of aesthetic distance and mimetic induction in therapeutic process: Examining a drama-based treatment for military-related traumatic stress. *Drama Therapy Review*, *4*(2), 153–165. https://doi.org/10.1386/dtr.4.2.153_1

Allison, C., Baron-Cohen, S., Wheelwright, S. J., Stone, M. H., & Muncer, S. J. (2011). Psychometric analysis of the Empathy Quotient (EQ). *Personality and Individual Differences*, *51*(7), 829-835. https://doi.org/10.1016/j.paid.2011.07.005

Altmann, T. & Roth, M. (2020). The risk of empathy: Longitudinal associations between empathy and burnout. *Psychology & Health, 36*(12), 1441-1460. https://doi.org/10.1080/08870446.2020.1838521

American Organization for Nursing Leadership (2023). *About AONL*. https://www.aonl.org/about/overview

Amine, K. (2018). Decolonizing theatre history in the Arab world. *Horizons/Théâtre, 12*, 10-25. https://doi.org/10.4000/ht.279

Applebee, G. (2006). A brief history of medical professionalism--and why

professionalism matters: as the medical profession evolves, the issues and challenges change, but the ongoing discussion continues to enrich professional practice. *Contemporary Pediatrics*, *23*(10), 53-60. https://link.gale.com/apps/doc/A456345080/AONE?u=tel_oweb&sid=googleScholar&xid=2d63613b

Aristotle. (2013). *The poetics.* (I. Bywater, Trans.). The Project Gutenberg EBook. https://www.gutenberg.org/files/6763/6763-h/6763-h.htm

Armstrong, C. R., Frydman, J. S., Rowe, C. (2019). A snapshot of empirical drama therapy research: Conducting a general review of the literature. *GMS Journal of Arts Therapies 1*:2. https://doi.org/10.3205/jat000002

Armstrong, C. R., Frydman, J. S., & Wood, S. (2019). Prominent themes in drama therapy effectiveness research. *Drama Therapy Review*, *5*(2), 173–215. https://doi.org/10.1386/dtr_00002_1

Armstrong, C. R., Tanaka, S., Reoch, L., Bronstein, L., Honce, J., Rozenberg, M., Powell, M. A. (2015). Emotional arousal in two drama therapy core processes: Dramatic embodiment and dramatic projection. *Drama Therapy Review, 1*(2), 147-160. https://doi.org/10.1386/dtr.1.2.147_1

Armstrong, C. R., Bronstein, L., Gingras, G., Han, E., Honce, J., Powell, M. A., & Rozenberg, M. (2016). A step toward empirical evidence: Operationalizing and uncovering drama therapy change processes. *The Arts in Psychotherapy*, *49*, 27-33. https://doi.org/10.1016/j.aip.2016.05.007

Aydogdu, A. L. F. (2023). Challenges faced by nurse managers during the COVID-19

pandemic: an integrative review. *Journal of Research in Nursing*, *28*(1), 54–69. https://doi.org/10.1177/17449871221124968

Back, A. L., Steinhauser, K. E., Kamal, A. H., & Jackson, V. A. (2016). Building resilience for palliative care clinicians: An approach to burnout prevention based on individual skills and workplace factors. *Journal of Pain and Symptom Management, 52*(2), 284-291. https://dx.doi.org/10.1016./j.jpainsymman.2016.02.002

Bailey, S. (2022). Ethnodramatherapy: Integrating research, therapy, theatre and social activism into one method, stephen snow (2022). *Drama Therapy Review*, *8*(2), 289-291. https://doi.org/10.1386/dtr_00112_5

Bansal, P., Bingemann, T. A., Greenhawt, M., Mosnaim, G., Nanda, A., Oppenheimer, J., Sharma, H., Stukus, D., & Shaker, M. (2020). Clinician wellness during the COVID-19 pandemic: Extraordinary times and unusual challenges for the allergist/immunologist. *The Journal of Allergy and Clinical Immunology: In Practice, 8*(6), 1781-1790. https://doi.org/10.1016/j.jaip.2020.04.001

Beauregard, M., Stone, R., Trytan, N., & Sajnani, N. (2017). Systemic barriers in mental health care for LGBTQI and gender nonconforming drama therapists and clients. *Drama Therapy Review*, *3*(2), 285-312. https://doi.org/10.1386/dtr.3.2.285_1

Bechtel, A., Wood, L. L., & Teoli, L. (2020). Re-shaping body image: Tape sculptures as arts-based social justice. *Arts in Psychotherapy*, *68*, N.PAG. https://doi.org/10.1016/j.aip.2019.101615

Bellack, J. P., & Dickow, M. (2019). Why nurse leaders derail: preventing and

rebounding from leadership failure. *Nursing Administration Quarterly*, *43*(2), 113-122. https://doi.org/10.1097/NAQ.0000000000000345

Bixler, J. (1949). *Play in Therapy.* New York, Wiley.

Blacker, J., Watson, A., & Beech, A. R. (2008). A combined drama-based and CBT approach to working with self-reported anger aggression. *Criminal Behaviour and Mental Health*, *18*(2), 129-137. https://doi.org/10.1002/cbm.686

Boal, A. (1995). The rainbow of desire: the Boal method of theatre and therapy. (trans. A. Jackson). Routledge

Boal, A. (1979). *Theater of the oppressed.* New York. NY: Theatre Communications Group.

Bogue, R. J., & Carter, K. F. (2022). The nurse wellbeing self-assessment supports the model of leadership influence for health professional wellbeing. *Nursing Outlook*, *70*(3), 478-486. https://doi.org/10.1016/j.outlook.2022.02.001

Boland, L. L., Mink, P. J., Kamrud, J. W., Jeruzal, J. N., & Stevens, A. C. (2019). Social support outside the workplace, coping styles, and burnout in a cohort of EMS providers from Minnesota. *Workplace Health & Safety*, *67*(8), 414-422. https://doi.org/10.1177/2165079919829154

Bornmann, B. A. (2022). Drama Therapy Family Mask Protocol in a forensic setting: Participant and therapist experience. *Drama Therapy Review*, *8*(2), 281-287. https://doi.org/10.1386/dtr_00111_7

Bornmann, B. A., & Crossman, A. M. (2011). Playback Theatre: Effects on students' views of aggression and empathy within a forensic context. *The Arts in Psychotherapy*, *38*(3), 164-168. https://doi.org/10.1016/j.aip.2011.04.004

Brady, K. J., Ni, P., Sheldrick, R. C., Trockel, M. T., Shanafelt, T. D., Rowe, S. G., Schneider, J. I., & Kazis, L. E. (2020). Describing the emotional exhaustion, depersonalization, and low personal accomplishment symptoms associated with Maslach Burnout Inventory subscale scores in US Physicians: An item response theory analysis. *Journal of patient-reported outcomes*, *4*, 1-14. https://doi.org/10.1186/s41687-020-00204-x

Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*, *9*(1), 3–26. https://doi.org/10.1037/qup0000196

British Association of Dramatherapists. (2020). About us. https://www.badth.org.uk/about-us

Brown-Johnson, C. G., Chan, G. K., Winget, M., Shaw, J. G., Patton, K., Hussain, R., Olayiwola, J. N., Chang, S., & Manoney, M. (2019). Primary care 2.0: Design of a transformational team-based practice model to meet the quadruple aim. *American Journal of Medical Quality*, *34*(4), 339-347. https://doi.org/10.1177/1062860618802365

Buchan, J., Catton, H., & Shaffer, F. (2022). Sustain and retain in 2022 and beyond: The global nursing workforce and the COVID-19 pandemic. *International Council of Nurses*. https://www.intlnursemigration.org/wp-content/uploads/2022/01/Sustain-and-Retain-in-2022-and-Beyond-The-global-nursing-workforce-and-the-COVID-19-pandemic.pdf

Buck, K., Williamson, M., Ogbeide, S., & Norberg, B. (2019). Family physician burnout and resilience: A cross-sectional analysis. *Family Medicine, 51*(8), 657-663. https://doi.org/10.22454/FamMed.2019.424025

Büssing, A., Falkenberg, Z., Schoppe, C., Recchia, D. R., & Poier, D. (2017). Work stress associated cool down reactions among nurses and hospital physicians and their relation to burnout symptoms. *BMC Health Services Research, 17*(551), 1-13. https://doi.org/10.1186/s12913-017-2445-3

Byers, O. M., Fitzpatrick, J. J., McDonald, P. E., & Nelson, G. C. (2021). Giving while grieving: Racism-related stress and psychological resilience in Black/African American registered nurses. *Nurse Outlook, 69,* 1039-1048. https://doi.org/10.1016/j.outlook.2021.05.010

Card, A. J. (2018). Physician burnout: Resilience training is only part of the solution. *Annals of Family Medicine, 16*(3), 267-270. https://doi.org/10.1370/afm.2223

Carter, K. F., & Bogue, R. J. (2022). Application of the model of leadership influence for health professional wellbeing during COVID-19. *Nursing Outlook, 70*(3), 458-464. https://doi.org/10.1016/j.outlook.2022.02.010

Cassidy, S., Turnbull, S., & Gumley, A. (2014). Exploring core processes facilitating therapeutic change in Dramatherapy: A grounded theory analysis of published case studies. *The Arts in Psychotherapy, 41*(4), 353–365. https://doi.org/10.1016/j. aip.2014.07.003

Chapman, E. J. (2014). Using dramatic reality to reduce depressive symptoms: A qualitative study. *The Arts in Psychotherapy, 41*(2), 137-144. https://doi.org/10.1016/j.aip.2014.01.001.

Chattopadhyay, M. (2013). A historical study of ancient Indian theatre-communication in the light of Natyashastra. *Global Media Journal: Indian Edition, 4*(2), 1–16.

Christianson, J., Johnson, N., Nelson, A., & Singh, M. (2022). Work-related burnout,

compassion fatigue, and nurse intention to leave the profession during COVID-19. *Nurse Leader*, https://doi.org/10.1016/j.mnl.2022.06.007

Clarke, V., & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling & Psychotherapy Research*, *18*(2), 107–110. https://doi.org/10.1002/capr.12165

Clough, B. A., March, S., Leane, S., & Ireland, M. J. (2019). What prevents doctors from seeking help for stress and burnout? A mixed-methods investigation among metropolitan and regional-based Australian doctors. *Journal of Clinical Psychology*, *75*(3), 418-432. https://doi.org/10.1002/jclp.22707

Cohen, N. (1944). Puppetry with psychoneurotic soldiers. *Puppetry Journal*, 4(2), 7-9.

CommonSpirit Health (2022, November 9). News and perspectives: CommonSpirit update. https://www.commonspirit.org/news-and-perspectives/news/statement-it-security-issue

Cook, A. (2021). A post-intentional phenomenological investigation of inclusivity in a therapeutic theatre production. *Drama Therapy Review*, *7*(2), 169-191. https://doi.org/10.1386/dtr_00072_1

Curran, F. (1939). The drama as a therapeutic measure in adolescents. *American Journal of Orthopsychiatry*, *9*, 215.

Davidoff, E. (1939). Reactions of a juvenile delinquent group to story and drama techniques. *Psychiatric Quarterly*, *13*, 245-258.

Dent-Brown, K., & Wang, M. (2006). The mechanism of storymaking: A grounded theory study of the 6-part story method. *The Arts in Psychotherapy*, *33*(4), 316-330. https://doi.org/10.1016/j.aip.2006.04.002

Dev, V., Fernando, I. A. T., Lim, A. G., & Consedine, N. S. (2018). Does self-compassion mitigate the relationship between burnout and barriers to compassion? A cross-sectional quantitative study of 799 nurses. *International Journal of Nursing Studies, 81*, 81-88. https://doi.org/10.1016/j.ijnurstu.2018.02.003

de Witte, M., Orkibi, H., Zarate, R., Karkou, V., Sajnani, N., Malhotra, B., Ho, R. T. H., Kaimal, G., Baker, F. A., & Koch, S. C. (2021). From therapeutic factors to mechanisms of change in the creative arts therapies: A scoping review. Frontiers in Psychology, 12, Article 678397. https://doi.org/10.3389/fpsyg.2021.678397

Dohrn, J., Ferng, Y-H., Shah, R., Diehl, E., & Frazier, L. (2021). Addressing mental and emotional health concerns experienced by nurses during the COVID-19 pandemic. *Nursing Outlook, 70*(1), 81-88. https://doi.org/10.1016/j.outlook.2021.07.009

Doomen, L. (2018). The effectiveness of schema focused drama therapy for cluster C personality disorders: An exploratory study. *The Arts in Psychotherapy, 61*, 66-76. https://doi.ort/10.1016/j.aip/2017.12.002

Dimino, K., Learmonth, A., & Fajardo, C. C. (2021). Nurse managers leading the way: Reenvisioning stress to maintain healthy work environments. *Critical Care Nurse, 41*(5), 52-58. https://doi.org/10.4037/ccn2021463

Duarte, J. & Pinto-Gouveia, J. (2017). Empathy and feelings of guilt experienced by nurses: A cross-sectional study of their role in burnout and compassion fatigue symptoms. *Applied Nursing Research. 35*, 42-47. https://doi.org/10.1016/j.apnr.2017.02.006

Dunne, P., Afary, K., Paulson, P. (2021). Narradrama. In D. R. Johnson & R. Emunah (Eds.) *Current Approaches in Drama Therapy (3rd Ed.).* p. 206-249. Thomas.

Dutheil, F., Aubert, C., Pereira, B., Dambrun, M., Moustafa, F., Mermillod, M., Baker, J. S., Trousselard, M., Lesage, F.-X, & Navel, V. (2019). Suicide among physicians and health-care workers: A systematic review and meta-analysis. *PLoS One, 14*(12), e0226361. https://doi.org/10.1371/journal.pone.0226361

Dyrbye, L N., West, C. P., Satele, D., Boone, S., Tan, L., Sloan, J., & Shanafelt, T. D. (2014). Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Academic Medicine, 89*(3), 443-451. https://doi.org/10.1097/ACM.0000000000000134

Dyrda, L. (2023, February 16). CommonSpirit took $150M hit from ransomware attack. *Becker's Health IT.* https://www.beckershospitalreview.com/cybersecurity/commonspirit-took-150m-hit-from-ransomware-attack.html

Ehrlich, H., McKenney, M., & Elkbuli, A. (2020). Strategic planning and recommendations for healthcare workers during the COVID-19 pandemic. *American Journal of Emergency Medicine, 38*(7), 1446-1447. https://doi.org/10.1016/j.ajem.2020.03.057

Emunah, R. (2020). *Acting for real: Drama therapy process, technique, and performance (2nd Ed.)*. Routledge.

Epstein, R. M., & Krasner, M. S. (2013). Physician resilience: What it means, why it matters, and how to promote it. *Academic Medicine, 88*(3), 301-303. https://doi.org/10.1097/ACM.0b013e318280cff0

Fancourt, D., & Finn, S. (2019). What is the evidence on the role of the arts in improving health and well-being? A scoping review. *Health Evidence Network (HEN) Synthesis Report, 67*. Copenhagen: WHO Regional Office for Europe. https://www.who.int/europe/publications/i/item/9789289054553

Felsman, P., Gunawardena, S., & Seifert, C. (2020). Improv experience promotes divergent thinking, uncertainty tolerance, and affective well-being. *Thinking Skills and Creativity, 35*, 1-14. https://doi.org/10.1016/j.tsc.2020.100632

Felsman, P., Seifert, C. M., Sinco, B., & Himle, J. A. (2023). Reducing social anxiety and intolerance of uncertainty in adolescents with improvisational theater. *The Arts in Psychotherapy, 82*, 101985. https://doi.org/10.1016/j.aip.2022.101985

Feniger-Schaal, R., & Koren-Karie, N. (2021). Using drama therapy to enhance maternal insightfulness and reduce children's behavior problems. *Frontiers in Psychology, 11*, Article 586630. https://doi.org/10.3389/fpsyg.2020.586620

Fink, A. M., & Milbrath, G. R. (2023). A concept analysis of nurses in conflicts after World War II. *Journal of Advanced Nursing*, 79, 31– 47. https://doi.org/10.1111/jan.15454

Frydman, J. S., Cook, A., Armstrong, C. A., Rowe, C., Kern, C. (2022). The drama therapy core processes: A Delphi study establishing a North American perspective. *Arts in Psychotherapy*, Article 101939 (In Press). https://doi.org/10.1016/j.aip.2022.101939

Frydman, J. S. & Mclellan. (2014). Complex trauma and executive functioning:

Envisioning a Cognitive-based, trauma-informed approach to drama therapy. In N. Sajnani & D. R. Johnson, Eds. Trauma-Informed Drama Therapy: Transforming Clinics, Classrooms, and Communities. P. 152- Charles C. Thomas

Frydman, J. S., & Segall, J. (2016). Investigating the glass escalator effect among registered drama therapists: A gender-based examination of professional trajectory. *Drama Therapy Review, 2*(1), 25-39. https://doi.org/10.1386/dtr.2.1.25_1

Fryrear, J. L., & Stephens, B. C. (1988). Group psychotherapy using masks and video to facilitate intrapersonal communication. *The Arts in Psychotherapy, 15*(3), 227-234. https://doi.org/10.1016/0197-4556(88)90007-X

Gee, P. M., Weston, M. J., Harshman, T., & Kelly, L. A. (2022). Beyond burnout and resilience: The disillusionment phase of COVID-19. *AACN Advanced Critical Care*. https://doi.org/10.4037/aacnacc2022248

Geiss, D., Confino, M., Wei, E., Reyes, M., Coll, J., Rodriguez, T., Foster-Mahfuz, A., Foote, B. A., Segall, J., Mastromano, C., Bajaj, K.. (2022). Answering the call to action: A multimodal wellness response to psychological distress in health care workers during the COVID-19 pandemic in the Bronx. American Journal of Medical Quality, 37(3),191-199. https://doi.org/10.1097/JMQ.0000000000000003

Giddens, J., & Mansfield, J. A., (2023). A new era for nursing education: Implications for practice. *Journal for Nurses in Professional Development 39*(1),1-4. https://doi.org/10.1097/NND.0000000000000955

Giordano, F., Scarlata, E., Baroni, M., Gentile, E., Puntillo, F., Brienza, N., & Gesualdo,

L. (2020). Receptive music therapy to reduce stress and improve wellbeing in Italian clinical staff involved in COVID-19 pandemic: A preliminary study. *The Arts in Psychotherapy, 70,* Article 101688. https://doi.org/10.1016/j.aip.2020.101688

Gleichgerrcht E, & Decety J (2013) Empathy in clinical practice: How individual dispositions, gender, and experience moderate empathic concern, burnout, and emotional distress in physicians. *PLOS ONE 8*(4): e61526. https://doi.org/10.1371/journal.pone.0061526

Godfrey, K. M., & Scott, S. D. (2021). At the heart of the pandemic: Nursing peer support. *Nurse Leader.* 1541-4612. https://doi.org/10.1016.j.mnl.2020.09.006

Goldsby, E., Goldsby, M., Neck, C. B., & Neck, C. P. (2020). Under pressure: Time management, self-leadership, and the nurse manager. *Administrative Sciences*, *10*(3), 38. http://dx.doi.org/10.3390/admsci10030038

Gordon, J., Shenar, Y., & Pendzik, S. (2018). Clown therapy: A drama therapy approach to addiction and beyond. Arts in Psychotherapy, 57, 88–94. https://doi.org/10.1016/j.aip.2017.12.001

Grabbe, L., Higgins, M. K., Baird, M., Craven, P. A., & San Fratello, S. (2020). The Community Resiliency Model® to promote nurse well-being. *Nurse Outlook, 68*(3), 324-336. https://doi.org/10.1016/j.outlook.2019.11.002

Griffith, D. M., & Semlow, A. R. (2020). Art, anti-racism and health equity: "Don't ask me why, ask me how!" *Ethnicity and Disease, 30*(3), 373-380. https://doi.org/10.18865/ed.30.3.373

Hales, T. W., & Nochajski, T. H. (2019). A structural regression analysis of trauma-

informed climate factors, organizational commitment, and burnout among behavioral healthcare providers in a large public hospital. *Journal of Community Psychology. 48*, 777-792. https://doi.org/10.1002/jcop.22292

Havsteen-Franklin, D., de Knoop, J., Agtarap, T., Hackett, S., & Haeyen, S. (2023). Evaluation of an arts therapies approach to team development for non-acute healthcare teams in low control and high-pressure environments, *The Arts in Psychotherapy*, 83, Article 102003. https://doi.org/10.1016/j.aip.2023.102003

Hill, J. E., Harris, C., Danielle L., C., Boland, P., Doherty, A. J., Benedetto, V., Gita, B. E. & Clegg, A. J. (2022). The prevalence of mental health conditions in healthcare workers during and after a pandemic: Systematic review and meta-analysis. *Journal of Advanced Nursing*, 78, 1551– 1573. https://doi.org/10.1111/jan.15175

Hinton, D. E., & Kirmayer, L. J. (2017). The flexibility hypothesis of healing. *Culture, Medicine & Psychiatry, 41*(1), 3-34. https://doi.org./10.1007/s11013-016-9493-8.

Hobeck, J. (2014). Dramatherapy with parents and children in parallel groups: Developing an approach for healthier family dynamics. *Dramatherapy, 36*(2-3), 104-120. https://doi.org/10.1080/02630672.2015.1014389

Holman, D., Simmons, D., Ockenden, N., & Graffy, J. P. (2021). Learning from the experience of peer support facilitators and study nurses in diabetes peer support: A qualitative study. *Chronic Illness, 17*(3), 269-282. https://doi.org/10.1177/1742395319873378

Horwitz, S. (1945). The spontaneous drama as a technique in group therapy. *Nervous Child Journal*, 4, 252-273.

Houser, M. M., Worzella, G., Burchsted, S., Marquez, C., Domack, T., & Acevedo, Y.

(2018). Wellness skills for medical learners and teachers: Perspective taking and cognitive flexibility. *Medical Education Portal, 14*(10674), 1-10. https://doi.org/10.15766/mep_2374-8265.10674

Hricová, M. (2020). The mediating role of self-care activities in the stress-burnout relationship. *Health Psychology Report, 8*(1), 1-9. https://doi.org/10.5114/hpr.2019.89988

Huang, L., Lin, G., Tang, L., Yu, L., & Zhou, Z. (2020). Special attention to nurses' protection during the COVID-19 epidemic. *Critical Care, 24,* Article 120. https://doi.org/10.1186/s13054-020-2841-7

Huet, V. (2015). Literature review of art therapy-based interventions for work-related stress. *International Journal of Art Therapy, 20*(2), 66-76. https://doi.org/10.1080/17454832.2015.1023323

Hunt, P. A., Denieffe, S., & Gooney, M. (2017). Burnout and its relationship to empathy in nursing: A review of the literature. *Journal of Research in Nursing*, *22*(1/2), 7–22. https://doi.org/10.1177/1744987116678902

Ilievová, Ľ., Žitný, P., & Karabová, Z., (2015). The effectiveness of drama therapy on preparation for diagnostic and therapeutic procedures in children suffering from cancer. *Journal of Health Sciences*, *5*(2), pp.53-58.

Javidi, N., Khalathbarib, G., & Javidi, N. (2022). The effectiveness of psychodrama on reducing generalized anxiety and changing metacognitive beliefs in women with breast cancer. *Medibiotech Journal, 6*(1), 7-14. https://medbiotech.net/article_144288.html

Jennings, S., & Holmwood, C. (Eds.). (2016). *Routledge international handbook of*

drama therapy. Routledge.

Johnson, D. R. (2021). Development of the modern profession of drama therapy in North America. In D. R. Johnson & R. Emunah, (Eds.) *Current Approaches in Drama Therapy* (3rd Ed.), p. 5-21. Thomas

Johnson, D. R. (1988). The diagnostic role-playing test. *The Arts in Psychotherapy, 15*(1), 23-36. https://doi.org/10.1016/0197-4556(88)90049-4

Johnson, P. B. (2019). Caring for the caregiver: Achieving the quadruple aim through a peer support program. *Nurse Leader*, 1541-4612. https://doi.org/10.1016/j.mnl.2019.03.009

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

Jones, P. (1996). *Drama as therapy: Theatre as living*. Psychology Press.

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. In The Arts in Psychotherapy, 35 pp. 271–279). https://doi.org/10.1016/j.aip.2008.06.004

Jones, P. (2014). Narrative vignettes and online inquiry in researching therapist accounts of practice with children in schools: An analysis of the methodology. *Counselling and Psychotherapy Research, 14*(3), 227–234. https://doi.org/10.1080/14733145.2013.813953

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.

Jose, S. (2016). *Progressing through grief: Guided exercises to understand your emotions and recover from loss*. Althea Press.

Jung, C. G. (1915). *The theory of psychoanalysis* (No. 19). Journal of nervous and mental disease publishing Company.

Jung, C. G. (1936). The concept of the collective unconscious. *Collected works*, *9*(1), 99-104. http://www.bahaistudies.net/asma/The-Concept-of-the-Collective-Unconscious.pdf

Jung, H.-S., & Baek, E. (2020). A structural equation model analysis of the effects of emotional labor and job stress on depression among nurses with long working hours: Focusing on the mediating effects of resilience and social support. *Work*, *66*(3), 561–568. https://doi.org/10.3233/WOR-203198

Kalmoe, M. C., Chapman, M. B., Gold, J. A., & Giedinghagen, A. M. (2019). Physician suicide: A call to action. *Missouri Medicine, 116*(3), 211-216. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6690303/

Kaur, E. (2021). The elephant in the room – Becoming a Sikh dramatherapist: An a/r/tographic journey of utilising an intersectional feminist approach with Landy's role method to challenge power and privilege in dramatherapy. *Dramatherapy, 42*(1–3), 7–17. https://doi.org/10.1177/02630672221121446

Kaynan, B., & Wade, C. (2018). Therapeutic theatre as family therapy: Integrating drama therapy and experiential family therapy. *Drama Therapy Review, 4*(1), 9-23

Kejani, M., & Raeisi, Z. (2020). The effect of drama therapy on working memory and its components in primary school children with ADHD. *Current Psychology*, 41, 417-426. https://doi.org/10.1007/s12144-019-00564-8

Kostidakis, T. (2021). Dramatherapy and Greek traditional shadow puppetry. In R. Hougham & B. Jones, (Eds.), *Dramatherapy: The nature of interruption*. Routledge.

Kelly, L. (2020). Burnout, compassion fatigue, and secondary trauma in nurses: Recognizing the occupational phenomenon and personal consequences of caregiving. *Critical Care Nursing Quarterly, 4*3(1), 73-80. https://doi.org/10.1097/CNQ.0000000000000293

Keulen-de Vos, M., van den Broek, E. P. A., Bernstein, D. P., Keulen-de Vos, M., van den Broek, E. P. A., & Vallentin, R. (2017). Evoking emotional states in personality disordered offenders: An experimental pilot study of experiential drama therapy techniques. *The Arts in Psychotherapy, 53*, 80-88. https://doi.org/10.1016/j.aip.2017.01.003

Khalid, I., Khalid, T. J., Oabajah, M. R., Barnard, A. G., & Qushmaq, I. A. (2016). Healthcare workers emotions, perceived stressors and coping strategies during a MERS-CoV outbreak. *Clinical Medicine & Research, 14*(1), 7-14. https://doi.org/10.3121/cmr.2016.1303

Kim, J. S., & Choi, J. S. (2016). Factors influencing emergency nurses' burnout during an outbreak of Middle East Respiratory Syndrome coronavirus in Korea. *Asian Nursing Research, 10*(4), 295-299. https://doi.org/10.1016/janr.2016.10.002

Klein, C. J., Dalstrom, M. D., Weinzimmer, L. G., Cooling M., Pierce, L., & Lizer, S. (2020). Strategies of advanced practice providers to reduce stress at work. *Workplace Health & Safety, 68*(9), 432-442. https://doi.org/10.1177/2165079920924060

Kratscheid, L., DeMeester, D. A., Orton, V., Smith, A., Livingston, C., & McLennon, S. M. (2017). Moral distress and associated factors among baccalaureate nursing students: A multisite descriptive study. *Nursing Education Perspectives, 38*(6), 313-319. https://doi.org/10.1097/01.NEP.0000000000000214

Krieger, T., Zimmermann, J., Huffziger, S., Ubl, B., Diener, C., Kuehner, C., & Holtforth, M. G. (2014). Measuring depression with a well-being index: further evidence for the validity of the WHO Well-Being Index (WHO-5) as a measure of the severity of depression. *Journal of affective disorders*, *156*, 240-244.

Kuhn, C. M., & Flanagan, E. M. (2017). Self-care as a professional imperative: Physician burnout, depression, and suicide. *Canadian Journal of Anaesthesia = Journal Canadien d'anesthésie, 64*(2), 158-168. https://doi.org/10.1007/s12630-016-0781-0

Labrague, L. J. (2021). Psychological resilience, coping behaviours and social support among health care workers during the COVID-19 pandemic: A systematic review of quantitative studies. *Journal of Nursing Management, 29*, 1893-1905. https://doi.org/10.1111/jonm.13336

Labrague, L. J., McEnroe-Petitte, D. M., Leocadio, M. C., Van Bogaert, P., & Cummings, G. G. (2018). Stress and ways of coping among nurse managers: An integrative review. *Journal of Clinical Nursing, 27*(7-8), 1346-1359. https://doi.org/10.1111/jocn.14165

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., Wu, J., Du, H., Chen, T., Li, R., Tan, H., Kang, L., Yao, L., Huang, M., Wang, H., Wang, G., Liu, Z., & Hu, S. (2020). Factors associated with mental health outcomes among health care workers

exposed to coronavirus disease 2019. *JAMA Network Open, 3*(3), Article e203976. https://doi.org/10.1001/jamanetworkopen.2020.3976

Lancee, W. J., Maunder, R. G., Goldbloom, D. S., & SARS Study. (2008). Prevalence of psychiatric disorders among Toronto hospital workers one to two years after the SARS outbreak. *Psychiatric Services, 59*(1), 91-95. https://doi.org/10.1176/ps.2008.59.1.91

Lara-Cabrera, M. L., Betancort, M., Muñoz-Rubilar, A., Rodríguez-Novo, N., Bjerkeset, O., & Cuevas, C. D. L. (2022). Psychometric properties of the WHO-5 well-being index among nurses during the COVID-19 pandemic: A cross-sectional study in three countries. *International Journal of Environmental Research and Public Health*, *19*(16), 10106. https://doi.org/10.3390/ijerph191610106

Larkin, P. (2022). Self-compassion for clinicians. In D. L. Harris and A. H. Y. Ho (Eds.), *Compassion-Based Approaches in Loss and Grief*. (1st Ed.). Routledge.

Lassner, R. (1947). Playwriting and acting as diagnostic therapeutic techniques with delinquents. *Journal of Clinical Psychology, 3*, 349-356.

Lawson, C., & Weberg, D. (2023). Leading through times of transformation: Purpose, trust, and co-creation. *Nurse Leader*. https://doi.org/10.1016/j.mnl.2023.01.015

Le Cunff, A-L. (2022). *Habits, routines, rituals.* Ness Labs. https://nesslabs.com/habits-routines-rituals

Lefevre, G. (1948). A theoretical basis for dramatic production as a technique of psychotherapy, Mental Health, 12-15.

Lee, S. M., Kang, W. S., Cho, A.-R., Kim, T., & Park, J. K. (2018). Psychological impact

of the 2015 MERS outbreak on hospital workers and quarantined hemodialysis patients. *Comprehensive Psychiatry, 87*, 123-127. https://doi.org/10.1016/j.comppsych.2018.10.003

Lemaire, J. B., & Wallace, J. E. (2010). Not all coping strategies are created equal: A mixed methods study exploring physicians self-reported coping strategies. *BMC Health Services Research, 10*, 208-217. https://doi.org/10.1186/1472-6963-10-208

Lewis, S., Willis, K., Bismark, M., & Smallwood, N. (2022). A time for self-care? Frontline health workers' strategies for managing mental health during the COVID-19 pandemic. *SSM - Mental Health, 2*, Article 100053-. https://doi.org/10.1016/j.ssmmh.2021.100053

Lim, B. T., Moriarty, H., & Huthwaite, M. (2011). "Being-in-role": A teaching innovation to enhance empathetic communication skills in medical students. *Medical Teacher, 33*(12), e663-e669. https://doi.org/10.3109/0142159X.2011.611193

Locke, R., & Lees, A. (2020). A literature review of interventions to reduce stress in doctors. *Perspectives in Public Health, 140*(1), 38-53. https://doi.org/10.1177/1757913919833088

Loveridge, S. (2017). Straight talk: nurse manager role stress. *Nursing Management, 48*(4), 20-27. https://doi.org/10.1097/01.NUMA.0000514058.63745.ad

Lundén, M., Lundgren, S. M., Morrison-Helme, M., & Lepp, M. (2017). Professional

development for radiographers and post-graduate nurses in radiological interventions: Building teamwork and collaboration through drama. *Radiography, 23*(4), 330-336. https://doi.org/10.1016/j.radi.2017.06.005

Lyle, J. & Holly, S. B. (1941). The therapeutic value of puppets. *Bulletin of the Menninger Clinic, 5*, 223-226.

MacKay, B., Gold, M., & Gold, E. (1987). A pilot-study in drama therapy with adolescent girls who have been sexually abused. *The Arts in Psychotherapy, 14*(1), 77-84. https://doi.org/10.1016/0197-4556(87)90037-2

Mahomed, F. (2020). Addressing the problem of severe underinvestment in mental health and well-being from a human rights perspective. *Health and human rights*, *22*(1), 35. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348439/

Maslach, C., Jackson, S. E., Leiter, M. P. (2018). *Maslach Burnout Inventory Manual* (4th Ed.). Mind Garden, Inc. www.mindgarden.com

Maslach, C., & Leiter, M. P. (2017). New insights into burnout and health care: Strategies for improving civility and alleviating burnout. *Medical Teacher*, *39*(2), 160–163. https://doi.org/10.1080/0142159X.2016.1248918

Maunder, R. G., Lancee, W. J., Balderson, K. E., Bennett, J. P., Borgundvaag, B., Evans, S., Fernandes, C. M. B., Goldbloom, D. S., Gupta, M., Hunter, J. J., Hall, L. M., Nagle, L., M., Pain, C., Peczeniuk, S. S., Raymond, G., Read, N., Rourke, S. B., Steinberg, R. J, Stewart, T. E., …Wasylenki, D. A. (2006). Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak. *Emerging Infectious Diseases, 12*(12), 1924-1932. https://doi.org/10.3201/eid1212.060584

Maynard, K. (2018). To be Black. To be a Woman. Can dramatherapy help Black women to discover their true self despite racial and gender oppression? *Dramatherapy, 39*(1), 31-48. https://doi.org/10.1080/02630672.2018.1432668

Mayor, C. (2019). Drama therapists as 'double agents': Being caught by and creatively resisting neoliberal school reform climate. *Drama Therapy Review, 5*(1), 49-67. https://doi.org/10.1386/dtr.5.1.49_1

Mayor, C., & Frydman, J. (2021). Understanding school-based drama therapy through the core processes: An analysis of intervention vignettes. *Arts in Psychotherapy, 73*, 1-10. https://doi.org/10.1016/j.aip.2021.101766

McAlonan, G. M., Lee, A. M., Cheung, V., Cheung, C., Tsang, K. W. T., Sham, P. C., Chua, S.E., & Wong, J. G. W. S. (2007). Immediate and sustained psychological impact of an emerging infectious disease outbreak on health care workers. *Canadian Journal of Psychiatry, 52*(4), 241-247. https://doi.org/10.1177/070674370705200406

McKeon, J. (2022, November 10). Most EHRs back online at CommonSpirit Health following ransomware attack. *Health IT Security.* https://healthitsecurity.com/news/most-ehrs-back-online-at-commonspirit-health-following-ransomware-attack

McLachlan N., & Laletin L. (2015). An evaluation of a mindfulness group in CAMHS using dramatherapy practice. *Dramatherapy, 37*(2-3), 78-88. https://doi.ort/10.1080/02630672.2016.1162823

Melvin, E. (2021). Investigating dramatherapists' experiences of adult clients' stigma in

relation to their mental health difficulties. *The Arts in Psychotherapy, 73*, Article 101768. https://doi.org/10.1016/j.aip.2021.101768

Membrive-Jiménez, M. J., Velando-Soriano, A., Pradas-Hernandez, L., Gomez-Urquiza, J. L., Romero-Béjar, J. L., Cañadas-De la Fuente, G. A., & De la Fuente-Solana, E. I. (2022). Prevalence, levels and related factors of burnout in nurse managers: A multi-centre cross-sectional study. *Journal of Nursing Management, 30*(4), 954-961. https://doi.org/10.1111/jonm.13575

Michaeli, I. (2017). Self-Care: An Act of Political Warfare or a Neoliberal Trap? *Development, 60*(1/2), 50–56. https://doi.org/10.1057/s41301-017-0131-8

Moreno, J. L. (1946). Psychodrama Vol. 1, New York, Beacon House.

Moreno, J. L., & Jennings, H. H. (1934). *Who shall survive?: A new approach to the problem of human interrelations*. Nervous and mental disease publishing co. [electronic resource]

Mukhalalati, B. A., & Taylor, A. (2019). Adult learning theories in context: a quick guide for healthcare professional educators. *Journal of medical education and curricular development, 6*. https://doi.org/10.1177/2382120519840332

Mulder, L., Belay, Bl, Mukhtar, Q., Lang, J. E., Harris, D., & Onufrak, S. (2020). Prevalence of workplace health practices and policies in hospitals: Results from the workplace health in America study. *American Journal of Health Promotion, 34*(8), 867-875. https://doi.org/10.1177/0890117120905232

Munjuluri, S., Bolin, P. K., Amy Lin, Y. T., Garcia, N. L., Gauna, L., Nguyen, T., &

Salas, R. (2020). A pilot study on playback theatre as a therapeutic aid after natural disasters: Brain connectivity mechanisms of effects on anxiety. *Chronic Stress*. https://doi.org/10.1177/2470547020966562

Murthy, R. S., & Lakshminarayana, R. (2006). Mental health consequences of war: a brief review of research findings. *World psychiatry*, *5*(1), 25. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472271/

Musicka-Williams A (2020) "We copy to join in, to not be lonely": Adolescents in special education reflect on using dramatic imitation in group dramatherapy to enhance relational connection and belonging. Frontiers in Psychology, 11, Article 588650. https://doi.org/10.3389/fpsyg.2020.588650

National Academies of Sciences, Engineering, and Medicine (NASEM) (2019). *Taking action against clinician Burnout: A systems approach to professional well-being.* Washington, DC: The National Academies Press. https://doi.org/10.17226/25521

Nazaire, K. (2021). The effectiveness of Build-A-Bop as a tool to build self-efficacy on an inpatient unit. *Expressive Therapies Capstone Theses*. 447. https://digitalcommons.lesley.edu/expressive_theses/447

Nitsun, M., Stapleton, J., & Bender, M. (1974). Movement and drama therapy with long-stay schizophrenics. *British Journal of Medical Psychology, 47*, 101-119. https://doi.org/10.1111/j.2044-8341.1974.tb02275.x

Nurmeksela, A., Mikkonen, S., Kinnunen, J., & Kvist, T. (2021). Relationships between nurse managers' work activities, nurses' job satisfaction, patient satisfaction, and medication errors at the unit level: a correlational study. *BMC Health Services Research*, *21*(1), 1–13. https://doi.org/10.1186/s12913-021-06288-5

Nursing Executive Center. (2018). *Rebuild the foundation for a resilient workforce: Best practices to repair the cracks in the care environment.* The Advisory Board Company. https://www.advisory.com/topics/nurse-engagement-and-burnout/2018/08/rebuild-the-foundation-for-a-resilient-workforce

North American Drama Therapy Association (2022, June 15). https://www.nadta.org/what-is-dramatherapy-

O'Connor, M.-F., & Seeley, S. H. (2022). Grieving as a form of learning: Insights from neuroscience applied to grief and loss. *Current Opinion in Psychology*, *43*(1), 317–322. https://doi-org.ezproxyles.flo.org/10.1016/j.copsyc.2021.08.019

O'Dowd, E., O'Connor, P., Lydon, S., Mongan, O., Connolly, F., Diskin, C., McLoughlin, A., Rabbitt, L., McVicker, L., Reid-McDermott, B., & Byrne, D. (2018). Stress, coping, and psychological resilience among physicians. *BMC Health Services Research, 18,* Article 730. https://doi.org/10.1186/s12913-018-3541-8

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

Park, J. S., Lee, E. H., Park, N. R., & Choi, Y. H. (2018). Mental health of nurses working at a government-designated hospital during a MERS-CoV outbreak: A cross-sectional study. *Archives of Psychiatric Nursing*, *32*(1), 2-6. https://doi.org/10.1016/j.apnu.2017.09.006

Patel, V., Brackman, S., Shafi, U., Causey, A., Melnik Allen, L., Dittmar, A., & Panda,

M. (2021). Overview of an emergent, arts-based resiliency curriculum to mitigate medical trainee burnout. *Arts & Health*, *13*(1), 98-106. https://doi.org/10.1080/17533015.2020.1802608

Pendzik, S. (2021). Autobiographical therapeutic performance in drama therapy. *Current approaches in drama therapy. 3rd ed.* Springfield, IL: Charles C. Thomas, 338-361.

Pendzik, S. (2006). On dramatic reality and its therapeutic function in drama therapy. *The Arts in Psychotherapy, 33*, 271-280. https://doi.org/10.1016/j.aip.2006.03.001

Penconek, T., Tate, K., Bernardes, A., Lee, S., Micaroni, S. P., Balsanelli, A. P., de Moura, A. A., & Cummings, G. G. (2021). Determinants of nurse manager job satisfaction: A systematic review. *International Journal of Nursing Studies*, *118*, 103906. https://doi.org/10.1016/j.ijnurstu.2021.103906

Perls, F. S. (1951). *Gestalt therapy: Excitement and growth in the human personality*. Delta Book.

Petersen, J., Wendsche, J., & Melzer, M. (2023). Nurses' emotional exhaustion: Prevalence, psychosocial risk factors and association to sick leave depending on care setting—A quantitative secondary analysis. *Journal of Advanced Nursing*, *79*(1), 182-193. https://doi.org/10.1111/jan.15471

Peterson, U., Bergström, G., Samuelsson, M., Åsberg, M., & Nygren, Å. (2008). Reflecting peer-support groups in the prevention of stress and burnout: Randomized controlled trial. *Journal of Advanced Nursing, 63*(5), 506-516. https://doi.org/10.1111/j.1365-2648.2008.04743.x

Poghosyan, L., Aiken, L. H., & Sloane, D. M., (2009). Factor structure of the Maslach

burnout inventory: An analysis of data from large scale cross-sectional surveys of nurses from eight countries. *International Journal of Nursing Studies, 46*, 894-902. https://doi.org/10.1016/j.ijnurstu.2009.03.004

Prasad, K., McLoughlin, C., Stillman, M., Poplau, S., Goelz, E., Taylor, S., Nankivil, N., Brown, R., Linzer, M., Cappelucci, K., Barbouche, M., & Sinsky, C. A. (2021). Prevalence and correlates of stress and burnout among US healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study. *EClinicalMedicine, 35*, 100879. https://doi.org/10.1016/j.eclinm.2021.100879

Rahmani, F. Hosseinzadeh, M., & Gholizadeh, L. (2023). Complicated grief and related factors among nursing staff during the Covid-19 pandemic: a cross-sectional study. BMC Psychiatry, 23(73). https://doi.org/10.1186/s12888-023-04562-w

Ray, P., & Pendzik, S. (2021). Autobiographical therapeutic performance as a means of improving executive functioning in traumatized adults. *Frontiers in Psychology, 12*, Article 599914. https://doi.org/10.3389/fpsyg.2021.599914

Reider, N., Olinger, D., & Lyle, J. (1939). Amateur dramatic as a therapeutic agent in the psychiatric hospital. Bulletin of the Menninger Clinic, 3(1), 20-26.

Reitz, K. M., Terhorst, L., Smith, C. N., Campwala, I. K., Owoc, M. S., Downs-Canner, S. M., Diego, E. J., Switzer, G. E., Rosengart, M. R., & Myers, S. P. (2021). Healthcare providers' perceived support from their organization is associated with lower burnout and anxiety amid the COVID-19 pandemic. *PloS one, 16*(11), e0259858. https://doi.org/10.1371/journal.pone.0259858

Rousseau, C., Gomez-Carrillo, A., & Cénat, J. (2022). Safe enough? Rethinking the

concept of cultural safety in healthcare and training. *The British Journal of Psychiatry, 221*(4), 587-588. https://doi.org/10.1192/bjp.2022.102

Russell, A., de Wildt, G., Grut, M., Greenfield, S., & Clarke, J. (2022). What can general practice learn from primary care nurses' and healthcare assistants' experiences of the COVID-19 pandemic? A qualitative study. *BMJ Open,12,* Article 055955. https://doi.org/10.1136/bmjopen-2021-055955

Sajnani, N., & Johnson, D. R. (2014). *Trauma-informed drama therapy: Transforming clinics, classrooms, and communities*. Charles C. Thomas, Publisher, Ltd.

Sajnani, N., Marxen, E., & Zarate, R. (2017). Critical perspectives in the arts therapies: Response/ability across a continuum of practice. *The Arts in Psychotherapy, 54,* 28-37. https://doi.org/10.1016/j.aip.2017.01.007

Sajnani, N., Tomczyk, P., Bleuer, J., Dokter, D., Carr, M., & Bilodeau, S. (2016). Guidelines on cultural response/ability in training, research, practice, supervision, advocacy and organizational change. *Drama Therapy Review, 2*(1), 141–149. https://doi.org/10.1386/dtr.2.1.141_7

Savage, M. (2018). Young women adopted from foster care create personal public service announcements: Narrative constructs in arts-based enquiry. *Qualitative Research in Psychology*. https://doi.org/10.1080/14780887.2018.1442692

Schlak, A. E., Rosa, W. E., Rushton, C. H., Poghysyan, L., Root, M. C., & McHugh, M. D. (2022). An expanded institutional- and national-level blueprint to address nurse burnout and moral suffering amid the evolving pandemic. *Nursing Management, 53*(1), 16-27. https://doi.org/10.1097/01.NUMA.0000805032.15402.b3

Schneider, A., Hering, C., Peppler, L., & Schenk, L. (2023). Effort-reward imbalance and its association with sociocultural diversity factors at work: findings from a cross-sectional survey among physicians and nurses in Germany. *International Archives of Occupational and Environmental Health*, 1-13.

Schwartz, R. C. (2021). *No bad parts: Healing trauma & restoring wholeness with the Internal Family Systems model*. Sounds True. https://doi.org/10.1080/00207284.2020.1805616

Seppälä, P., Mauno, S., Feldt, T., Hakanen, J., Kinnunen, U., Schaufeli, W., & Tolvanen, A. (2009). The construct validity of the Utrecht Work Engagement Scale: Multisample and longitudinal evidence. *Journal of Happiness Studies*, *10*(4), 459–481. https://doi.org/10.1007/s10902-008-9100-y

Shah, M. K., Gandrakota, N., Cimiotti, J. P., Ghose, N., Moore, M., & Ali, M. K. (2021). Prevalence of and factors associated with nurse burnout in the US. *JAMA Network Open, 4*(2), Article e2036469. https://doi.org/10.1001/jamanetworkopen.2020.36469

Shanafelt, T. D., Boone, S., Tan, L., Dyrbye, L. N., Sotile, W., Satele, D., West, C. P., Sloan, J., & Oreskovich, M. R. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, *172*(18), 1377-1385. https://doi.org/10.1001/archinternmed.2012.3199

Shanafelt, T. D., West, C. P., Dyrbye, L. N., Trockel, M., Tutty, M., Wang, H., Carlasare, L. E., & Sinsky, C. (2022). Changes in burnout and satisfaction with work-life integration in physicians during the first 2 years of the COVID-19 pandemic.

Mayo Clinic Proceedings, 97(12), 2248-2258. https://doi.org/10.1016/j.mayocp.2022.09.002

Shapiro, J., & Galowitz, P. (2016). Peer support for clinicians: A programmatic approach. *Academic Medicine, 91*(9), 1200-1204. https://doi.org/10.1097/ACM.0000000000001297

Sherlock, C., & John, C. (2016). Adaptation practice: Teaching doctors how to cope with stress, anxiety and depression by developing resilience. *British Journal of Medical Practitioners, 9*(2), 1-7. https://www.bjmp.org/content/adaptation-practice-teaching-doctors-how-cope-stress-anxiety-and-depression-developing-resilience

Shiyab, W. E., Ferguson, C., Rolls, K., & Halcomb, E. (2023). Solutions to address low response rates in online surveys. *European Journal of Cardiovascular Nursing*, zvad030.

Sibeoni, J., Bellon-Champel, L., Mousty, A., Manolios, E., Verneuil, L., & Revah-Levy, A. (2019). Physicians' perspectives about burnout: A systematic review and metasynthesis. *Journal of General Internal Medicine*, *34*, 1578-1590. https://doi.org/10.1007/s11606-019-05062-y

Singh, T., Johnston, A. C., D'Arcy, J., & Harms, P. D. (2023). Stress in the cybersecurity profession: a systematic review of related literature and opportunities for future research. *Organizational Cybersecurity Journal: Practice, Process and People*.

Sischka, P. E., Costa, A. P., Steffgen, G., & Schmidt, A. F. (2020). The WHO-5 well-

being index – validation based on item response theory and the analysis of measurement invariance across 35 countries. *Journal of Affective Disorders Reports, 1*, Article 100020. https://doi.org/10.1016/j.jadr.2020.100020

Smallwood, N., Bismark, M., & Willis, K. (2023). Burnout in the health workforce during the COVID-19 pandemic: Opportunities for workplace and leadership approaches to improve well-being. *BMJ Leader*. https://doi.org/10.1136/leader-2022-000687

Snow, S., D'Amico, M., & Tanguay, D. (2003). Therapeutic theatre and well-being. *The Arts in Psychotherapy, 30*(2), 73-82. https://doi.org/10.1016/S0197-4556(03)00026-1

Solomon, A. P. (1950). Drama Therapy, in W. R. Dunton (ed.) Occupational Therapy, Principles and Practice, Springfield, IL, Charles C. Thomas.

Solomon, A. P., & Fentress, T. L. (1947). A critical study of analytically orientated group psychotherapy utilizing the technique of dramatization of the psychodynamics. *Occupational Therapy and Rehabilitation, 26,* 423.

Sonke, J., Rollins, J., Brandman, R., & Graham-Pole, J. (2009). The state of the arts in healthcare in the United States. *Arts & Health: International Journal for Research, Policy & Practice, 1*(2), 107-135. https://doi.org/10.1080/17533010903031580

Sonnentag, S. & Fritz, C. (2007). The recovery experience questionnaire: Development and validation of a measure for assessing recuperation and unwinding from work. *Journal of Occupational Health Pyschology, 12*(3), 204-221. https://doi.org/10.1037/1076-8998.12.3.204

Spencer, R., Pryce, J. M., & Walsh. J. (2014). Philosophical approaches to qualitative research. In P. Levy, (Ed.), *The Oxford Handbook of Qualitative Research*, p. 81-89. Oxford.

Spreng, R. N., McKinnon, M. C., Mar, R. A., & Levine, B. (2009). The Toronto Empathy Questionnaire: Scale development and initial validation of a factor-analytic solution to multiple empathy measures. *Journal of Personality Assessment, 91*(1), 62-71. https://doi.org/10.1080/00223890802484381

Stevens, A. D. F., Bleuer, J., Morris, M. E., Shamir, O., Weisman, P. S., Wichmann, S., & Nasser, K. (2020). Black Lives Matter: A call to action and position statement from the Cultural Humility, Equity and Diversity Committee of the North American Drama Therapy Association. *Drama Therapy Review*, *6*(2), 239-246.

Sullivan, G. M., Berger, J. S., Yarris, L. M., Artino, A. R., Jr., & Simpson, D. (2018). Are physicians commodities? The perspective of a group of JGME editors. *Journal of Graduate Medical Education, 10*(4), 374-375. https://doi.org/10.4300/JGME-D-18-00501.1

Swensen, S. J., & Shanafelt, T. D. (2020). *Strategies to reduce burnout: 12 actions to create the ideal workplace*. Mayo Clinic Scientific Press.

Taku, K. (2014). Relationships among perceived psychological growth, resilience and burnout in physicians. *Personality and Individual Differences*, *59*, 120-123. https://doi.org/10.1016/j.paid.2013.11.003

Tamata, A. T., & Mohammadnezhad, M. (2023). A systematic review study on the factors affecting shortage of nursing workforce in the hospitals. *Nursing open*, *10*(3), 1247-1257. https://doi.org/10.1002/nop2.1434

Tang, S. X., Seelaus, K. H., Moore, T. M., Taylor, J., Moog, C., O'Connor, D., Burkholder, M., Kohler, C. G., Grant, P. M., Eliash, D., Calkins, M. E., Gur, R. E., & Gur, R. C. (2019). Theatre improvisation training to promote social cognition: A novel recovery-oriented intervention for youths at clinical risk for psychosis. *Early Intervention in Psychiatry*, 1-9. https://doi.org/10.1111/eip.12834

Tedding van Burkhout, E., & Malouff, J. M. (2016). The efficacy of empathy training: A meta-analysis of randomized controlled trials. *Journal of Counseling Psychology, 63*(1), 32-41. https://doi.org/10.1037/cou0000093

Thomas, V., Lambert, A. W., Wang, C-h., & Gauthier, A. (2020). Using simulation exercises to teach nursing students the concept of empathy. The ABNF Journal, 31(2), 61-66.

Topp, C. W., Østergaard, S. D., Søndergaard, S., & Bech, P. (2015). The WHO-5 Well-Being Index: A systematic review of the literature. *Psychotherapy and Psychosomatics, 84*, 167-176. https://doi.org/10.1159/000376585

Traunmüller, C., Stefitz, R., Gaisbachgrabner, K., & Schwerdtfeger, A. (2020). Psychological correlates of COVID-19 pandemic in the Austrian population. *BMC Public Health, 20*(1), 1-16. https://doi.org/10.1186/s12889-020-09489-5

Trigo, T. R., de Freitas, C. C. S., Wang, Y. P., Ribeiro, F. G., de Lucia, M. C. S., Siqueira, J. O., Iosifescu, D. V., Hallak, J. E. C., & Fraguas, R. (2018). The influence of depression on the psychometric properties of the Maslach Burnout Inventory-Human Services Survey: A cross-sectional study with nursing

assistants. Frontiers in Psychiatry, 9, Article 695. https://doi.org/10.3389/fpsyt.2018.00695

Truax, A. (2020). The queer expansion of role theory: A drama therapy intervention with LGBTQ+ adults. [masters thesis] Digitalcommons.lesley.edu

Tuisku, K., Virtanen, M., De Bloom, J., & Kinnunen, U. (2016). Cultural leisure activities, recovery and work engagement among hospital employees. *Industrial Health, 54*(3), 254-262. https://doi.org/10.2486/indhealth.2015-0124

U.S. Bureau of Labor Statistics. (2020, April 27). Registered nurses made up 30 percent of hospital employment in May 2019. *The Economics Daily*. https://www.bls.gov/opub/ted/2020/registered-nurses-made-up-30-percent-of-hospital-employment-in-may-2019.htm

Van Bommel, T. (2021) The power of empathy in times of crisis and beyond. *Catalyst.* https://www.catalyst.org/reports/empathy-work-strategy-crisis/

Vanheule, S., Rosseel, Y., & Vlerick, P. (2007). The factorial validity and measurement invariance of the Maslach Burnout Inventory for human services. *Stress & Health: Journal of the International Society for the Investigation of Stress*, *23*(2), 87–91. https://doi.org/10.1002/smi.1124

Vávra, J., Valenta, M., Lakota, T., & Šochmanová (2020). Humor in dramatherapy in addicted persons. *Journal of Exceptional People, 1*(16), 78-79. https://www.ceeol.com/search/article-detail?id=979579

Versluys, B. (2017). Adults with an anxiety disorder or with an obsessive-compulsive disorder are less playful: A matched control comparison. *The Arts in Psychotherapy*, *56*, 117-128. https://doi.org/10.1016/j.aip.2017.06.003

Vetter, M. H., Vetter, M. K., & Fowler, J. (2018). Resilience, hope and flourishing are inversely associated with burnout among members of the Society for Gynecologic Oncology. *Gynecologic Oncology Reports, 25*, 52-55. https://doi.org/10.1016/j.gore.2018.06.002

Victorson, D., Sauer, C., Horowitz, B., & Wolf-Beadle, J. (2021). Development and implementation of a brief healthcare professional support program based in gratitude, mindfulness, self-compassion, and empathy. *JONA: The Journal of Nursing Administration*, *51*(4), 212-219. https://doi.org/10.1097/NNA.0000000000001000

Viscardis, K., Changfoot, N., Rice, C., Pileggi, V., Underhill, A., Chandler, E., Montgomery, P., & Mykitiuk, R. (2019). Difference within and without: Health care providers' engagement with disability arts. *Qualitative Health Research, 29*(9), 1287. https://doi.org/10.1177/1049732318808252

von Harscher, H., Desmarais, N., Dollinger, R., Grossman, S., & Aldana, S. (2018). The impact of empathy on burnout in medical students: new findings. *Psychology, Health & Medicine*, *23*(3), 295–303. https://doi.org/10.1080/13548506.2017.1374545

Waddimba, A. C., Scribani, M., Hasbrouck, M. A., Krupa, N., Jenkins, P., & May, J. J. (2016). Resilience among employed physicians and mid-level practitioners in upstate New York. *Health Services Research, 51*(5), 1706-1734. https://doi.org/10.1111/1475-6773.12499

Wade, C. (2020). #UsToo: A musical comedy about sexual assault and harassment. *Drama Therapy Review*, *6*(2), 129-148. http://doi.org/10.1386/dtr_00024_1

Wei, H., Kifner, H., Dawes, M. E., Wei, T. L., & Boyd, J. M. (2020). Self-care strategies to combat burnout among pediatric critical care nurses and physicians. *Critical Care Nurse*, *40*(2), 44-53. https://doi.org/10.4037/ccn2020621

Weston, M. J., & Nordberg, A. (2022). Stigma: A barrier in supporting nurse well-being during the pandemic. *Nurse Leader*, *20*(2), 174-178. https://doi.org/10.1016/j.mnl.2021.10.008

Williams, Britton M. (2017). Role power: Using Role Theory in support of ethical practice. *Drama Therapy Review*, *3*, 1. 131-148. https://doi.org/10.1386/dtr.3.1.131_1

Williams, E. S., Manwell, L. B., Konrad, T. R., & Linzer, M. (2007). The relationship of organizational culture, stress, satisfaction, and burnout with physician-reported error and suboptimal patient care: Results from the MEMO study. *Health Care Management Review*, *32*(3), 203-212. https://doi.org/10.1097/01.HMR.0000281626.28363.59

Wood, L. L. (2015). Eating disorder as protector: The use of internal family systems and drama therapy to help clients understand the protective functions of their eating disorders. In A. Heiderscheit (Ed.), *Creative arts therapies and clients with eating disorders* (pp. 293 – 325). Jessica Kingsley Publishers.

Wood, L. L., & Pignatelli, E. C. (2019). The scribble story technique: An arts-based supervision process. *Journal of Creativity in Mental Health*, *14*(2), 229–242. https://doi.org/10.1080/15401383.2019.1566041

Wood, L. L., & Schneider, C. (2015). Setting the stage for self-attunement: Drama

therapy as a guide for neural integration in the treatment of eating disorders. *Drama Therapy Review*, *1*(1), 55. https://doi.org/10.1386/dtr.1.1.55_1

WADth. (2021). World Alliance of Dramatherapy:Mission and objectives, [English]. https://www.worldallianceofdramatherapy.com/mission

World Health Organization (2022, June 16). Latest: WHO highlights urgent need to transform mental health and mental health care. Newsroom: News Releases. https://www.who.int/news-room/releases/17-06-2022-who-highlights-urgent-need-to-transform-mental-health-and-mental-health-care

Xu, J., Xu, Q., Wang, C., & Wang, J. (2020). Psychological status of surgical staff during the COVID-19 outbreak. *Psychiatry Research, 288,* Article 112955. https://doi.org/10.1016/j.psychres.2020.112955

Yakushko, O., & Blodgett, E. (2021). Negative reflections about positive psychology: On constraining the field to a focus on happiness and personal achievement. *Journal of Humanistic Psychology, 61*(1), 104-131. https://doi.org/10.1177/0022167818794551

Yates, S. W. (2020). Physician stress and burnout. *The American Journal of Medicine, 133*(2), 160-164. https://doi.org/10.1016/j.amjmed.2019.08.034

Ybarra, P. (2020). Gestures toward a hemispheric theatre history: A work in progress. *Theatre History Studies*, *39*, 123. https://doi.org/10.1353/ths.2020.0007

Yuguero, O., Marsal, J. R., Esquerda, M., Vivanco, L., & Soler-González, J. (2017). Association between low empathy and high burnout among primary care physicians and nurses in Lleida, Spain. *European Journal of General Practice, 23*(1), 4-10. https://doi.org/10.1080/13814788.2016.1233173

Yusek, C. (2020). Dealing with stress using social theatre techniques with young Syrian students adapting to a new educational system in Turkey: A case study. *Intervention Journal, 16*(2), 175-180. https://doi.org/10.4103/INTV.INTV_38_18

Zhang, C., Yang, L., Liu, S., Ma, S., Wang, Y., Cai, Z., Du, H., Li, R., Kang, L., Su, M., Zhang, J., Liu, Z., & Zhang, B. (2020). Survey of insomnia and related social psychological factors among medical staff involved in the 2019 novel coronavirus disease outbreak. *Frontiers in Psychiatry, 11*, Article 306. https://doi.org/10.3389/fpsyt.2020.00306

Zimmermann, N. & Mangelsdorf, H. H. (2020). Emotional benefits of brief creative movement and art interventions. *The Arts in Psychotherapy, 70*, Article 101686. https://doi.org/10.1016/j.aip.2020.101686

Zwack, J., & Schweitzer, J. (2013). If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. *Academic Medicine, 88*(3), 382-389. https://doi.org/10.1097/ACM.0b013e3182816